Anchor Hanover Group

Devonshire House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Devonshire House is a residential care home providing care to up to 69 people. The service provides support to mainly older people some of whom are living with dementia. At the time of our inspection there were 49 people using the service.

People's experience of using this service and what we found
Staff were not always following safeguarding procedures when they identified unexplained bruising. The provider took action to ensure this was resolved.

The quality assurance system had not been effective in identifying the issues we found during the inspection. Action plans were not always clear regarding who was responsible for the action and by when.

Medicines were stored and managed safely within the home. Medicines were administered in a timely manner and in a way that respected people's preferences. The risk of people falling did not consider the contribution of the medicines they were prescribed.

Staffing levels meant that people were safe and they received their care in a timely manner. Recruitment procedures had been followed to ensure new staff were suitable.

Staff felt supported to carry out their roles effectively. People and staff were asked their opinions on the quality of the service. The local authority had supported the home with improving the safe use of medicines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (report published March 2019).

Why we inspected
We received concerns in relation to the number of falls, medication errors and unexplained bruising. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Devonshire House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to following safeguarding procedures and quality assurance at this inspection. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Devonshire House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors, a medicines inspector and one Expert by Experience carried out this inspection. We used a large team so that inspectors did not have to move between areas of the home to reduce the risk of spreading any infections during the pandemic. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience made video calls and telephone call to people and their relatives.

Service and service type
Devonshire House is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Devonshire House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who live at Devonshire House and three family members of people who live in the home. We also spoke with the registered manager, district manager, two deputy managers, two team leaders and two care assistants.

We reviewed a range of records. This included care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested some further records after we had visited the home so that we could conclude the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating remains the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The systems to protect people from the risk of abuse were not always being followed.
- Although staff had received safeguarding training and safeguarding procedures were in place these were not always being followed.
- We looked at three people's records. Two people's contained information about unexplained bruising and on one occasion blisters to both feet. No safeguarding referral, or phone calls to the safeguarding team to discuss if referrals were needed, had been made for five incidents, no investigation had taken place and no healthcare professional advice or treatment had been sought. The providers regional director responded immediately to our concerns and put an action in place before the end of the day.

Safeguarding procedures had not been followed to protect people from abuse or improper treatment. This was a breach of Regulation 13(Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments and care plans did not always contain current information for staff to follow. For example, one person's risk assessment and care plan had not been updated to include the information from a physiotherapist assessment in January about the level of assistance they required to walk.
- Staff were not always following safety procedures to ensure that risks in the home are reduced. We saw the risk assessments for two people stated that when they had unexplained bruising staff should seek advice from a healthcare professional when bruising was found, however this had not happened.
- One person had lost a significant amount of weight over six months. However, the information to guide staff about their needs and risks was conflicting. One risk assessment stated that they should be on nourishing snacks and weighed weekly, however their nutrition care plan did not include that information and had not been updated since April 2021. We discussed this with a member of staff and they updated the care plan immediately.
- Due to staff vacancies there was a high usage of agency staff. Many of the agency staff had worked in the home before and knew people well. The registered manager was sent a staff profile for each agency member of staff. However, we identified that this did not include if they had completed safeguarding and fire training. This could mean that staff did not have the necessary training.
- There was an accident and/incident reporting procedure in place. However, this had not always been effective at recording all incidents on the providers electronic system which was used to analyse the trends and themes. The number of falls had been analysed and recent information showed that there had been a reduction.

● The provider was aware of the reporting issues and had recently held a meeting with the staff to establish their expectations and remind staff of the procedure to follow.
● We discussed with the registered manager that the falls risk assessment should include medicines that may contribute to a risk of fall. Records for transdermal patches (medicines administered through the skin) were not always completed accurately and to reflect the administration advice of the manufacturers

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider took action immediately after our feedback to identify any other incidents that had not been dealt with appropriately and took the necessary action.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● Staffing levels were determined according to peoples assessed needs. There were sufficient staff to ensure that people were safe. Staff confirmed that they had time to carry out their roles. We saw that staff were busy but also had time to stop and chat with people and support them with activities.
● People gave us mixed feedback about the staffing levels. One person told us, "Staff work hard, are very sympathetic, they used to have time to chat but not now, I am fond of all of them." Another person told us, "Got a buzzer, normally you hear them go on all day, they come very quickly, never very long, same mornings, evenings, nights and weekends." The registered manager is continuing to assess the staffing levels to ensure they are adequate.
● Safe recruitment practices for permanent staff had been followed. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Using medicines safely
● The records and levels of stock tallied to show that people received their medication as prescribed.
● We saw evidence of learning from medicines errors and changes put in place to ensure incidents were not repeated. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. One person told us, "I have tablets four times a day, they watch you take them, never missed any."

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● The home was following government guidance in relation to people visiting the home.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's quality assurance system had not always been effective at identifying areas for improvement and ensuring action was taken in a timely manner. There had been a lack of robust oversight to ensure safe care was being provided to people. For example, appropriate action had not been taken in response to someone developing blisters on their toe. Although it had been recorded in their care plan no medical attention had been sought. This issue had not been identified until we raised it during the inspection.
- Audits did not always have clear action plans or show when actions had been completed. Some actions continued from month to month. Not all audits were an accurate reflection of what we found during the inspection. For example, the safety checklist had not identified issues we found with unexplained bruising.
- The monitoring systems in place had not identified the issues we found regarding some care plans and risk assessments needing updating.
- Staff raised concerns that there was a lack of willingness to report concerns to the management team. The provider was aware of this and had recently held a meeting to make staff aware of the expectations.

The systems in place to monitor and improve the quality of the service were not always effective at identifying areas for improvement. This was a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had a clear set of values in place. They were sharing the values with staff through meetings and supervisions.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The Commission had not been notified of all safeguarding incidents in a timely manner. However, this was not due to a reluctance in reporting to the Commission but because the incidents had not been communicated to the management team.
- Staff told us that they thought the training and support they received equipped them for their roles. One person told us, "They are good, kind sympathetic staff"
- Feedback from complaints was used to improve the service being offered. One person told us, "I have seen the manager two or three times to complain – they had some poor workers in the garden and I was outraged

as they took limbs of the magnolia tree, that was eight days ago and they did not come back, I was listened to."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The service had worked with organisations including local authorities to make improvements. For example, a high number of medicines administration errors had been reported to the local authority. The registered manager provided an action plan to reduce the number of errors and this had been successful.

● The management team welcomed our inspection and feedback. They showed their commitment to making the improvements needed and keeping people at the heart of these. They took action immediately regarding the issues the inspection had identified and provided extra staff into the home to support the management team in identifying any other areas of concern.

● Surveys were given out to people and their families asking them to rate the service and provide feedback. Staff meetings were held regularly where staff could add to the agenda and raise any ideas or issues. One family member told us, "Your thoughts and views are taken onboard and considered – it is useful."

● Equality and diversity support needs were well managed, and staff supported everyone to meet their specific needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Procedures had not always been followed to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures had not been followed to protect people from abuse or improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems were not always effective. Regulation 17(1)