Harbour Healthcare Ltd

Devonshire House and Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 and 3 November 2016 and was unannounced. Devonshire House (previously known as Bickleigh Down), provides care across five units. It incorporates three residential units and two nursing units, for people who may require nursing care and for people who are living with dementia. Devonshire House provides care and accommodation for up to 77 people. On the day of the inspection 49 people lived in the home. Devonshire House is owned by Harbour Healthcare Ltd. At the time of the inspection, Harbour healthcare Ltd, had owned Devonshire House for five months.

A manager was employed to manage the service. They were in the process of registering with Care Quality Commission. 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. At the start of the inspection, the manager had been in post for two days. They were supported by a deputy manager who was also new to post, as well as nurses and/or senior carers who were responsible for the day to day running of each unit.

The inspection was prompted in part by notification of an incident following which a service user sustained an injury. The information shared with the CQC about the incident indicated potential concerns about the management of risk of falls relating to new flooring that had been fitted. Incident records showed that only one person had slipped on the new flooring and that the fall had been due to a spilt drink. We identified during the inspection that spillages were not always cleared away as soon as possible. The provider told us they would work with the staff team to improve their practice in this area.

Risk assessments to guide staff how to help mitigate risks relating to people's care were not always up to date, reflective of people's needs or followed by staff. Records to guide staff how to keep people safe if there was an emergency such as a fire were not always clear and during a fire alarm, some staff were not clear what actions to take. The manager and provider were in the process of reviewing everyone's risk assessments and monitoring whether staff followed them. They also told us they would also ensure they clarified the guidance for staff regarding how to keep people safe in an emergency.

People who needed hoists to help them move did not have slings (which are used on the hoist) which had been assessed for their individual needs. This put people at a risk of injury or cross contamination from other people. The provider told us they would immediately order individual slings for people, according to their assessed needs.

People and staff told us there were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. However, these were not always deployed in the most effective way to meet people's needs. On the second day of inspection, this had resulted in two people still being in bed at midday. Staff told us this would not be the normal choice of the individuals. The manager and provider told us they had already made some changes to how staff were deployed and would have a closer overview of this in the

future.

The manager and some staff had attended training on the Mental Capacity Act 2005 (MCA).
Staff had a basic knowledge of the MCA but when people lacked the capacity to make decisions for themselves, care plans did not always provide clear information for staff about how to ensure their rights were protected. The manager told us they would ensure staff received training and support to understand the MCA and review people's care plans to include clear details for staff. Where people's liberty was restricted in their best interests, the correct legal procedures had been followed. We have made a recommendation about the implementation of the MCA.

People were supported to see a range of health and social care professionals including social workers, chiropodists, district nurses and doctors. However, records to monitor people's health were not always completed regularly or accurately. When people were at risk of skin damage, their pressure mattresses had not always been monitored to ensure they were at the correct setting for their needs. Staff also told us they were not aware of best practice regarding skin care for these people. The provider had already identified records were not being completed effectively and had put plans in place to improve recording in the future. The manager told us they would have a close overview of how records were being completed and would arrange training for staff regarding skin care.

The manager and provider had recently implemented actions to improve the safe management of medicines. However, fridge temperatures, recorded to help ensure medicines which required refrigeration remained effective, had not always been recorded. When people had been prescribed medicines to be taken 'when required', information was not always available to staff regarding when to administer the medicines. The manager told us they would have a closer overview of record keeping and work had begun, to improve people's medicines care plans during the inspection.

Staff told us they had not always had the opportunity to read people's care plans and that they were not always easy to understand. People's care plans had not always been reviewed to reflect their up to date needs. Care plans were being transferred to the provider's own system. The provider told us they had asked a senior staff member from a sister home to support the manager and staff to write personalised care plans for people. During the inspection, the manager spent time producing summaries of people's likes, dislikes and care needs to give staff guidance when they were supporting people.

People told us they enjoyed the food. Mealtimes were a positive experience, which people told us they looked forward to. People told us meals were of sufficient quality and quantity and there were always alternatives on offer for them to choose from. People were involved in planning the menus and their feedback on the food was sought.

Some staff had received training in how to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected. The manager told us they would prioritise refreshing staff knowledge of safeguarding. Recruitment practices were safe. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

People told us they felt well cared for. Comments included, "I can't fault the care." We observed staff talking in a kind, affectionate way with people and taking action to alleviate any anxiety.

The manager and provider had clear values about how they wished the service to be provided and these values were being shared with the whole staff team. Staff talked positively about the future of the service

and told us the manager and provider were approachable and transparent. There was a complaints procedure in place and any complaints had been investigated and responded to within the timeframes set out in the policy.

A comprehensive range of audits were in place to monitor the quality of the service. However these had not always been completed thoroughly. This meant areas for improvement were not always identified or acted upon. Audits had also been carried out by the provider which had contributed to a service improvement plan. This was then used to prioritise areas of improvement and keep staff up to date with any changes being made. The provider told us, "People need a good quality and safe standard of care and we're going to get it right."

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's risk assessments were not always up to date or reflective of their needs. This meant staff did not always have sufficient information to help them mitigate risks to people.

People's personal emergency evacuation plans (PEEPs) were not always clear. Some staff were unclear what to do in the event of an emergency, such as a fire. This meant people may not be kept as safe as possible during a fire or other emergency.

People's hoist slings were not assessed for their individual needs. This meant they may be at risk of injury or cross contamination from other people.

People at risk of skin damage were supported by staff who did not have a good understanding of best practice regarding skin care.

Records to monitor people's health were not always completed. This meant it was difficult to monitor any changes to their health needs.

There were sufficient staff on duty to meet people's needs safely. However, staff were not always deployed in the best way to meet people's needs. This meant some people were left waiting for their needs to be met.

Staff told us they would recognise abuse and knew what action to take to keep people safe.

Action had been taken to improve medicines management procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had a basic understanding of the Mental Capacity Act 2005 (MCA) and promoted choice and independence whenever possible. However, people's care plans

did not contain clear information for staff about how to protect people's rights, if they were assessed as lacking capacity. This meant staff may not have been aware of or respected people's choices. We recommend that the provider considers current guidance on ensuring people's rights are protected under the MCA.

People's records which monitored their health needs or concerns were not always completed correctly. This meant staff did not have an accurate overview of whether people's needs had changed.

People were asked for their consent before care was provided.

New staff completed an induction and staff received ongoing training to help ensure they skills and knowledge remained up to date.

Is the service caring?

Good

The service was caring.

People were looked after by staff who treated them with kindness and respect. Staff spoke about the people they were looking after with fondness.

Friends and relatives were able to visit without restriction.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always easy to understand and were not reviewed regularly. This meant staff could not always rely on them to provide guidance on how people wanted their care delivered.

People knew how to make a complaint and raise any concerns. The service took these issues seriously and acted on them in a timely and appropriate manner.

People were encouraged to make choices about their day to day life.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were in place but these had not always been completed accurately or action taken as a result. This meant improvements were not always made where required.

Staff were motivated and inspired to develop and provide quality care and were positive about changes the provider was making to improve the service.

Staff told us they felt supported and confident raising concerns or ideas with the manager or provider.

The provider and manager were open and honest about what improvements needed to be made within the service.

Devonshire House and Lodge

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.

The inspection took place on 2 and 3 November 2016 and was unannounced. The inspection was prompted in part by notification of an incident following which a service user sustained an injury. The information shared with the CQC about the incident indicated potential concerns about the management of risk of falls relating to new flooring that had been fitted. This inspection examined those risks.

The inspection was carried out by one inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using care services or of caring for someone who has used care services.

Prior to the inspection we reviewed the records held about the service. This included notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with five people and seven relatives. We also spent time with people during lunch time and observed how staff interacted with people around the home.

We reviewed five people's records in detail. We also spoke with eight members of staff and reviewed three personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the manager reviewed the quality of the service. This included a range of audits, questionnaires to staff, minutes of meetings and policies and procedures. We were supported during the inspection by the manager and the deputy manager of Devonshire House along with the regional manager. The managing director and the nominated individual of Harbour Healthcare Ltd were also present

during part of the inspection.

Following the inspection we sought the views of some professionals who know the service well. These were a physiotherapist, a domiciliary dentist and a tissue viability nurse.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

Before the inspection, concerns were raised with us that newly fitted flooring had resulted in someone slipping over and injuring themselves. The provider explained the person had slipped on a spilt drink but that there hadn't been any further falls in that area of the home. However, we did observe during the inspection that spilt drink and food was not cleaned up promptly which could have resulted in a slip hazard for someone. The provider told us they would address this concern with staff to ensure any spillages were cleaned up immediately. Following the inspection, they told us they would make this a weekly agenda item at staff meetings and include it in the monthly newsletter for staff. In addition, the manager would monitor how promptly spillages were cleaned up whenever they were in each unit.

People moved freely around the home and were enabled to take everyday risks. People made their own choices about how and where they spent their time. People had risk assessments in place to give staff guidance on how to mitigate any risks to people's health or wellbeing. These were reviewed but not always promptly; they were not always thorough or followed in practice. For example one person's risk assessment identified the need for them to have a safety mat in place, so they didn't injure themselves if they fell out of bed. When we saw the person on the first day of the inspection, there was no mat in place to keep them safe. This meant the person may have injured themselves if they had fallen out of bed. On the second day of inspection, the mat had been put in place by the person's bed and the manager confirmed to us, that this practice had continued following the inspection. The provider also told us the person's risk assessment would be reviewed and information reminding staff to always leave the safety mat in place would be put in the person's room.

Another person had a risk assessment in place to guide staff how to reduce the risk of falling for the person. The person had had a fall in October 2016 but the risk assessment had not been reviewed since July 2016. This meant information to guide staff on how to keep the person safe did not reflect the person's current needs. Another person, whose care plan identified them as having severe swallowing difficulties, did not have a risk assessment in place regarding the related risks to them. This meant staff may not have been consistently following best practice to keep them safe. Following the inspection, the provider told us they had set deadlines by which people's risk assessments would be reviewed and updated. Risk assessments were in the process of being transferred over to the provider's system and a senior staff member told us, "The risk assessments are much easier now."

Some people required the use of a hoist when staff supported them to move. In order for people to be safe when hoisted, they should have a sling (which is used on the hoist), that has been assessed for their individual needs. People did not have individual slings but were sharing slings with other people. This placed them at risk of injury or cross infection from other people. Following the inspection, the provider confirmed action had been taken to ensure individual slings were available for people.

Where people's health needs had prompted regular monitoring and recording, for example of their skin

health, these had not always been completed regularly or in full. This left people at risk, as any further deterioration may not be identified and further advice sought as required. In addition to this, staff members told us they were not aware of best practice when caring for people whose skin was at risk of deterioration. One person whose skin health needed monitoring regularly, had been found to have a serious pressure sore which had not been identified earlier. A healthcare professional reported that with appropriate monitoring this would have been identified earlier. They had alerted the local authority safeguarding team with their concerns.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's pressure mattresses, used to help maintain their skin health, had not been monitored to ensure they were set correctly for people's needs. This meant staff may not have been aware the pressure mattresses were not meeting the person's needs; putting them at a greater risk of skin damage. The provider had already begun taking action regarding record keeping before the inspection; and following the inspection they confirmed they would arrange pressure care training for all care and nursing staff to improve their knowledge and practice. They also told us they had delegated responsibility for checking people's pressure mattresses to specific staff members.

People told us there were enough staff and when they used their call bell staff came promptly.
Staff told us they felt that generally there were enough staff, but at times, there were not enough to meet people's needs in a timely way. For example, a staff member had been required to support someone to go out, during the second day of the inspection. A staff member explained this had then resulted in two people still being in bed at midday as there were no longer enough staff to support everyone to get up when they wanted. They told us these people would not normally choose to be in bed at this time saying, "It causes stress on care assistants when we are lower on staff." They described another unit as "Manically busy" every morning and the relative of someone on this unit told us they were concerned that their relative still hadn't had a wash by 2pm. A staff member added, "There are some lovely people here and I'd like to spend time with them. I feel we could spend more time with people if we worked differently." Another staff member felt staffing levels affected what activities people could take part in telling us, "It would be nice to take people out or even just out into the garden more; but it's about having enough staff here."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they would gain a closer overview of how staff were deployed around the home. The provider explained they had already taken some action towards ensuring the staff team was used as effectively as possible. They told us the four units within the home had been changed slightly so people who required nursing care had their rooms on a different unit to those who required residential care. This meant nursing staff were able to focus on the needs of the people who required nursing care.

Medicines were given to people as prescribed and disposed of safely. Medicines were locked away as appropriate, however, where refrigeration was required, temperatures had not always been logged regularly to ensure they fell within guidelines that ensured quality of the medicines was maintained. The manager told us they would ensure these were checked regularly in the future. When people had medicines that had been prescribed to be taken 'as required'; there was no information describing when people would need these medicines and how staff would know. For example, one person who had limited communication was prescribed a medicine to be taken 'as required'. The person would not be able to tell staff they needed the medicine and their care plan did not describe how staff would know how to administer it. As the service was

regularly using agency nurses, it was particularly important details of when people would need these medicines were recorded. A senior staff member who had responsibility for medicines told us they would ensure this information was in place as soon as possible.

The provider told us they had already identified that medicines had not always been managed safely. They had therefore arranged recent medicines training for all staff who administered medicines. They were also arranging for a local pharmacy to complete an internal audit of the medicines systems and processes to help ensure they improved practice. The manager told us they had already spent time gaining an overview of medicines procedures within the home and identified what actions needed to be taken as a result to improve practice. Some actions had already been taken, for example, body maps were being put in people's rooms so staff were clear where to apply prescribed creams and topical medicine administration records (MARs) were being put with them so staff could sign immediately to say they had been administered. This helped ensure people's medicines were administered safely and as required.

At the time of the inspection, the majority of nursing staff within the home were being provided by an external nursing agency. Even though the provider tried to use agency staff who were familiar with the service, this still meant there was a lack of consistency of care for people. Relatives told us, "People need to see familiar faces" and "If the staff keep changing they don't know everyone's little foibles." The provider was in the process of recruiting permanent nursing staff and told us, "Until we get a nursing team in place, it'll be all hands on deck."

People had PEEPs (Personal emergency evacuation plans) in place to guide staff in the event of an emergency, however they did not give clear guidance about what was expected of staff to keep people safe. During the inspection, the fire alarm went off twice and we observed staff on some units did not know what the procedure was to keep people and themselves safe. This meant people might not be kept as safe as possible during an emergency. The provider told us they had asked an external company to complete a fire audit in the near future and would use this information to inform staff of their roles and responsibilities. Following the inspection, the provider confirmed they would be carrying out specific fire alarms tests and training for staff who worked on those units and would ensure that within a month of the inspection, the staff team would be knowledgeable of the fire procedure and their role within it.

People told us they felt safe. People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. The provider told us, "People need a good quality and safe standard of care and we're going to get it right."

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Staff told us they had not received safeguarding training recently but they knew who to contact externally should they feel their concerns had not been dealt with appropriately. For example, the local authority or the police. One staff member told us, "I would recognise abuse and I would report it immediately to a nurse or the deputy, the manager, the regional manager or externally." The contact number for the local authority safeguarding team was also displayed visibly within the home. The manager told us, "I intend to meet with every member of staff within my first month here and will reiterate the importance of reporting safeguarding concerns." They also confirmed they would prioritise safeguarding refresher training for those staff members who had not received it recently.

People were supported by suitable staff. Recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

Records showed any accidents and incidents had been reported and appropriate action had been taken.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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. Staff members had a basic understanding of the Mental Capacity Act 2005 but were not always clear about how people's mental capacity might affect their ability to make a decision and what support they would need. When people lacked capacity, their records did not always reflect how their mental capacity affected their ability to make every day decisions, when they needed support from staff, and when staff might need to make decisions in people's best interests. The manager told us they would review people's care plans regarding their mental capacity and ensure they provided sufficient detail for staff. Following the inspection the provider told us consolidating staff's understanding of the MCA would be a priority within training plans.

We recommend that the provider considers current guidance on ensuring people's rights are protected under the MCA.

People can only be deprived of their liberty to 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 (DoLS). Appropriate applications had been made on behalf of people.

People told us staff always asked for their consent before commencing any care tasks. We observed staff always asked for people's consent and gave them time to respond at their own pace. This included administering medicines and personal care. Staff offered to come back later if the person did not want the care at the time.

Identified changes in people's health or well-being prompted a referral to their GP or other health care professionals. A healthcare professional told us they had no concerns about the service.

New members of staff completed a thorough induction programme, which included being taken through the home's policies and procedures and training to develop their knowledge and skills. Staff had a mentor to support them through this period and shadowed experienced members of the team until both parties felt confident they could carry out their role competently.

On-going training was then planned to support staff's continued learning and was updated when required. All staff had been asked by the manager to complete the provider's online mandatory training within a fixed time frame. Other courses, such as manual handling and first aid, taught by an external trainer had also been booked, so the provider could reassure themselves staff's training was up to date and their knowledge

and skills reflected best practice. A senior member of staff told us they would be working with the manager to develop competency assessments of staff's' work, to check they were working to the required standards.

Staff confirmed they had regular training and felt confident requesting any further training they felt they would benefit from. For example, one staff member told us they had asked to complete a national qualification appropriate to their role and this had been agreed by the provider. Another member of staff told us they appreciated the fact that training courses were now repeated so it gave all staff a chance to attend.

Staff members confirmed they felt supported in their roles and one staff member told us the manager and provider were, "As good as gold!" The manager told us they would implement a regular supervisions system for all staff members as soon as possible. They also explained their intention to spend time around the home with staff and to encourage staff to speak to them if they needed any support or advice.

People told us the food was good and they were given a choice at meal times about what and where they wanted to eat. Residents meetings were used to discuss people's meal preferences so they could be incorporated within the menu. People confirmed their food choices were respected. Staff were aware of people's dietary needs and preferences and any concerns were recorded and actioned. For example, one person had lost weight so staff had referred them to the GP, highlighting the fact that the person was struggling to use a knife and fork. A pureed diet had been recommended which the person managed more successfully and had started to put on weight. Staff who worked in the kitchen told us, "We attend handover to find out any changes to people's requirements and we are given the likes and dislikes of people when they move in too." People were offered drinks during meals and from a drinks trolley staff brought twice a day. However drinks were not always easily available to people the rest of the time, for example, when drinks were present in people's rooms or in the corridor, there were not always cups available for people to use. The manager told us they would monitor this in the future and ensure there were sufficient cups available for people to use.

A member of staff described how the atmosphere and appearance of the home affected people's experiences. They told us they felt this was so important to people, they had painted and redecorated one of the units themselves, to help improve people's feeling of wellbeing. The provider told us they were aware of the impact the environment had on people and the need for it to be stimulating. They explained their plans to update the home to make it feel more homely and interesting for people living there. They told us this would include buying items that were of interest to people that could be displayed around the home or used by people, as they wished. Following a comment by a staff member that some people would prefer drinking out of cups and saucers, rather than out of mugs, the provider bought cups and saucers. A staff member told us, "The building as a whole already looks nicer and more homely for the residents."

Good

Is the service caring?

Our findings

People felt well cared for, they spoke highly of the staff and the quality of the care they received. Comments included, "I can't fault the care." Staff spoke to and treated people in a kind, caring way. For example, a staff member told one person, "You look lovely today" and different staff members were regularly heard describing people as 'lovely'. One staff member told us, "I absolutely love my job. Every day's different. We can learn so much from people. It's good to go home knowing I've done good! I learn things every day. I look at it as though it's my mum or dad sitting in that chair and how I'd want them to be treated. They're paying for a service so the care needs to reflect that." A healthcare professional confirmed they had observed staff working with people in a particularly caring way.

People's privacy and dignity was respected. Staff informed us of various ways people were supported to have the privacy they needed. For example, one staff member commented how they would place towels over laps, close curtains and doors, and do whatever they could to make the person feel comfortable.

People's confidential records were not always kept locked away so other people could not have access to them. On the first day of the inspection, some office doors were left open and unlocked. These offices held confidential information about people. By the second day of the inspection, all office doors had keypad locks on them, posters had been put up reminding staff to lock the door and staff had been reminded of their responsibilities regarding confidential information.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. We saw staff interacted with people in a caring, supportive manner and took practical action to relieve people's distress. For example, one staff member gave someone a big hug to alleviate their anxiety. The person seemed to enjoy their hug and seemed more relaxed as a result. Other staff members used their in depth knowledge of another person to help them calm down when they had become anxious. A healthcare professional told us they felt staff were very sensitive to people's wellbeing and showed concern when someone felt anxious.

Some staff knew the people they cared for and other staff were still getting to know people. Staff who knew people well were able to tell us about individual's likes and dislikes, things people needed support with and how changes in daily routines affected them. The manager told us they planned for all staff to get to know everyone in the home. They explained this would mean if staff who regularly worked with individuals were unavailable, they would still be supported by people who understood their needs. Whilst staff were still learning about people's needs, the manager intended to improve the information shared at handover between staff, so they were provided with key information about the people they were supporting. Where staff didn't know people well, they asked other staff members for guidance or advice. One staff member confirmed, "The staff are very approachable and will help you out with anything."

Friends and relatives were able to visit without unnecessary restriction. Visitors told us they were always made to feel welcome and could visit at any time. One visitor confirmed, "I can visit whenever I like, and even if all the family wanted to visit in the middle of the night, we'd still be welcome!" Staff told us they had

good relationships with people's friends and families, and this meant they could support people to maintain these relationships.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place which included some personalised detail about how they chose, preferred and needed to be supported. However, staff told us they did not always find them easy to read and some staff told us they had never had time to read them. The provider was in the process of transferring all care plans onto Harbour Healthcare Ltd's care planning paperwork. The provider had arranged for a senior staff member from another service owned by Harbour healthcare Ltd, to assist staff at Devonshire house to write personalised care plans. A member of staff told us, "We've tried to write the care plans to be as personalised as possible."

People and where appropriate, those who mattered to them, were being more actively involved in the process to help ensure their views and preferences were recorded, known and respected by all staff. The manager told us, "Whenever staff are completing records about people, it's important people are included, as far as possible."

People's care plans were reviewed but this had not been done consistently for everyone and meant that not all care plans reflected people's up to date needs. For example, one person had recently been prescribed a new medicine for pain relief but this had not been added to their care plan.

Some relatives raised concerns about people's belongings being lost in the home and feeling it necessary to take their loved one's clothes home to wash so they didn't get lost. Other relatives told us of people's equipment such as hearing aids or parts of wheel chairs getting lost. The provider was due to implement an electronic system which meant it was easier for people's clothes to be identified and the manager told us they would also review the laundry procedures and would discuss concerns with staff about how people's belongings were looked after.

People were empowered to make choices and have as much control and independence as possible. Some people could not communicate their needs easily but staff took the time to ask people what they wanted and listened patiently to their response. For example, whether they wanted sugar in their tea or whether they wanted help to move to a different room. Communication between staff and people receiving support demonstrated dignity and respect at all times.

Relatives and residents meetings had been held by the provider to help ensure they were aware of any changes people wanted to the service. They told us these meetings were used to encourage people and relatives to share any ideas or concerns about the service, and would be held quarterly in the future.

People had a range of activities they could be involved in with at least two different activities planned for each day. People were able to choose what activities they took part in and suggest other activities they would like to participate in. Relatives told us they appreciated the effort staff put in to involving people in activities; however some staff had identified that these activities did not suit everyone and not everyone's needs were catered for. The manager and provider acknowledged that this was an area for development.

The service had a policy and procedure in place for dealing with any concerns or complaints. People's concerns and complaints were encouraged, investigated and responded to in good time.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led.

People's records had not always been updated with changes to their needs or wishes. For example, the service operated a system called, 'resident of the day' which involved each resident's paperwork being reviewed and checked on a specific day. These had been completed for some residents but had not been completed thoroughly. The manager told us they would ensure these were completed and actioned more thoroughly in the future.

The provider had identified concerns with the accuracy and timeliness of record keeping within the home and had implemented various actions to help improve the quality of record keeping, such as moving records to one centralised location. They continued to work with staff to find ways that aided them to complete records in a timely, accurate way and intended to appoint senior staff members who would be responsible for ensuring these records were completed to the standard required. They told us, the manager would also receive regular updates from senior staff about key monitoring information for each individual which would enable them to have an overview of any changes to people's health.

Auditing systems, put in place to monitor the quality of the service and identify areas for improvement had not always been completed thoroughly or actions taken as a result. A schedule of audits covering different areas of the service for example, catering, infection control and medicines was in place with clear guidance about what each audit should look at and what evidence should be collected as a part of it. Some of these audits had not identified concerns found during the inspection and where areas for improvement had been identified, it was not clear whether any actions had been taken as a result. The manager told us they would have an overview of these in the future and would ensure actions were taken accordingly. The manager was required to send a regular report to the provider which enabled them to have an overview of changes to people's needs along with any operational concerns within the service, and identify any emerging themes. The provider explained, "I use this as a snapshot of what is happening and can then look deeper into information, if necessary."

The provider told us they had carried out audits since they had taken responsibility for the service, which were designed to reflect what would be looked at during a CQC inspection. They explained, "The concerns identified during the CQC inspection aren't things we weren't already aware of. We have plans to address them." As a result of the areas for improvement identified in the audit, the provider had made the decision not to accept any new people into Devonshire house. They told us, "We are not open to admissions until we get the quality right." The manager explained that all required improvements were added to the 'service improvement plan' and actions were prioritised, in discussion with the provider, according to how urgent they were. They also added that these actions would be communicated with the staff team and 'driving up quality sessions' would be held to help ensure staff understood any changes and what was expected of them.

Staff were positive about the new provider and manager telling us they felt things had improved since they

had taken responsibility for the home. Comments included, "It's improved dramatically already. Things have even changed since Monday (when the manager started in post)", "There have been concerns but it's on an even keel now" and "I think the residents are happier now." One staff member told us about the new manager, "I think they're exactly what we need."

The manager understood that building strong relationships with people, relatives and staff was important. As they were new to their role and the service, the manager made an effort to introduce themselves to everyone who came into the home. They told us, "I want visitors and relatives to know I'm approachable." They also explained they ensured they walked round the home at least twice a day to gain an overview of what was happening in the service and to make themselves easily available and approachable for staff. They told us, "I also use this time to make sure I thank staff for their work." The regional manager told us they had attended the service during the night to check on the quality of care provided at this time and to give staff working at this time the opportunity to raise any ideas or concerns they had. After the inspection, the provider confirmed the manager had also attended the service through the night and would continue with this in the future.

Even though the manager was new to the service staff told us they felt empowered to have a voice and share their opinions and ideas they had. Comments included, "I've got the feeling they'll listen. It's quite refreshing." Staff told us the provider had asked them to complete surveys about their views of the home and they felt these had been listened to and acted upon. The provider told us they had also set aside time specifically for staff to raise any concerns or ideas with them. They added they planned to carry out a further survey after the manager had been in post for three months to help check whether staff felt improvements had been made.

The manager told us they planned to hold staff meetings regularly to provide a forum for open communication. They explained they would hold a staff meeting every week which followed the same agenda for one month. This would help ensure all staff had the opportunity to attend every month. A staff meeting was held during the inspection. This had been planned for the provider to introduce the new manager to the staff team. The manager used the meeting to share their plans for the future and to thank the staff for aiding the manager's transition into the job. Staff were also given the opportunity to ask questions and raise any concerns they had about impending changes. Staff members told us, "They're open and honest about what needs doing" and "The manager was positive and honest that things weren't perfect. It was refreshing to hear some positivity. It was nice the owner came too. I respect their transparency. They shared information they didn't have to."

The service inspired staff to provide a quality service. Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care. The way staff described their hopes for the future of the service showed they had already begun to adopt the same ethos and enthusiasm as the provider and manager. When staff talked about what changes and improvements they hoped to see, such as making the service feel more homely, they reflected those highlighted by the manager and provider.

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the manager, and were confident they would act on them appropriately. A recent team meeting was used to reiterate to staff the importance of raising concerns with the manager, provider or external agencies to help ensure people were protected from unsafe treatment.

As the manager was new to the service, they were keen to gain feedback from people, relatives and staff about the service. They were already using this information to plan how they would develop the service, and any concerns raised were acted upon promptly. For example, after feedback received as part of the inspection, and concerns raised by a family member, the manager immediately developed easy to read records which summarised a person's interests, likes and dislikes and care needs. These were then placed in people's rooms for staff to refer to when supporting the person. They involved the family member, who had raised concerns in designing the record that would reflect their relative's care needs, to help ensure the information was accurate. The manager told us, "Relatives need to know that if they raise concerns, there will be a response and I will act."

The provider and manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care. The care and treatment of service users did not always meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always safe. Risks to the health and safety of service users were not always assessed. Actions identified to mitigate risks were not always followed. Equipment used by the service provider for providing care or treatment to service users was not assessed as being safe for their individual needs. Staff providing care or treatment to service users did not always have competence, skills and experience to do so safely.