Donness Nursing Home Limited

Donness Nursing Home

Inspection report

42 Atlantic Way
Westward Ho!
Bideford EX39 1JD
Tel: 01237 474459
Website: not applicable

Date of inspection visit: 11 February and 9 March 2016
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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service caring?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection on 2, 9 and 11 December 2015. 13 breaches of regulation were found and we served two warning notices, relating to staffing and good governance. During the inspection in December 2015, we shared our concerns about staff practice and staffing levels with the local authority safeguarding team, commissioners and clinical commissioning group. They are currently reviewing and monitoring people's care. There is a whole home safeguarding process in place.

After the comprehensive inspection we received concerning information from several sources. This information suggested that people's physical and emotional needs were not being managed appropriately because of low staffing levels. There were also allegations of poor practice by some staff. We raised these additional concerns with the local authority safeguarding team. We visited the home on 11 February and 9 March 2016 for a focused unannounced inspection to look at how staff were deployed in the home. The date by which the service should be compliant with the warning notice relating to staffing was 15 February 2016. During this inspection, some staff practice led us to raise concerns with the provider regarding how people's privacy and dignity was maintained.

On the first day of the inspection, we arrived at the home at 4.30am to check on the staffing levels at night and to see how people were being supported by staff. On the second day of the inspection we arrived at 3.30pm to judge how people's health and social care needs were being met and to check on staffing levels.

We judged that although there had been some improvements the warning notice had not been met. This was because some shifts were operating at lower levels than the provider's assessed level even when people's care needs had increased. The approach to replacing staff when they rang in sick was still not consistent. New

Summary of findings

staff were not provided with an induction which enabled them to shadow experienced staff before working as part of the shift. Care records did not consistently demonstrate people experienced regular care in line with risks to their health and their well-being. There was still no system for staff to check each other's location in a building with bedrooms based over three floors, apart from using call bells in people's rooms.

Following the focussed inspection, CQC were contacted by a relevant professional regulatory body who informed us that a staff member working at the home had not been registered with them for a number of years. This meant the staff member had been working in the role of a health professional when they did not hold the appropriate registration. We contacted the provider and local authority on the same day as receiving this information. The provider told us the staff member was no longer working at the home. We are taking further action and will report on this when it is completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?
The service was not safe.

Staffing levels were not consistent and poorly managed, which did not ensure people were safe or that the risks to their health were appropriately managed. This meant people's care and social needs were not consistently met.

Inadequate

Is the service caring?
Aspects of the service were not caring.

Some staff practice undermined people's dignity, safety and privacy.

Requires improvement

Donness Nursing Home

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 regulation associated with staffing under the Health and Social Care Act 2008. The team inspected the service against two of the five questions we ask about the services: is the service safe and is the service caring.

We visited Donness Nursing Home on 11 February and 9 March 2016. The inspection was unannounced and was carried out by two CQC inspectors on each day.

We reviewed all information about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing the daily life in the home including the care and support being delivered in communal areas. We also visited people in their rooms. We spoke with or met the people who used the service. We spoke with the provider and six staff.

We reviewed records relating to staffing levels, staff sickness and looked at a range of care records for five people, and spot checked night and personal care records for 11 other people.

Inadequate

Is the service safe?

Our findings

At the inspection carried out in December 2015, there were not sufficient numbers of staff on duty to provide care and support for the people living at the home. We served a Warning Notice which said the provider must meet the legal requirements by 15 February 2016. The provider's action plan said they would be compliant with the Warning Notice by 15 February 2016. However, when we met with the provider on 23 February 2016, they confirmed they had not met the assessed staffing levels at night.

At this inspection we looked to see if the Warning Notice had been met. We found the deployment of staff did not always meet the care and social needs of the people who lived at the home. Some staff on duty were not always suitably skilled and experienced. We also found that some risks to people were still not well managed. By the end of the second day of the inspection, some of the issues regarding risk that we had raised had been met.

On the first day of this inspection we arrived unannounced on 11 February 2016 at 4.30am in the morning. This was because we had received concerns about low staffing levels and poor staff practice at night. As we approached the home, we saw there were four rooms, which we identified as bedrooms that had lights on.

After entering the home, we checked on the well-being of people using these rooms because one of the concerns shared with us was that night staff began to wake people up at this time when this was not the people's preference.

One person whose light was on told us they were unwell. There was an unpleasant odour in the room. They said their last drink had been given to them "a long time ago". They said they would like another. We called staff using the call bell, which was not in easy reach of the person; the person said "she might come this time." We later saw staff entering their room with a drink.

The rota for the night of 10 February 2016 showed only a nurse and a care worker were assigned to be on duty. Staff confirmed they were only the two staff members on shift and arrangements had not been made to request an additional staff member. Previous rotas showed the provider had assessed that three staff were needed to provide care at night. The provider confirmed other night shifts had also only had two staff on duty. The Care Quality Commission had not been notified of issues relating to staffing levels despite this potentially impacting on the provision of care.

We expressed concern to the provider that the night shift on 10 February 2016 was understaffed. This was particularly significant as staff told us 15 people had experienced diarrhoea and vomiting in the last ten days. Records showed ten people were still experiencing symptoms when the two night staff started their shift. This impacted on the level of care people needed to support them with their symptoms. Since our inspection in December 2015, a protocol had been put in place to demonstrate how replacement staff were organised when staff rung in sick and shifts were understaffed. Records showed this system was not routinely followed, which staff confirmed, and had not been followed on the night of our visit.

Due to the low staffing levels, we ensured we did not interfere with the staff members' work and spent a minimal time with talking with them. The two staff members spent a significant amount of time looking for each other as they were providing care over three floors. There was no system in place for them to be able to contact each other unless they used a call bell. One person waited an

hour and 45 minutes for a drink; a staff member said our visit had led to this delay. We looked to see how often people had been checked that night. The records were not completed contemporaneously so the last care entry for 23 people was either 11pm or 12 pm. This meant there had been no recording for up to five hours. Staff told us people had been checked.

Records for checks on other nights had entries recorded every hour. Night staff told us some people were re-positioned regularly but staff confirmed there was no record for this type of care at night. The design of the 'comfort' chart meant there was only space to record up to 9pm. This was despite one person being assessed as at high risk of potential pressure damage to their skin. This concern was highlighted to the provider at the end of our visit.

Night staff said some people had to be routinely moved because of significant risks of damage to their skin. Charts showed this was generally at the time specified between two or three hours but according to these records there

Is the service safe?

had been times in the evening and night in February 2016 when people had not been moved for up to 13 hours. Nursing notes for February 2016 stated one person's skin was 'very red' and staff were reminded to change the person's position. The provider said there was only one person with a pressure sore, which in their opinion indicated staff were assisting people at the times required but not recording their actions. The person with a pressure sore said they were moved by staff but did not know when, records showed the pressure sore was being monitored and treated by nursing staff.

Night staff told us people had been encouraged not to use communal areas to help minimise the risks of more people being infected by the gastro-intestinal outbreak. Housekeeping staff arrived at 7am and began cleaning; we accompanied them into one room. A person was distressed; they were pulling at the bedrails which were in place. They told us "it's not fair". Staff said this person normally chose to get up early. They had no means of calling for help as they could not reach the call bell. They shared a room and the other person had a call bell above their bed but it was out of both of their reach. We waited to ensure staff assisted them. Because of the time of the inspection, it was not possible to meet everyone as some people were asleep. However, four people either did not have a call bell or were unable to reach one.

The provider told us they were aware of some problems raised by night staff about poor practice and had plans to meet with them to address the issues. However, they confirmed they had not carried out any unannounced spot checks to check if the allegations of poor practice were true. Since the December 2015 inspection, three night staff had left.

On the second day of our inspection, there were three staff on duty, including a nurse, in the afternoon when the assessed level was four. The fourth staff member was attending a moving and handling training session taking place in the home and came on duty at 4.30pm.

A staff member said the provider had increased staffing on some afternoon shifts to increase the staff on duty from four to five, which they said had impacted positively on the quality of care. However, rotas showed this had only occurred six times out of 24 shifts. At the December 2015 inspection, staff said it was hard to support people with baths and showers because of low staffing levels. A spot check on people's records showed there were still significant gaps between this type of care being provided, for example up to ten days.

CQC received a concern in February 2016 that new staff were not given appropriate induction training to move people safely. The provider told us new staff were not using equipment on their own until they had completed training on 9 March 2016. New staff had been recruited to work at night in January 2016 but rotas showed that on their first shift they were not shadowing experienced staff. Instead, they were working as part of the shift. And on one night shift, two new staff were working on the same shift for the first time with only one other staff member to support them.

On the second day of the inspection care records in people's rooms were up to date. Records for people who needed support because of risk of damage to their skin showed people were being turned or moved at the times indicated by nursing staff. People had call bells in place or in reach. A motion sensor used to monitor a person's safety was working and staff responded quickly to the alarm.

In the December 2015 CQC inspection, we highlighted how the well-being and safety of people in communal areas was compromised because staff were providing care in other areas of the building. On this inspection, a staff member sat with five people in the lounge in the early evening and engaged with two people in a kind and compassionate manner. One person was active during the evening; records showed this was their usual routine. Nursing notes for the day of our inspection emphasised the person needed to be monitored by staff at all times and a GP had been asked to review the person's medicines. The person's daily notes showed there had been incidents in February and March 2016 where they had been at risk of falls by using the stairs without assistance and without staff knowledge. Their records showed they were at high risk of falls and that the system to prevent them using the stairs was not effective.

Staff confirmed they had attended a meeting held by the provider and were aware that improvements in practice were needed and that staff were being recruited. Staff had been recruited since our last inspection but staff had also left.

We judged that although there had been some improvements the warning notice had not been met. This

Inadequate

Is the service safe?

was because some shifts were operating at lower levels than the provider's assessed level even when people's care needs had increased. The approach to replacing staff when they rang in sick was still not consistent. New staff were not provided with an induction which enabled them to shadow experienced staff before working as part of the shift. Care records did not consistently demonstrate people experienced regular care in line with risks to their health and their well-being. There was still no system for staff to check each other's location in a building with bedrooms based over three floors, apart from using call bells in people's rooms.

Following the focussed inspection, CQC were contacted by a relevant professional regulatory body who informed us that a staff member working at the home had not been registered with them for a number of years. This meant the staff member had been working in the role of a health professional when they did not hold the appropriate registration. We contacted the provider and local authority on the same day as receiving this information. The provider told us the staff member was no longer working at the home.

Requires improvement

Is the service caring?

Our findings

During this inspection, some staff practice led us to raise concerns with the provider regarding how people's privacy and dignity was maintained. One person was fast asleep, a bright overhead light had been left on and the television was playing loudly, which we could hear from the corridor and through a closed door. The person was unable to instigate this arrangement. Staff were unable to explain why the person had been left in this manner. The person's care plan did not state this was their preferred sleeping arrangement.

We met a person who shared a bedroom; the curtain between both people was drawn back so they could see each other, despite one person being physically unwell. Neither person was able to instigate this arrangement. With both of their permission, we drew the curtain to protect both of their dignity and privacy. A bright spotlight was angled directly above one person's head; they said it was too bright, so with their permission we changed the position so it did not disturb either of the people sharing the room. The provider told us later this style of light was the person's choice.

There were two people up when we arrived at 4.30am, both people were dressed. One person indicated it was their choice and was waiting for a drink; they looked dishevelled during our visit. The second person was unable to tell us if it was their choice but staff said this was their routine. Staff were heard encouraging them to accept personal care.

Staff said people were given a choice when they got up, which the provider agreed with. However, other staff said the numbers of people who were up by the time day staff arrived at 7.30am depended on staffing levels at night rather than people's personal preferences. They alleged each member of the night staff were expected to get at least four to five people up before they finished their shift.

During the second day of our inspection, staff spoke kindly when they supported people; their manner was unrushed and friendly. However, some people were given more attention than others. Most people responded well to conversation but spent the majority of their time unengaged with their surroundings. The provider said they had not yet been able to recruit staff to promote more activities. One staff said in their opinion there had been an improvement in the atmosphere in the home and the way in which staff worked. Written feedback to the provider from the relatives of two people was positive about the standard of care, while a third person said the care seemed to have improved recently with 'more attention being paid'. They noted in the past people were left too much on their own.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not have suitable arrangements in place to ensure people's dignity was maintained in a consistent manner.**