Devonshire Manor Homes Limited

Devonshire Manor

Inspection report

38-40 North Road
Birkenhead
Merseyside
CH42 7JF

Tel: 01516522274
Website: www.devonshiremanorcarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this inspection on 26 and 27 June 2018. The inspection was unannounced.

Devonshire Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Devonshire Manor offers accommodation for people who require support with their personal care. There are 14 single bedrooms and one shared bedroom with communal bathrooms for people to use. A stair lift enables people's access to bedrooms on the upper floors.

On the day of our visit, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post approximately seven months at the time of our visit.

At our last inspection of the service in March 2017, we identified breaches of Regulations 11,12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the management of risk, the implementation of the mental capacity act and the governance arrangements at the home. After the March 2017 inspection, the provider submitted an action plan to CQC outlining the action they intended to take to improve the service. At this inspection we found that the provider had not taken sufficient action to address the breaches we had previously identified in accordance with their action plan. We also identified additional concerns with the management of medication, the safety of the premises, safeguarding people from the risk of abuse, staff training and recruitment. This meant the provider continued to be in breach of Regulations 11,12 and 17 of the Health and Social Care Act with breaches of Regulation 13 (safeguarding people from abuse and improper treatment) Regulation 18 (staffing) and Regulation 19 (fit and proper persons) also identified.

We looked at the care files belonging to three people who lived at the home. We found that people's risks in relation to their care had not always been assessed. Care plans lacked clear information about the management of people's risks and where professional advice had been given, care plans had not always been updated to reflect this. We saw that people's care plans contained some person centred information about their individual needs, wishes and preferences but some of the information about the support people required was generic with the same standard statements made about a number of people's needs. This aspect of care planning required improvement.

Some of the moving and handling practices used by staff to support people's mobility was unsafe. One person's moving and handling needs required further assessment to ensure that the support provided was effective in mitigating the risk of the person falling.

The management of medication was not always safe. People's medication administration records contained missing signatures which meant it was difficult to tell if people had received the medication they needed on certain days. The stock of medication in the home was not always correct and some medication could not be accounted for. Records showed that the manager had identified similar issues in a number of consecutive medication audits. This indicated that the issues we identified during our inspection were repetitive and had not been adequately addressed.

The home was visibly clean and free from odours during our visit. The home's electrical installation, fire alarm, fire extinguishers and moving and handling equipment had all been inspected in accordance with legal requirements. We saw that one of the home's hoists was unsafe to use but staff had not been clearly advised of this. The home's gas installation had been tested and we saw that remedial work was required to ensure the home's boilers were suitable for use. The provider had failed to ensure this remedial work was undertaken in a timely manner. The provider's fire risk assessment was inadequate and the risk of Legionella bacteria developing in the home's water supply had not been risk assessed or checked. Some of the infection control measures employed in the home such as the handling of soiled bedding or clothing required improvement as they did not meet the infection control standards set out by the Department of Health.

Where people's capacity to consent to decisions about their care was in question, the Mental Capacity Act 2005 (MCA) had not always been followed to ensure people's legal consent was obtained. This was discussed with the provider at the last inspection but no adequate action to address this had been taken.

Most of the interactions between staff and people who lived at the home were positive. We observed however that on a few occasions during our visit, people were spoken to abruptly or inappropriately. We discussed this immediately with the manager. We also heard staff talking about people's needs and care with other staff members in front of the person's peers and the person themselves. This was not very respectful and did not show people's right to confidentiality was respected. During our inspection two people's appointments with the practice nurse were undertaken in the communal lounge in front of others. Whilst people's appointments were not of a particularly sensitive nature, people were not given the choice of having their needs discussed in private. This indicated that people's right to privacy was not always promoted in the delivery of care.

Records showed that a number of safeguarding incidents and other incidents of a notifiable nature such as serious injuries had not been properly investigated or reported to the Local Authority or CQC as and when required. Reporting notifiable incidents is a legal requirement of the provider's registration with CQC.

Staff recruitment was not always robust. Adequate checks on the safety and suitability of staff to work with vulnerable people had not always been completed prior to employment. Employment references were not verified and some staff members had been employed to work at the home before either their criminal conviction check had cleared or before previous employer references had been received by the provider. This meant the provider could not be assured that at the time these staff member were employed they were safe to work with vulnerable people.

We looked at staff training records. We saw that three members had not had sufficient training to do their job role. This meant there was a risk that they did not have the skills, knowledge or competency to provide effective and safe support. Despite this the provider had permitted them to work in the home. Staff had received appropriate supervision in their job role from the manager and staffing levels overall were sufficient to meet the needs of the people who lived there.

People said they got enough to eat and drink and that the food provided was good. Catering staff had information on people's special dietary requirements and people's food and drink preferences in order meet people's needs.

People who lived at the home and their relatives spoke positively about the home and the staff. A health care professional we spoke with also told us that people looked well cared for and that the staff team were approachable and pleasant. People told us that staff were kind to them and treated them well. None of the people we spoke with had any complaints or concerns about the service and no formal complaints had been received by the manager since they came into post. The provider's complaints procedure however required improvement. It lacked sufficient information on which organisations people could contact in the event of a complaint. The contact details for the provider and name of the manager were also not provided.

Since the new manager's appointment we saw that they had worked hard to get to know the home, the staff team and the people they cared for. Records showed that they had addressed a number of issues in order to improve the service such as staff attitudes and the day to day practices of staff. Regular staff meetings and resident meetings had been set up to enable staff and people who lived at the home to participate in decisions about the service and to gain their feedback. The manager was at the time of the inspection was in the process of reviewing people's care plans and recognised that further improvements were still required.

The manager had undertaken a range of quality assurance audits to identify and monitor the quality and safety of the service. These audits were ineffective in identifying and addressing the areas of concern we found during the inspection. The provider was involved with the service but their involvement lacked any effectiveness. They had failed to have clear and adequate oversight of the service which meant they failed to address the breaches identified at the last inspection. Furthermore since the last inspection, the quality and safety of the service had declined further. This demonstrated that the governance systems in place were ineffective and that the provider's leadership of the service required significant improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Information with regards to people's risks and their management was not always clear. Moving and handling support was not always safe.

Staffing levels were satisfactory. Staff recruitment was not robust as sufficient checks on a staff member's suitability had not always been undertaken.

Safeguarding incidents were not always identified or reported appropriately.

The premises and the equipment in use were not always safe and infection control procedures required improvement.

Medication administration was not always safe and it was sometimes difficult to tell if people medicines were given as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity was not assessed in accordance with the Mental Capacity Act 2005 where people's capacity to make a specific decision was in question.

Three staff members had not completed sufficient training which meant there was risk they did not have the necessary skills to provide effective care. Staff hadreceived supervision in their job role

People said they were well looked after by staff.

People told us the food was good and they got enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Most of the staff team spoke with people kindly but there were a few occasions were people were spoken to abruptly or in an inappropriate manner. This was disrespectful.

People's right to privacy was not respected and some people's needs were discussed openly in front of others.

People we spoke with were happy with the staff that supported them.

People were supported to maintain relationships with family and friends and their bedrooms were personalised with the things that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans contained some good information about the person but some of the guidance given to staff was generic and was not based on the person's individual needs.

The provider's complaints policy lacked sufficient information on who to contact in the event of a complaint. People we spoke with had no complaints about the service.

People received support from a range of health and social care professionals such as GPs, district nurse, dieticians and speech and language therapy.

Activities for people to enjoy were provided and people's activity preferences were respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to aid good governance but these were not effective. They had not picked up issues we identified during our inspection.

The concerns identified at the last inspection had not been addressed and the provider's leadership of the service was ineffective.

There were opportunities for staff and people who lived at the home to make suggestions for improvement.

Devonshire Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 27 June 2018. The inspection was unannounced. The inspection was carried out by an adult social care inspector.

Prior to our visit we looked at any information we had received about the home and we contacted the Local Authority for their feedback. On the day of the inspection we spoke with three people who lived at the home, two relatives and a visiting healthcare professional. We also spoke with the manager, the provider, a senior carer and a care assistant.

We looked at the home's communal areas and visited a sample of people's individual bedrooms. We reviewed a range of records including three care records, medication records, staff recruitment and training records, policies and procedures and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At the last inspection of the service in March 2017 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's risks in the delivery of care were not always assessed and managed. At this inspection we found the same. We also found concerns with the management of medication and the safety of the premises. This meant that the provider continued to be in breach of Regulation 12 (safe care and treatment). Breaches of Regulation 13 with regards to safeguarding people from abuse and Regulation 19 with regards to the recruitment of staff were also found.

We looked at care files belonging to five people who lived at the home. We saw that risks in relation to malnutrition, pressure sores, moving and handling and falls were all assessed but we found that staff did not always have adequate guidance on how to manage these risks in the delivery of care. Risks associated with people's health conditions were also not properly assessed or described.

For example, one person lived with epilepsy and another person had a health condition that impacted on their breathing. Neither of these medical conditions had been risk assessed and staff had no care plan or risk management advice to follow with regards to the management of these conditions. Some of people who lived at the home lived with mental health needs. This sometimes meant that they experienced episodes of distress or displayed behaviours that challenged. Despite this, people's behavioural risks were not risk assessed and staff had little guidance on how to support the person in a safe and appropriate way.

During our visit we saw that the moving and handling techniques used by staff to support people's mobility was not always safe. On the day of our visit, one person's ability to weight bear was not assessed appropriately by staff before the person was prompted to stand. As a result the person's safety was placed at serious risk. It was obvious that this person was not always able to stand safely. We asked the manager if the person's ability to wear bear and mobilise had been assessed by a healthcare professional to see if they required any equipment to assist them. The manager told us that no assessment had been undertaken. We asked the manager to act on this without further delay.

Medication was kept securely and at safe temperatures. We checked a sample of people's medication administration records (MARs). There were gaps in people's records were staff had not signed the person's medication chart to confirm that the person's medication had been administered. This was poor practice. It meant it was difficult to tell if people had received the medication they needed. We saw that some people regularly refused some of their medication but there was no evidence that staff had taken any action with regards to this. For example, by alerting the person's GP or by re-offering the person their medication later on the same day.

Some medicines needed to be given at specific times in order to work properly and to avoid unwanted and potentially dangerous side effects. We found however that the time at which medicines were administered was not recorded. This meant staff could not be sure that time specific medications or medications that required a set time between doses were given safely. For example, one person's antibiotic medication was

to be given every six hours. The times that this medication was administered were not recorded. This meant it was impossible for staff to tell whether six hours had passed between each dose in order to be sure that the next dose of this medication was safe to administer.

Information on people's medication allergies were not always identified. For example, one person's hospital discharge notes indicated that they were allergic to Penicillin but their medication administration charts stated the person had no medication allergies. This placed the person at risk of being prescribed a medication that was not safe for them to use.

We checked the balance of five medicines to see if the stock of medication left matched what had been administered. We found that the stock of one person's pain relief medication was incorrect and a dose of one person's medication could not be unaccounted for. We saw that the manager had audited medication practices in the home on a regular basis. When we looked at these audits, we saw that there was a consistent pattern of missing staff signatures from people's MARs and discrepancies in the amount of medication left in the home that could not be accounted for. This was similar to what we found during our visit. This did not demonstrate that the management of medication was robust or safe.

External contractors were employed to test and maintain the home's electrical, moving and handling equipment, fire alarm and nurse call bell system. We saw that the electrical installation, fire extinguisher and fire alarm had all been certified as safe to use. Fire extinguishers were in place and regularly serviced. On the day of the inspection, the home's gas safety certificate was out of date. A more up to date certificate was provided after the inspection but this certificate showed that parts of the system required remedial work to be undertaken. We asked the provider for evidence that this work had been completed. The provider advised that the work had not yet been undertaken. This meant that no appropriate action had been taken by the provider to ensure the gas installation was suitable for use.

One of home's hoists had been identified as unsafe to use. Despite this, there was no label or sign on the hoist to alert staff to this or to advise them not to use this equipment. We asked the manager to label the hoist accordingly without delay to prevent staff using this piece of equipment inadvertently to support people's moving and handling needs.

We asked the provider for a copy of their fire risk assessment. This was not available on the day of the inspection but a copy of the last fire risk assessment was emailed to CQC by the provider shortly after the inspection. We saw that the fire risk assessment was completed in December 2017. It had not been fully completed and failed to sufficiently assess and mitigate the risk of a fire occurring at the home.

Three people's automatic bedroom guards that trigger the bedroom door to close in the event of a fire in order to prevent its spread were continually beeping on both days of our inspection. When a door guard beeps it usually means there is a fault. We asked the provider about this. They told us they had changed the batteries in the door guards but that they continued to beep. Despite this the provider had not organised for a competent person or company to visit the home to identify the fault and check that the door guards would still work in the event of a fire. We asked the provider to do this without further delay.

We checked the arrangements in place for the management of Legionella infection. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. The risk of legionella bacteria occurring in the home's water supply had not been risk assessed and there were no checks in place to ensure that the water in use at the home was circulated at temperatures sufficient to control the risk of Legionella.

We saw that the home on the day of our visit was clean but other aspects of infection control required improvement. This was because some of the practices employed at the home did not comply with the Department of Health's "Code of practice on the prevention and control of infection and related guidance. For example, guidance clearly states that "Under no circumstances should a manual sluice facility or sluicing basin be used or situated in the laundry". A manual sluice is normally a sink unit which staff use to flush soiled matter off items such as bedding before putting them in the wash. To prevent cross contamination purposes, this type of equipment should not be placed in the laundry were non soiled items are laundered. The home did not have a proper manual sluice but the manager had told staff to use a bucket in the laundry for sluicing purposes by placing soiled items in the bucket for soaking prior to washing. This was not good infection control practice and contravened the Department of Health's infection control guidance.

During our visit we also saw that two pressure cushions were chipped and cracked which would have made cleaning them for infection control purposes difficult. We asked for these cushions to be taken out of use. The manager acted upon this immediately.

These examples indicate that people's care was not always safe and appropriate. This meant there was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records belonging to four staff members. We found safe recruitment practices had not been followed. Previous employer references sought by the provider had not always been verified. Most of the previous employer references in staff files were on the home's (Devonshire Manor) letterhead. There was no name, address or position of the previous employer or referee on the reference request itself and the references had not been signed or dated. Some references were telephone references that had not been followed up with a written reference and in some cases the reference provided did not correspond with the referee stated on the staff member's application. There was no explanation why. This meant there was no evidence that staff member's references were from appropriate and reliable sources.

We saw that a criminal conviction check was undertaken for each staff member. Three out of the four staff members however commenced working at the home before their criminal conviction check had been cleared and in some instances before their previous employer references were obtained by the manager. This meant that at the time the decision to employ the staff member was made the manager could not be assured the staff member was of good character and suitable to work with vulnerable people.

Where staff members had criminal convictions the risks associated with this were not assessed or considered prior to employment. There was little evidence that additional checks were put into place to monitor the safety and suitability of these staff member's once employed. This placed people who lived at the home at risk.

These example were a breach of Regulation 19 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have robust recruitment procedures in place to check staff were safe and suitable to work in the home.

During our visit, the people we spoke with told us they felt safe at the home. The relatives we spoke with felt the same. We found however improvements to the safety of the service were required. We identified a number of safeguarding incidents that had not been appropriately reported or referred to the Local Authority or CQC. For example, there were a number of physical altercations between some people who lived at the home which had not been properly responded to. A small number of unexplained injuries had also occurred that had not been properly investigated or reported. Unexplained injuries can be a sign of

potential abuse. It is good practice to ensure that any unexplained injuries are fully investigated and reported to the local authority and CQC in accordance with local safeguarding procedures.

These examples were a breach of Regulation 13 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to follow robust safeguarding procedures.

Overall staffing levels at the home were adequate to meet people's needs. There were a couple of times during the inspection when people were sat in the communal lounge without staff supervision. On two occasions we had to seek staff assistance for people as they needed help but once requested staff responded quickly. We spoke with the provider and manager about this. They told us that a staff member was always expected to be in the lounge with people at all times but that they were currently one staff member down on the rota which had impacted on their ability to do this.

People who lived at the home had adequate personal emergency evacuation plans (PEEPs) in place. PEEPs provide emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. This information assists staff and emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation.

We looked at the provider's accident and incident records and saw that when an accident and incident had occurred, staff responded promptly to ensure people received any medical support they required.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us that they could choose how they lived their life at the home. We saw examples of this during our visit. For example, people got up and went to bed at a time of their choosing, they chose how they spent their day and what they wanted to eat and drink. Some people wished to participate in activities whereas others did not and we saw that their choice was respected. We found however that where specific decisions needed to be made about people's care, the provider had not always followed the Mental Capacity Act 2005 (MCA) in order to gain people's consent. This failure to implement and comply with the MCA was identified at the last inspection and the provider assured us that action would be taken. At this inspection, we found that these assurances had not been fulfilled. This meant the provider remained in breach of Regulation 11 (Need for Consent) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some people who lived at the home had dementia or other mental health needs which raised concerns about their ability to understand and consent to certain decisions. When we checked their care files, there was no evidence that the provider had assessed people's capacity to consent when their capacity to do was in question.

For example, one person lived with dementia. Their care records indicated that the local authority had previously raised concerns about their capacity to make some decisions about their care. We saw that this person had recently received hospital treatment but when we checked the person's care file we found no evidence that their capacity to understand and consent to this treatment had been obtained in accordance with the MCA.

We saw that some people were subject to deprivation of liberty safeguards (DoLS) that meant that they were unable to leave their home of their own accord. We saw that there was a MCA assessment form in some people's files but it was unclear if these assessment related to people's DoLs. This was because the specific decision for which these capacity assessment were for had not been identified and the assessment itself was generic. This meant there was little evidence that people's capacity to keep themselves safe outside of the home had been assessed appropriately before a decision to deprive them of their liberty was made.

People's care files contained generic statements about their capacity to consent which suggested people lacked capacity in all areas of decision making. These statements and assumptions did not show that the provider understood the MCA. The MCA states "The MCA states that "A person must be assumed to have capacity unless it is established that he/she lacks capacity".

These examples demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have proper processes in place to ensure people's consent to their care was legally obtained.

We looked at staff training and supervision records. Supervision records showed that staff members had received appropriate supervision in their job role. Training records showed that most staff with the exception of three staff members had completed training in a range of topics such as safeguarding, health and safety, fire, food hygiene, moving and handling, infection control, first aid, dementia care and the mental capacity act. Staff with responsibility for administering medicines had also received training in medication administration.

The three staff members without sufficient training had not completed training in infection control, dementia care, the mental capacity act, fire, food hygiene or safeguarding. One staff member had also not completed moving and handling training. This meant there was a risk that these staff members lacked the skills and knowledge to care for people effectively. We spoke with the manager and provider about these staff members and asked them to ensure that these staff members completed the required training as soon as possible.

These examples demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not all of the staff at the home had completed sufficient training to do their job role.

All of the people and relatives we spoke with told us there was always plenty to eat and drink. Everyone told us the food was good. One person said "Dinner (today) was very nice. I don't really like puddings, so I have ice-cream. I like ice-cream".

People were able to choose where they ate their meals and we saw that people ate in the communal lounge, their own bedroom or the dining room. Most people ate in the dining room or the lounge area. People's meals were served pleasantly and the environment in which people dined was relaxed and sociable. People's meals were of a good portion size and the meals provided looked and smelt appetising. People who required it were gently encouraged and prompted to eat their meal. We saw however that some staff wore latex gloves when serving food or supporting people with their meal which did not look very nice.

We saw that catering staff had information displayed in the kitchen on people's special dietary requirements for example, fortified or soft diets as well as information about people's likes and dislikes. One person did not like vegetables on their plate and on the day of our visit we saw that this person's preferences were respected when their roast dinner was served.

Information in people's care files about their nutritional needs was at times unclear. Where professional advice in respect of people's nutritional well-being had been recommended, care plans had not always been updated consistently to reflect this advice. We saw that changes in people's nutritional health were not always picked up in a timely manner. For example, one person's weight records showed that they had lost half a stone in weight during the previous month. When we checked their dietary records we saw that this person had regularly refused their main meal during the previous month but found no evidence that any

action had been taken to investigate or act on this. We drew this to the manager's attention and they acted on this straightaway. It should not have taken the inspector however to have to point this out before any action was taken.

We saw that people had access to routine healthcare appointments such as dental, optical and chiropody care and one person told us that if they felt unwell staff were quick to organise a doctor's appointment. Records showed people had specialist support from the community dietician, speech and language therapy teams and district nurse with regards to their physical well-being.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with told us staff were kind and treated them well. Relatives we spoke with felt the same. One person said "The girls are nice". One relative told us they were always "Made welcome" when they visited and another said "Staff are very nice".

During our visit, we observed many positive interactions between staff and people who lived at the home. It was obvious that people felt relaxed and comfortable in their company but at times we found that some people were spoken to abruptly or inappropriately by a staff member on duty. This was not very respectful. We drew this to the manager's attention.

We also heard staff discuss people's needs in front of other people who lived at the home and the person themselves, as if the person was 'not there'. This did not show that staff respected people's right to confidentiality or that they considered the person they cared for as a 'person' as opposed to a task. For example, one staff member was heard to say "She's a nightmare" about one person and although this statement was made with no malice it was inappropriate. The person was asleep at the time of this discussion and had no idea that they were being talked openly about in front of their peers in the communal lounge by care staff and domestic staff.

During the afternoon of the second day of our visit, a practice nurse visited two people at the home. These appointments were carried out in the communal lounge. Whilst these consultations were not of a particularly sensitive nature, the consultation by the nurse could be heard by all of the people sat in the lounge. We did not hear staff ask people if they wished to have their consultation with the nurse in private before these consultations were undertaken. This did not demonstrate that people's right to privacy was always promoted.

People's personal records were in the majority stored securely with the exception of people's medication administration records for prescribed creams. These charts were displayed on the back of people's bedroom door and contained details of where people's creams were to be applied including a body map.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect and their right to privacy was not always promoted.

We saw that people were supported to maintain relationships with their friends and family. People's relatives and visitors visited throughout the day and received a warm welcome. We saw that staff tended to people's personal hygiene needs in a discrete and respectful manner.

We saw that people's bedrooms were personalised to them. People had family photographs and the keepsakes that were important to them close at hand. This showed that the service ensured that people had the things that were important to them close by.

Requires Improvement

Is the service responsive?

Our findings

People's care files contained some person centred information that helped staff understand the people they were caring for. There was a 'Take a walk in my shoes' documentation that contained information about the person's past life, occupation, family, likes and dislikes, preferred routines and the things that made them anxious or upset. There was also a pen picture of the person. This was good practice but some information around the support people required was generic. For example, we saw that the same statements about the support people needed was contained in the care files of the three people whose care files we looked at. One person's care plan clearly demonstrated that this information was copied and pasted from one care plan to another as this person's care plan contained the name of the other person whose care plan it had been copied from. We drew this to the manager's attention.

Staff spoken with on the day of our visit had a basic understanding of the day to day care needs of the people they looked after but it was not always sufficient. For example one staff member told us about most of the person's needs but was unclear about the extent and location of the person's skin issues. The manager and the staff member also differed on the support the person required with regards to their continence. It was difficult to tell from the person's care file who was correct as the person's continence information was unclear and not up to date.

We noted that information in people's care files about their end of life wishes was limited. This meant there was a risk that the staff would not know what people's wishes were should their health decline. We also saw that the service was not always responsive to people's needs.

For example, a health and social care professional recommended that one person was given alternative communication strategies such as a set of pictures or gestures to aid non-verbal communication as they found it difficult to communicate verbally. At the time of our inspection there was no evidence this had been acted upon. The new manager was not in post when this advice was given but we asked them to follow it up during the inspection. Another person was experiencing frequent episodes of challenging behaviour but no advice or guidance from a relevant health and social care professional such as the community mental health team had been sought. We asked the manager to seek advice.

We saw that the manager had commenced formal care reviews with people and their relatives in order to discuss their on-going care needs and satisfaction with the service. This was good practice.

Daily records of people's needs and the support they received were maintained. We saw that records showed that people's general day to day care recorded. Some people's dietary intake required monitoring. We saw that this information was recorded appropriately on a food and drink chart by staff members after each mealtime. Where people required thickening medication to be added to their drinks, this was added as required and the staff we spoke with knew the correct amount of thickening agent to add to people's drinks.

On the second day we visited we spoke with a visiting healthcare professional. They told us that whenever

they visited people at the home that they were always smartly presented. They told us that people looked well cared for and that staff were approachable and helpful.

On the days we visited we saw that people enjoyed a pampering session and a group naming game. People participated and enjoyed both. We saw that resident meetings took place regularly and that the activities people would like to participate in were discussed. We saw that in May 2017, people who lived at the home had asked not to have the TV on in the communal lounge but music instead and during our visit we saw that this preference was respected. The type of music people wished to listen to had been discussed and on the days we visited the music playing reflected people's choices. Everyone seemed to enjoy the music and it was a pleasant, homely atmosphere.

We saw that the provider's complaint procedure was displayed on a noticeboard for people to refer to. Details of who to address complaints to was unclear. The name and contact details for the provider were not given. The name of the manager was not stated and the contact details for the local authority complaints department were also not listed. This meant the information displayed required improvement.

People we spoke with were not always able to talk in depth about the care they received but they were able to tell us that they were happy with the support provided. The manager in post was fairly new but the relatives we spoke with told us that they were approachable. One relative told us the new manager "Had sorted a few things out" since arriving and that the service had improved. They told us they had "No complaints". Another relative told us that if it wasn't for Devonshire Manor, their relative "Would not be here".

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of this service we found that the governance arrangements in place to monitor the quality and safety of the service were ineffective. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the service was not well-led. At this inspection we found that the provider had failed to make any adequate improvements to the management of the service and the service continued to be poorly led by the provider. This meant there was a continued breach of Regulation 17.

The previous manager of the service left the employment of the provider in approximately April 2017. The service was without a manager for a period of about 6 months. A new manager of the service was appointed and at the time of this inspection, the manager had only been in post for approximately seven months.

We saw that the manager undertook a range of checks on the quality and safety of the service. These checks were ineffective in identifying or addressing the issues we found during the inspection. For example, the manager's medication audits showed that missing signatures and incorrect stock balances were frequently found and we found the same again during this inspection. The repetitive nature of these discrepancies indicated that the action taken to address them and improve the safety of medication management was ineffective.

People's care records did not always contain accurate, up to date or sufficient information about people's needs or risks and the care they required. There were no objective care plan audits undertaken by the manager to ensure that staff had clear information on people's needs and sufficient guidance on how to provide them with safe and appropriate care.

Health and safety audits were completed. These audits failed to identify that the provider did not have a copy of the home's latest gas safety certificate or that the remedial work recommended by British Gas on the gas installation had not been undertaken. The audits also failed to ensure that an unsafe hoist at the home was clearly labelled and made unavailable for use, that the fire risk assessment was inadequate or that the risk of Legionella was assessed with regards to the home's water supply.

The provider's recruitment policy was poor. It did not clearly outline the steps the provider would take to ensure that staff employed were fit and proper to work with vulnerable people. As a result the provider's governance arrangements were not robust enough to ensure that the recruitment of staff was safe.

Infection control audits were undertaken. We saw that the home on the day of our visit was clean but other aspects of infection control required improvement. For example, the laundering our soiled items, the maintenance and decontamination of shared items such as pressure cushions and hoists and the checking of the home's cleaning schedules to ensure the necessary cleaning activities had been undertaken.

The provider's governance arrangements with regards to ensuring safeguarding incident and other notifiable incidents were investigated and reported appropriately were insufficient. This resulted in a failure

by the provider to notify the Local Authority and CQC of such incidents when they occurred. We advised the provider and the manager that this aspect of governance required better diligence.

These examples indicate that the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not always well-led by the provider in order to ensure risks to people's health, safety and welfare were managed.

Since the manager's appointment we saw that they had worked hard to address some of the issues facing the service. For example, they had identified and addressed a number of staffing issues and concerns relating to the day to day practices of staff. They were in the process of reviewing people's care files in order to make improvements. They had set up a number of care reviews with people and their families to formally review the person's care and their satisfaction with the service. Resident meetings and staff meetings now regularly took place and it was clear from the minutes of these meetings that people and staff were able to discuss their views about the service. The manager had also organised for people's satisfaction of the service to be obtained more formally through the use of a satisfaction questionnaire. A 'You said, We did' board had been set by the manager in the communal corridor to keep people informed of the changes or improvements to the service as a result of people's suggestions. This was good practice. Overall we found that the manager in the short time they had been employed had worked hard to get to know the service, the staff and the people who lived at the home.

On the day of our visit, the culture of the home was open and inclusive. Both the provider and manager were pleasant, approachable and receptive to any feedback given. Staff we spoke with felt supported in the workplace and the people who lived in the home were happy with the support they received. The atmosphere at the home was relaxed and homely and everyone we spoke had something positive to say about the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy, dignity and respect were not always promoted by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to their care had not been assessed in accordance with the MCA 2005 legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not always been investigated or responded to appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who lived at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed The provider did not have robust recruitment procedures in place which ensured that persons employed were safe and suitable to work at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Three staff members had not completed sufficient training to do their job role. This meant there was risk they did not have the skills and knowledge to provide effective care.