Donisthorpe Hall

Donisthorpe Hall

Inspection report

Shadwell Lane,
Leeds,
LS17 6AW
Tel: 0113 268 4248
Website: www.donisthorpehall.org

Date of inspection visit: 10 & 15 June 2015
Date of publication: 10/11/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

At the last comprehensive inspection in October 2014 we rated the service as requires improvement. We found three breaches in regulations because people were not protected against the risks associated with unsafe management of medicines, staff were not adequately trained and the provider did not have suitable arrangements for assessing and monitoring the quality of service delivery. We told the provider they must take action to meet the regulations.

After the comprehensive inspection in October 2014, the provider wrote to us to say what they would do to meet the regulations in relation to each breach. They told us they would complete all actions by the end of March 2015. At this inspection which took place on 10 and 15 June 2015 and was unannounced, we found that the provider had not completed their plan of action and legal requirements were still not met. We also found additional breaches.

Donisthorpe Hall provides residential, nursing and dementia care for a maximum of 189 residents. Care is provided in seven specialist units. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs. At the time of the inspection, the service had a

Summary of findings

registered manager. 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 this inspection we found people were not protected from risks associated with unsafe or inappropriate care. People using the service were not protected against the risks associated with the administration, use and management of medicines. People did not always receive their oral and topical medicines at the times they needed them or in a safe way.

Some people felt safe others did not. People were not protected from abuse or allegations of abuse because the provider did not always take appropriate action or report allegations to the appropriate agencies.

The service used a high level of agency staff and people were sometimes supported by staff who did not know how to meet their needs. We observed people did not always receive care in a timely way. Staff did not always receive appropriate training and support. The provider had effective recruitment and selection procedures in place.

There was a lack of consistency in the approach of staff. Some supported people in a kind and caring way but other staff lacked compassion. Most people felt staff treated them with kindness and respect.

People enjoyed the range of activities provided at the home. They received a varied and nutritional diet. People told us they received support with the healthcare but records to show people's health needs were met were not always completed. People did not always consent to their care and treatment.

There was a lack of consistency in how people's care was assessed, planned and delivered. There was not always enough information to guide staff on people's care and support.

The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not always implemented. The management team were visible and described by the staff team as approachable. The provider had recently recognised the home was not providing a good service and had commissioned an external agency to assist them to identify and address shortfalls.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 and a breach of (Registration Regulations) 2009. You can see the action we have told the provider to take at the end of this report.

Summary of findings

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.

People were not protected against the risk of abuse; the provider was not working within safeguarding guidance.

There was a lack of consistency in how risk was managed. Some systems helped keep people safe but other systems were not effective which meant people were not protected. Medicines were not managed safely.

There was a high usage of agency staff which resulted in people being cared for by staff who did not understand their needs.

Is the service effective?

Inadequate

The service was not effective.

Staff were not always appropriately trained and supported so people may be cared for by staff who do not have the right skills and knowledge.

Staff were not making decisions in line with legislation because they did not always seek people's consent to care and treatment.

People enjoyed the food and were offered a varied diet but experience at meal times was not positive for everyone.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff who supported them were caring and compassionate. People we spoke with told us their religion and beliefs were understood by the staff and met in a caring way.

Some staff provided good care but others were task focussed.

People were offered choice about what they wanted to do and where to spend their time. Staff had good information about people's history and got to know people well.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People did not always receive care that was planned to meet their individual needs and preferences. Care records did not sufficiently guide staff on people's care.

There was opportunity for people to be involved in a range of activities.

The provider had identified areas they could improve following concerns that were raised by people who used the service or their relatives.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The provider did not take appropriate action following the last CQC inspection. The systems in place to monitor the quality of service provision were not effective.

The provider recently introduced an external agency who had started looking at the systems in place. Audits had just commenced.

The provider failed to notify CQC about important events.

Donisthorpe Hall

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 was unannounced and took place on 10 and 15 June 2015. On day one, five adult social care inspectors, a pharmacist inspector, a specialist advisor in nursing, a specialist advisor in governance and two expert-by-experiences attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts had experience in older people's services. On day two, three adult social care inspectors, a specialist advisor in nursing and a specialist advisor in governance attended.

Before this inspection we reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home, information that was shared by the local safeguarding authority and information of concern that was sent to us anonymously.

We contacted the local authority, clinical commissioning group, health and social care professionals and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of this inspection there were 176 people living at Donisthorpe Hall. We spoke with 27 people who used the service, six relatives, 35 staff, including care workers, ancillary workers, nurses, care managers, activity workers, the registered manager, chief operating officer, operations manager, estates manager and head of human resources. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as rotas, staff recruitment and training records, policies and procedures, quality audits and medicines records. We looked at 15 people's care records.

Inadequate

Is the service safe?

Our findings

At the last inspection we rated this domain as requires improvement. The way medicines were managed was not always safe, emergency plans in the event of a fire were not fully operational, call bell leads had been removed from rooms because they had been identified as a risk to individuals but leads in en-suite were still in situ. At this inspection we found the provider had not made the required improvements. We also found additional concerns about people's safety.

We looked at how the provider was protecting people from avoidable harm and abuse and found they were not always taking appropriate action to safeguard people. The provider had policies and procedures for safeguarding vulnerable adults but did not follow these. Some people told us they felt safe; others told us they did not. One person told us they had reported concerns to the nurse in charge about the way they were treated by a member of staff; we saw no action was taken in response to the person's concerns. Another person told us they felt neglected and had reported this; they didn't feel their concerns were dealt with appropriately. Both these allegations should have been reported to the local safeguarding team and Care Quality Commission (CQC) but were not.

We looked at care records. One person, in December 2014 had unexplained bruising to both wrists but this was not followed up or reported to the local safeguarding authority or CQC.

One person had been injured at the beginning of June 2015 when receiving personal care. A nurse in charge told us the injury occurred because staff had not followed the person's care plan and had used incorrect equipment when bathing the person. This was a failure to provide appropriate care so should have been reported to the local safeguarding team and CQC but was not. At the inspection we received assurance from the provider they would refer the concerns to the local safeguarding authority, however, when we contacted the service four days after the inspection to ensure this had happened, we were told they had still not referred the cases. We raised this concern again and then received confirmation the cases were referred. We concluded the provider was not implementing robust safeguarding procedures and processes that made sure people were protected. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We looked at how risk was managed for people who used the service and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe; however, other systems were not effective so people were not protected.

At the last inspection we looked at emergency plans in the event of a fire and found these were not fully operational. The home was introducing a traffic light system (red, amber and green-RAG) to indicate the level of support people needed in the event of an emergency evacuation. This involved using colour indicators on people's bedroom doors. Some doors did not have colour indicators and some staff were not familiar with the new system. At this inspection, the management team told us they were no longer using the existing RAG system but had instead introduced an emergency evacuation list with this information. We spoke with five members of staff about the new RAG system but not everyone was familiar. We asked to look at one of the lists which were located around the home. This was not clearly visible so staff might have had difficulty locating this in an emergency. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We completed a tour of the premises as part of our inspection which included looking around twelve people's bedrooms, bath and shower rooms and various communal living spaces. We found all floor coverings were appropriate to the environment in which they were used. Carpets were of a high quality and were well fitted. We saw failures of equipment were speedily attended to and where potential failure was highlighted through routine maintenance programmes, remedial action was taken. The home had in place up-to-date certification for gas compliance, emergency lighting, electrical hard wiring and installation, water safety, fire appliances and installations, passenger lifts and hoists. We saw all portable electrical equipment had been tested. The temperature of water from taps in bathrooms and bedrooms were appropriate; all hot water outlets were fitted with thermostatic mixing valves (TMV's). Heating to the home was provided by cool wall radiators or covered panels so protecting vulnerable people from the

Is the service safe?

risk of a burn from a hot surface. We saw evidence of fire alarm testing, fire-fighting equipment was available and emergency lighting was in place. During our inspection we found two fire escapes were being used to store wheelchairs which were obstructing safe exit from the building. We were told the issue had previously been brought to the attention of staff but it was an on-going issue. Wooden hand rails were in situ along corridors; in one area these were loose. We saw upstairs windows all had opening restrictors in place, however, the restrictors were not tamperproof and a simple easily accessible catch allowed full opening of the window. This is contrary to the Health and Safety Executive guidance. The estates manager agreed to seek a solution to the window restrictors and address the on-going issue with the fire exits to ensure people's safety.

A health professional told us, "As far as we are aware it is a safe place we do not know of any incidents where the safety of patients, staff or visitors has been compromised. Security is good, all visitors are signed in and usually escorted when inside the building. We are not aware of or have experienced any signs of discrimination from either the management to staff or staff to residents." Another health professional told us, "At present the home is just about safe, but I do have concerns it could be teetering on the edge."

During both days of the inspection we observed housekeeping staff cleaning the home. Two ancillary staff discussed the cleaning routines and showed us their daily cleaning schedules. These showed specific areas were allocated to each worker. The home looked clean throughout, however, we noted a strong odour in one of the units. A health professional told us they had noted 'malodours' when they had visited.

We observed staff supporting people to move and transfer. We observed staff providing good support and keeping people safe. For example, staff ensured people were safe when walking and not at risk of falling. We also observed staff using a hoist to transfer people. Some did this confidently and skilfully but others were unsure of what they were doing. One person was walking with a frame and nearly tripped up on a wire from a vacuum cleaner. A visiting professional quickly intervened and prevented what could have been a serious accident.

In the main, staff we spoke with gave good examples of how they kept people safe. They said accidents and incidents were recorded and reported. However, we found this was not always the case. On the first day of the inspection, we observed one person was angry at lunchtime. They were banging on the table, and shouted and swore at two other people who were in the dining room; this went on for several minutes. Both people were upset and asked staff to intervene. One person said, "Is anyone in charge in this room? He's like an animal. Either he goes or I go." A member of staff responded by saying, "You're goading him all the time. You were goading him." When we returned five days later we asked to look at the incident record but were told one was not completed. We looked at daily records and saw there was no reference to the incident.

Some people were provided with personal pendants to use when they wanted assistance, which helped keep them safe. We noted on both days of the inspection some people were not wearing their pendant and could not reach these because they were tied to bedframes. On one unit the call bell was sounding for long periods throughout the morning and the same room number kept showing on the call bell panel. The management team said call bell responses could be monitored. We asked to look at the morning log and saw there was no record of the calls from the room that had frequently requested assistance. After the inspection the registered manager sent us this information; we saw from the records that the person sometimes had to wait 22 minutes before staff responded.

In one unit we were told food and fluid charts were introduced for everyone because there were potential weight errors and inconsistencies in weight. We looked at three people's fluid and diet charts. We saw one person's chart was totalled incorrectly and there were gaps in the two other charts. In another unit, a registered nurse told us one person had lost weight and they were monitoring their fluid and food intake. When we asked to look at these, the charts could not be located for the last three months. We concluded that the care and treatment was not provided in a safe way because practicable steps were not taken to reduce risk to people. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Risks to individuals had not always been assessed and staff were unclear about potential risk. For example, we looked at the care records for one person who had lost weight. Two entries stated the person should be referred to a

Is the service safe?

dietician but we did not see a record to confirm this had happened. The nurse in charge said they had made a referral but had not recorded this, and as yet a dietician had not visited the person. We spoke with two care staff who had assisted the person but they did not know they were at risk of under nutrition or that they had lost weight. One member of staff said they were not aware of any recent changes and told us the person, "Eats independently but needs encouraging." When we looked at the person's care plan it stated they need assistance with eating but were not able to use a knife and fork independently. We concluded that the care and treatment of people was not always appropriate and did not always meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Although we saw some incidents were not dealt with appropriately, we also saw the management team did have a system to help manage risk. The chief operating officer told us, each morning a member of the care management team went around the units and collected accident/ incident forms from a designated accident form tray. These were then reviewed and entered on the central database. Any learning was then discussed at various team meetings. We looked at the central database and saw they were monitoring incidents and identifying where they could learn from incidents and improve practice in the home.

We received a mixed response when we spoke with people about the number of competent staff on duty. One strong view that was commonly shared with us was the high usage of agency staff, which people felt impacted on the standard of care provided. One person who used the service told us, "90% of the staff were good but the other 10%, the agency staff, spoil it for the rest." They said there was inconsistency in the agency staff supplied and there had been complaints about agency staff at resident meetings. Another person said "Sometimes the care is not good at night when there are agency staff on. The regular staff are very good. It's the temps that are the problem."

We noted that a relative had raised concerns at a recent resident and relative meeting. They had said their 'biggest worry is that when residents call for help they can't find anybody and asked if buzzers are monitored'. At a meeting in June 2015 and November 2014 the high use of agency staff was discussed. In November 2014 the meeting minutes stated 'recruitment is ongoing to help us reduce agency staff so that residents are familiar with carers'.

Staff we spoke with also raised concerns about staffing levels and the number of agency staff working at the home. One member of staff said, "We need more staff on a morning and some people need reassessing." Another member of staff said, "Residents have to wait to have their pad changed, sometimes up to one hour. Weekends are dreadful

We observed agency staff working on both days of the inspection who did not know the systems or the people they were supporting. We spoke with one member of staff who had never worked at the home before. They told us the handover was poor and they had not been given information about people's individual needs and preferences. We spoke with another member of staff who told us they had worked at the home before but never in the unit they were allocated that day. They confirmed they had not read people's care plans and were not familiar with people's individual needs.

We observed care being delivered and found at times staff could not perform their duties safely and meet people's needs in a timely way. In one unit, two members of staff were supporting 20 people. The senior member of staff was administering medicines and should have been able to do this without distraction, however, one person had fallen so they had to assist. A health professional visited and required information. After breakfast, people were asking to go to the toilet and wanted to leave the dining room but had to wait because there were not enough staff to help. In another unit, staff were unable to find the nurse in charge for over ten minutes, and the telephone call system to contact staff was not answered.

We also observed in other units there were enough staff on duty and people received good support in a timely way. We observed that staff were not rushing and made sure there was adequate supervision in communal areas at all times.

We reviewed staffing rotas and these provided a mixed picture but did show the use of agency staff was high. We concluded that there were not sufficient numbers of suitable staff deployed throughout the home and this

Inadequate

Is the service safe?

resulted in people not receiving safe, person centred care. This was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The home followed safe recruitment practices. We looked at the recruitment records for five members of staff and found relevant checks had been completed before staff had worked unsupervised at the home. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. Periodic checks, such as registration with professional bodies were usually carried out, however, we found one nurse's registration with the Nursing and Midwifery Council (NMC) had expired. This was rectified and we saw evidence the registration was renewed immediately. The provider's recruitment policy stated 'a copy of the pin number and date of renewal is maintained and monitored by the nurse manager once employment has commenced. The provider agreed to ensure all relevant registrations were checked to make sure they were up to date.

At this inspection we found that the service was not managing medicines safely. We looked at medication stocks, Medication Administration Records (MARs) and other records for 28 people living in the home and found concerns and/or discrepancies in each case.

Medicines in current use were generally stored safely in locked cupboards and trolleys. However we saw one senior care worker leave medicines for two people in unlabelled, unsealed medicines pots as neither person had been ready to take their medicines when they were offered. The medicines could not be identified and there was no way of telling which pot was prescribed for which person. This placed these people at an unacceptably high risk of being given the wrong medicines. We saw that controlled drugs (strong medicines with additional storage and recording requirements) had not been disposed of safely, and these, in common with other waste medicines were not stored safely.

Medication records that we looked at were frequently inaccurate and incomplete. The quantities of medicine received, brought forward from the previous month and disposed of had not always been accurately recorded. This made it impossible to calculate how much medication should be present and therefore whether or not medicines had been given correctly. There were missing signatures on records and it was unclear if medicines had been given or omitted at those times. Where medicines were prescribed at a variable dose, the actual dose administered had not always been recorded.

People did not always get their medicines at the correct times or when they needed them. On the day of our visit, the morning medicines round on one unit did not finish until lunchtime. This meant that some people who were due their medicines at 8am did not receive them until 12noon. This had a knock-on effect of placing these people at increased risk of being given the rest of the day's medicines too close together. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Inadequate

Is the service effective?

Our findings

At the last inspection we rated this domain as requires improvement. Staff had not received appropriate training, supervision and appraisal. After the inspection, the provider told us they were taking action to make sure staff received appropriate support, however, we found at this inspection regular supervision was still not being provided and training data was not up to date so we could not be sure all staff had received the right training.

We spoke with staff about training, supervision and appraisals. Staff told us they had completed a range of training course and felt their training needs were met. A member of staff who had only been employed for eight weeks confirmed they had completed an induction which included one week in a classroom setting. They described it as "very good". Another member of staff who had been in post for one year told us they had completed an induction and felt prepared for the job. Since starting the job they had only received one supervision session and had an appraisal at the same time. Two members of staff said they had not received supervision since February 2015. Housekeeping staff told us they received regular supervision. Supervision is where staff attend regular, structured meetings with a supervisor to discuss their performance and are supported to do their job well to improve outcomes for people who use services.

We also contacted a number of other professionals who were involved with Donisthorpe Hall and asked them to share their views with us. One told us there was a, "Shortage of trained staff; a lack of experience on the floor and staff were leaving." They also said, "New nursing staff felt unsupported."

We found that new starters were provided with a comprehensive induction programme. This consisted of a five day programme which was provided within the first three months of employment. A member of the human resources team showed us the induction timetable which consisted of the following topics: an introduction; the home; equality and diversity; whistleblowing; fire; moving and handling; health and safety; dementia awareness; infection prevention and control; dignity; end of life and e-learning modules were available for safeguarding, Mental Capacity Act (2005) (MCA), Deprivation of Liberty Safeguards (DoLS). A competency assessment was signed off at unit level. We received confirmation that new staff would complete the 'Care Certificate', which is an identified set of standards that health and social care workers adhere to in their daily working life.

The provider's 'training and development policy' identified what training staff needed to complete and the frequency of each course. A simpler format electronic training matrix had been introduced after the last inspection, which was colour coded to show when training was due. The matrix indicated only a low percentage of staff had completed the required training. For example, fire (50.36%); health and safety (36.33%); manual handling (82.01%); food hygiene (0.36%); infection control (30.58%); dementia awareness (14.03%); safeguarding adults (30.22%) and safe handling of medication (0%). We were told they were waiting for certificates to verify the training which had been completed in October/November 2014 and would then input this data on the matrix. We asked to see evidence that staff knowledge and implementation was checked following completion of specific training courses, however, this was not provided. The provider had a training plan that detailed scheduled training to be held from January to November 2015.

We looked at an appraisal matrix which confirmed that 57 out of 240 staff members' appraisals had not been completed. They told us appraisals were conducted annually and that appraisals would to be implemented in September/October 2015, using a new appraisal format.

The providers 'training and development' policy stated staff should receive supervision monthly. We were informed that staff files with supervision records were held centrally, however, we were informed some were also being held on individual units. Of the five files we reviewed that were held centrally only one member of staff had received a supervision session in the last month. We looked at supervision files held on one unit; these showed staff had not received monthly supervision.

We concluded that staff were not receiving appropriate support, training, supervision and appraisal as was necessary to enable them perform their job safely and appropriately. This was in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

At the last inspection we found there was a lack of consistency in how people's capacity to make decisions

Is the service effective?

about different aspects of their care and treatment was assessed and some people didn't have relevant paperwork to show legal processes were followed for lasting power of attorney. The management team told us they were reviewing Deprivation of Liberty Safeguards (DoLS) and agreed to work alongside the staff team to ensure DoLS and the key requirements of the Mental Capacity Act (2005) were fully understood. DoLS protect the rights of people by ensuring that if restrictions are in place they are appropriate and the least restrictive. At this inspection we found they had not taken action as agreed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager told us one person at the home was subject to DoLS and a further 10 authorisations had been recently submitted to the relevant supervisory body. We saw a further five authorisations being made ready for submission.

During our inspection we focussed on the areas of the home specifically related to caring for people with dementia. This area of the home amounted to 78 beds of which 71 were occupied. Our observations of the environment and people's care plans suggested the provider used a number of methods which may constitute a deprivation of liberty. All people in the area had a diagnosis which indicated a disorder or disability of mind and had been assessed as lacking in the capacity to consistently give consent to the arrangements for their care and treatment.

The entire communal area was covered by closed-circuit television (CCTV), all bedroom doors were alarmed to alert staff to people vacating their rooms. Some people had sensor mats at the side of their beds and other had sensor mats within their beds again as a means of alerting staff. The three discrete areas of the dementia unit were locked with access only by key-pads. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that accumulation of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty.

Whilst we saw some people had valid decision-making authorities in place such as having a lasting power of attorney or court appointed deputy we found this would not necessarily conflict with a DoLS authorisation. We judged the provider may be exercising control over people's care and movements. Discussion with the registered manager demonstrated they were aware of the need to seek authorisation to legally deprive people of their liberty. During our inspection in October 2014, the management team told us they were reviewing DoLS to ensure the requirements of the Mental Capacity Act (2005) were being met. Our observations indicated that whilst some progress had been made this piece of work was still outstanding. We assessed and the manager agreed the number of people who needed to be urgently assessed as to the need for a DoLS authorisation amounted to around 50 people. We saw the area covered by CCTV was signed to inform people they were entering an area covered by CCTV.

Four people were given their medicines covertly (hidden in food) without their knowledge and/or consent. Best practice guidance states that covert administration only takes place in the context of legal and best practice frameworks to protect both the person who is receiving the medicines and the care home staff involved in administering the medicines. We found this was not happening. In one case we found evidence an appropriate procedure had been used to initiate the giving of covert medicines. However, this had taken place four years previously and we could find no evidence of any review process since. The remaining three people who received covert medicines had no documentation available. There was no information with the care plans or MARs to tell nurses which medicines were to be given covertly or exactly how and in what circumstances they should be given. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent.

One member of staff discussed an incident that had happened earlier in the day, where a person who used the service was "upset". The member of staff said they had had to change one person's clothes when they had a bath and the person did not like this. The member of staff told us they and another member of staff had "tricked" the person to gain the person's consent to having their clothes changed and said, "We came up behind her to take her clothes." We concluded that where people were unable to give consent because they lacked capacity the provider was not acting in accordance with the legal framework. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Inadequate

Is the service effective?

The provider had a written policy on the use of restraint. We spoke with one member of staff about the use of restraint. They were able to demonstrate their knowledge and knew the difference between lawful and unlawful restraint practices. We spoke also with the registered manager about the use of bed-rails. Answers we received demonstrated that when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, family members were consulted before bed-rails were used.

We observed three people in a lounge who were seated in 'bespoke chairs' with the intention of tipping the person slightly backwards. In one case we observed the person had a lap belt in place. People had health needs assessments which identified the need for the observed posture to be maintained through the use of the observed appliances. Therefore, whilst the chairs restricted people's movements they were not being used for the purpose of restraint.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

We observed meals in all of the units at Donisthorpe Hall and found people had positive experiences. People we spoke with were generally satisfied with the quality and quantity of the food. Several people described it as good. One person said, "The soups are amazing." Another person said, "It always tastes very nice and you get plenty to choose from." One person said, "The food is basic but ok, it's not too bad." Another person said, "The food is alright." One person who ate in their room told us they thought the food was not well cooked and not warm enough when it arrived. They said, "It's too hard and others have complained about it as well."

Everyone told us they had a choice of food and we observed this at meal times. People were offered a choice of two dishes for each course during lunch. Staff checked people had enough to eat and offered additional portions. Choices of drinks were offered at meal times and throughout the day. We saw people being offered alternatives if they did not want to choose from the menu. For example, one person declined both choices for their starter and main course, and was offered a sandwich instead which they accepted.

Most staff we spoke with said meal times were consistently good and they were confident people ate healthily and had balanced diets. We spoke with one of the chefs who discussed the general catering arrangements. The home had a four week rolling menu which was varied and offered choice to people at meal times. They said there was always a very good supply of provisions which included fresh fruit and vegetables, and they catered for special dietary requirements and people's preferences were taken into account when menu planning.

During lunch we noted one person's experience was disrupted because staff were not organised. They were assisted by a member of staff to eat their soup. They were then taken by a care worker to another dining room in a different unit. We were told this was because they were monitoring the person's food intake for a nutritional assessment.

People who used the service told us that they had access to health care services such as GP, chiropody, and physiotherapy. One member of care staff said they didn't have any concerns about people's healthcare. If they noted anything they informed the nurse who would organise an appropriate health referral. They said there were regular GP visits. Another member of staff told us a chiropodist visited every six weeks. Two care staff said they did not know about people's dental or chiropody appointments. We saw health professionals visiting during our inspection.

A health professional told us some concerns had been raised about the home which included "referrals not coming through". Another health professional told us, "They are very good at communicating with us and other clinical teams that they have links with, and the communication is always about how they can improve patient care. They work closely with all clinical providers."

We saw a mixed overview when we looked at records of healthcare appointments people had attended. Some people's records showed they had regularly attended

Inadequate

Is the service effective?

appointments and their health needs were met. But there were no health appointments recorded for others so we were unable to establish if they had received appropriate support. For example, one person's care records indicated they had seen the community mental health team three times in 2015 but had not seen any other health professional. The mental health team had recommended a referral to a dietician because the person had lost weight.

We asked to look at the referral but were told by the nurse in charge it had been completed but not recorded. We were unable to see that people's day to day health needs were being met or that referrals were made to relevant health services when people's needs changed. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Requires Improvement

Is the service caring?

Our findings

In the main we received positive feedback when we spoke with people about their care. Most people told us the staff were caring and compassionate. Staff were described as "good", "very nice", "very friendly", One person said, "The staff are very caring and thoughtful." Another person said, "The care staff are very nice, some more than others but generally they are very sweet." Another person said, "Most of the staff are wonderful, although I may expect too much from others." One person told us they considered they had "a genuine personal relationship with staff". Some people, however, indicated there was a limit on interaction with staff. A number of people told us that the staff didn't have time to stop and talk to them. One person said, "They are so busy they have no time for a chat." Another person said, "They are pushed for time, they have no time to stand and talk, they've lots to do." One person told us they were lonely. They said, "Look at it, it's only 3.15pm. I just want someone to talk to."

The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs. The home had a Kosher (Jewish dietary requirements) policy and there was a synagogue on site. People we spoke with told us their religion and beliefs were understood by the staff and met in a caring way. One person who was a Christian told us that their Pastor visited and gave communion, and they sang. They said, "It's good for me. I feel very safe here. There's no worry."

We also received some positive feedback from visiting relatives. One visiting relative said they were encouraged to stay and have a meal with their loved one. Another visiting relative said, "It's very, very caring. We think it is way above most places. They've just had a big upheaval and it's been quite upsetting for a lot of people. We feel very reassured that they're properly cared for."

During the inspection we observed staff providing good care but also observed staff being task focussed. When we observed good care staff were attentive and caring in their approach. They provided encouragement, reassurance and treated people with kindness and respect. For example, we saw a care worker stroke a person's arm, in a comforting way, after bringing them a cup of tea, and another member of staff thumbing through a magazine with a person in a lounge area. When we observed staff being task focused we saw they did not speak to people in a caring way. They sometimes spoke abruptly or spoke very little. For example, one member of staff put people's meals in front of them and only said the person's name; there was no explanation about what food was being served or any discussion about whether the person wanted the meal. One person was banging on the table but this was ignored by staff; we later found out the person had wanted to go to the toilet. We spoke with an agency worker about their role. They did not know the name of the people they were supporting and referenced them as 'room numbers'.

In the main, people looked well cared for and were tidy and clean in their appearance. However, we noted one person had a dishevelled appearance and indicated they were unhappy; when we reviewed their care records we could not see how these aspects of their care were being addressed. We also received feedback from a health professional that they had observed some people looked 'unkempt'. Another health professional told us, "They are caring and regardless of the size of the Hall all the staff take the care of the residents very seriously. Also being a multi faith unit the spiritual needs of the residents appear well catered for."

When we asked about being able to make choices, people said they could make decisions for themselves. One person told us they had been able to choose their own room. Others said they had choices about what to wear, when to get up and go to bed. One person told us some members of staff members tended to treat them as a child at times and they didn't always ask what they wanted. We observed people being asked where they wished to sit after lunch.

Although people told us they could make day to day decisions we saw little evidence that people had been involved in the care planning process. When we asked people who used the service if they had been involved with planning their care, they either didn't know what a care plan was or said they were not interested. After we explained to one person they said they were unaware the care plans existed or that they could look at theirs. A visiting relative said, "I'm not involved in care plan discussions."

People told us that staff generally respected their privacy and knocked before entering their room. We noted information was displayed in the home to help people understand their care. This included information about the home and what people should do if they were unhappy about their care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated this domain as requires improvement. We found there was a lack of consistency in how well people's needs were assessed and their care and support was planned. Some care records contained good information about how care should be delivered and daily records showed people's needs were being appropriately met. But we also found care plans that were not up to date which put people at risk of not receiving the care they needed. At this inspection, the findings were very similar and we concluded the provider had not made the required improvements.

In one unit we looked at two people's care plans. These had not been updated since the previous CQC inspection in October 2014. Daily records and information about activities, and mental and physical conditions were recorded but difficult to read. There was a guide for writing care notes, which included headings to use but staff were not following these. One person's mental health had deteriorated in the previous four weeks and staff told us the person was vulnerable. The care plan and risk assessment did not reflect the person's need or guide staff on how to support them. We asked if there was an up to date care plan and risk assessment and were told if we came back in an hour it would be done.

In another unit, we looked at three people's care records and saw these did not identify how care should be delivered. One person's care records stated they had said, at a meeting with a visiting health professional, they needed something to do. It was agreed staff would try and engage the person with jobs such as folding serviettes. There was no reference to this in the person's care plan or evidence in their daily records to show this was being offered. Two of the care staff on duty were not aware this had been agreed. We did not see the person engaging in any activity other than watching television. We observed another person getting agitated with a member of staff who clearly did not know how to deal with the situation appropriately. The person's care plan stated 'staff to reassure [name of person] when anxious or agitated' but there was no information to guide staff during these incidents or how they should provide reassurance. A member of staff told us the person did get agitated but when we looked at the person's daily records there was no reference to any incidents occurring.

We looked at two care plans on another unit and saw these were individualised and had been updated on a monthly basis. For example, detail about how pain management was specific to the person. Risk assessments such as falls and pressure care were up to date. It was evident that family members had been involved in the care planning process.

In some units people had good information about their life history and personal likes and dislikes; others had very little information. For example, in one unit, we saw one person had a 'life story book' but it was blank with a note to see their relative. Another person's life story book had good information and we could get an overview of the person's life history.

At the last inspection we reported that some staff were not looking at care plans to find out about people's needs. At this inspection we found this had not changed. The management team told us all care records were being transferred to a computerised system and all staff should be accessing these. However, when we spoke with some staff it was evident they were not accessing the computerised care records. One care worker had worked at the home for seven months and did not have a password to access the system for the first six months. Another care worker told us they did not always update daily notes for people. Another care worker told us the paper based care record were the most up to date; another member of staff told us the computerised system was the most up to date.

Although it was evident some care planning and delivery was appropriate, we concluded overall, the provider was not designing care and treatment to ensure people's needs were met. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We received mixed feedback from stakeholders. A health professional told us, "The general opinion amongst our clinicians is that they are effective in what they do, residents appear happy and content. The facilities are excellent there are lots of activities for the residents." Another health professional told us they had found there was some "confusing/ inconsistent nursing records; a mixture between hard documentation and electronic", and they were awaiting an electronic system to be phased in but there was no timescale for implementation. They said, "Nursing records and care plans are not reflective of patient needs and not necessarily up to date."

Requires Improvement

Is the service responsive?

Several people told us they were encouraged to take part in social activities. One person told us there was "lots of entertainment" and that "staff encourage you to go on outings and participate in activities". A visiting relative said, "There's lots going on, there's even a cinema." During our inspection we saw people were engaged in different group and individual activity sessions. We observed a craft group, a karaoke session, a visiting singer which was attended by quite a few people, some of whom were dancing. We also saw activities advertised in each of the units which included painting, outings and discussion groups.

People told us they had regular visitors and they were welcome to visit anytime. We observed visitors at the home throughout both days of our inspection. During the inspection we received mainly positive feedback about the service from people who lived at the home and visitors. We saw people had sent a range of 'thank you' cards, letters and notes complimenting the home. Some example comments were "unbounded thanks to the wonderful staff at Donisthorpe Hall, all the nurses and carers in the units two and three for the affection they showed [name of person]" and "sincere gratitude to staff and executive of Donisthorpe Hall" and "thank you for caring for [name of person] so well" and "all of the team at Silver Lodge have been wonderful, have gone beyond the call of duty so many times when caring for [name of person]".

We asked people about raising concerns or complaints. Some said they would speak with the managers but others were unsure who they would speak with. Those who said they had complained or voiced concerns said they were content with the outcome. Some people had information about how to complain in their room.

The provider had introduced a new complaints policy and procedure in February 2015. We looked at the complaints log for 2015 and noted there had been 22 received. The summary contained the nature of the complaint, outcome of the complaint and lessons learned. We did not see the date recorded as to when the complaints were made and the date the complaint was resolved, therefore, we were unable to determine if they had been resolved in a timely manner. The management team agreed to ensure this information was recorded in future.

The provider had recorded a range of lessons learnt which included closer monitoring of communal areas, accompanying agency staff during medication administration, transferring staff to different units, better communication and encouraging relatives to receive dementia training. We saw some complaints and outcomes were shared with people and staff within scheduled meetings.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider was breaching three regulations. The breaches related to management of medicines, supporting workers and assessing and monitoring the quality of service provision.

After the last inspection we received a report of actions. The provider assured us they had made improvements to their service and confirmed the action plan had been completed at the end of March 2015. At this inspection we found the provider had not made the required improvements and were still in breach in the same areas. We also found they were breaching two other regulations.

We reported at the last inspection that there was a lack of consistency in service provision. We found inconsistencies in how well people's needs were assessed and their care and support was planned and how well people were protected when they lacked capacity. We found staff training and supervision was not being appropriately monitored, and there were inconsistencies when we looked at how risk and quality was being assessed and monitored. At this inspection we found the same problems were still evident.

The management structure was changed following the last inspection but we found the new arrangements were not working effectively. Care managers had recently been introduced four weeks prior to the inspection and were covering the whole service; they replaced most of the unit managers. However, there was real confusion about the care manager's role. Senior managers told us the care managers were involved with staff supervision, appraisals, admissions, care standards, audits, on-call, interviews, staff development and allocation of bank staff. We spoke with three care managers, who were previously unit managers, about their role. One care manager said they went "where needed". We asked about accident and incident records. One care manager said, "Health and safety deal with that." We asked about safeguarding records and a care manager told us they did not know if they were kept at unit level or held centrally. Two care managers told us they were unable to provide information about people who lived at the home because they didn't have this level of knowledge.

Some people told us the home was well managed; others did not. Several people said they didn't know who was in charge on their unit. One person who used the service said, "I feel I have confidence in the administration." Another person who used the service told us they thought there was too much internal politics going on with people trying to "score brownie points". They also said, "There is no one in charge of this unit since [name of member of staff] got promoted." Another person said, "New management with new ideas. They are moving people around and that is not good for me."

We looked at how people were involved in developing the service and found opportunities were very limited. The provider asked the views of people to help drive improvement but this was infrequent. Most people we spoke with told us they had not participated in any 'resident and relative' meetings. One person said they used to attend but didn't anymore. We looked at meeting minutes which showed there had been a meeting the day before our inspection and the previous one was held seven months before. Although they had not been held regularly we saw they had discussed a range of relevant topics at both meeting which included, use of agency staff, the environment, catering, activities, laundry and key worker role.

In the main, staff we spoke with generally felt the service was well managed; several described the management team as "approachable". One member of staff told us the care managers visited regularly and "they get involved, ask how things are going". Another member of staff told us they would feel confident approaching the care managers and the registered manager who visited the units daily. Another member of staff said, "Leadership is good and I am happy. I get support when I need it." One member of staff said, "It's like seven homes and is very segregated." They told us they were unsure if the unit they worked on had a unit manager. Another member of staff said, "They are changing things too quick."

One member of staff who had worked at the home for a year told us they had not attended a staff meeting and had not seen any meeting minutes. A nurse in charge of one unit told us they didn't know where the staff meeting minutes were kept or when the last one was held. One member of

staff said they attended group discussions twice a month. Another member of staff said they couldn't remember

Inadequate

Is the service well-led?

when they last held a staff meeting but attended daily handovers where they discussed residents' needs and other issues. We looked at handover notes and found only information relating to people's needs were recorded.

We looked at meeting minutes and saw a range of meetings were held, however, from the responses we received from staff it was evident not everyone was getting the opportunity to attend. The provider held a staff forum and a representative from each unit could attend. We saw the last meeting was held in March 2015 and they discussed staff shortages; NVQs (national vocational qualifications), footwear protection, fridges and clocking in/lateness. A registered nurse meeting was held on the first day of our inspection. A head of department meeting was held in April 2015 and January 2015. Quality assurance meetings, health and safety meetings, human resource meetings, quality sub-committee meetings and clinical services meetings were also held. Meeting minutes showed that a range of topics were discussed and areas of concern and action points were discussed.

We received mixed feedback from health professionals. One health professional told us there were "leadership issues" and "low staff morale". Another health professional told us, "The management team has recently undergone some changes but all our contact with them has always been very good they are helpful and are happy to discuss anything that they feel will improve the care that they give. They have always had an open line of communication between the GP practices and themselves and have been fundamental in exploring new ways of working with GP practices to improve residents care. Staff in general appear well trained and well led." Another health professional told us, "At present when visiting the home it feels rather chaotic, and there appears to be a lack of leadership. I understand there has been a recent management re –structure but this is impacting all units within the home. However, on a positive note, some of the units are using technology to aid patient care. Some of the staff are using a primary care IT system, which is helping improve communication between our practice and the home. I am also aware the home has shown some interest in Year of Care (which is about improving care for people with long-term conditions in the NHS). So in essence I feel the home is trying its hardest to change and keep up with the times."

At the last inspection we reported that the results of a 2014 'resident' satisfaction survey showed positive responses outweighed negative responses. Where negative responses were received the provider had identified further actions. At this inspection the provider told us no further surveys had been issued.

We looked at a range of quality assurance records but found these were not fully operational. A member of the management team shared with us the provider's 'Annual Quality Improvement Plan 2014', the 'Dementia Strategy 2013-2016' and the 'Strategy 2013-2016', and stated they were not effective so would be revised.

The management team told us a range of audits were held on the units which included mattress, infection control, care plan and medication, however, when we asked to look at these they were not available. On one unit we were told, they only had one audit, which was a mattress audit completed in May 2015. In another unit we were told no audits were available.

At the inspection we identified there was a lack of gathering, recording and evaluating information about the quality and safety of the service and concluded the provider's systems and processes were not operated effectively. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Although we found, that since the last inspection the provider had not been effectively assessing and monitoring the quality of the service or taking appropriate action to address shortfalls, we were reassured that the provider had started to take action to address a number of concerns prior to this inspection. They had identified that some systems and processes were not effective. During the inspection, the Chief Operating Officer shared with us the areas of concern they had highlighted. They had invited an external company to undertake quality assurance audits from June-August 2015. These had commenced just before the inspection and had already flagged up a number of issues and concerns. After the inspection, the provider wrote to us and outlined the actions they had already taken in response to the inspection feedback.

Before this inspection we reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home since the last inspection. We noted the provider had notified CQC about

Inadequate

Is the service well-led?

some significant events such as deaths and serious injuries, however, they had not sent any notification of abuse or allegations of abuse. We looked at the provider's 'monthly safeguarding reports' which detailed six incidents that were reported to the local safeguarding authority between November 2014 and May 2015, however, these had not been reported to CQC. The 'monthly safeguarding report' had a column on the spreadsheet titled 'CQC informed' The registered manager told us they were not aware these incidents needed reporting to CQC.

In May 2013, CQC inspected Donisthorpe Hall and reported that people were not adequately protected from the risk of abuse because the provider had not followed local guidance or national regulatory requirements on reporting allegations of abuse. We told the provider they must take action to address this. In August 2013 we carried out a follow up inspection and found the service had improved and were notifying CQC about incidents that affect the health, safety and welfare of people who used the service. It was evident at this inspection they had not maintained this and were again failing to report notifiable events. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents. we are dealing with this breach separately and will report on this when this work is complete.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care and treatment was not appropriate and did not meet people's needs. The registered person did not fulfil their duty by carrying out, collaboratively an assessment of the needs and preferences for care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment was not provided with the consent of the relevant persons.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess the risks to the health and safety of service users and did not do all that was reasonable to mitigate risk.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not have systems for the proper and safe management of medicines.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 7 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person did not have suitable arrangements to ensure people were safeguarded against the risk of abuse.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 12 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have systems that were effective to assess, monitor and improve the quality and safety of services.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 12 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

Sufficient numbers of competent staff were not deployed in order to meet people's needs in a timely way.

Staff did not receive appropriate support to enable them to carry out their duties they are employed to perform.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 7 September 2015.