Donisthorpe Hall

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 28 August and 4 September 2018 and was unannounced. At our last inspection published on 16 March 2018 we rated the service requires improvement. At this inspection we found the service remained requires improvement overall but improvements had been made. This is the third consecutive time the service has been rated Requires Improvement.

Donisthorpe Hall provides accommodation and nursing for up to 189 people in one adapted building. Donisthorpe Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection there were 70 people using the service. The registered manager told us they were going to change their registration from 189 to 90. People were lived across four units. The home is managed and run by Donisthorpe Hall, a private organisation. The organisation does not have any other services. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems and processes in place to protect people from the risk of harm. Some service certificates were due for renewal.

Usually there were enough staff on duty to meet people's needs but we found instances when one unit became very busy and task orientated.

Checks were carried out during the recruitment process to ensure only suitable staff were employed.

There were arrangements in place for the safe management of people's medicines and regular checks were undertaken.

The service was clean and had effective systems to protect people by the prevention and control of infection.

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

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act

2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were supported by staff who were supervised and appraised. Staff were mostly trained but some staff were not up to date with the provider's mandatory training.

Staff were caring and treated people with dignity and respect. Care plans addressed each person's individual needs, including what was important to them, and how they wanted to be supported.

People were involved in undertaking activities of their choice. However, one unit did not engage people with activities as much as the others.

People were cared for in a way that took account of their diversity, values and human rights.

People's end of life wishes were discussed and recorded.

People living at the service, their relatives and stakeholders told us that the management team was approachable and supportive. People and their relatives were supported to raise concerns and make suggestions about where improvements could be made.

The provider had systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed. However, some of the areas of concern we raised during the inspection, the registered manager hadn't acted upon, but advised us this was due to time constraints.

The registered manager kept themselves informed of developments within the social care sector and cascaded important information to the rest of the staff team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The health and safety of the environment was monitored but not all service checks were up to date.

Risk assessments were in place for areas of identified risk.

We observed enough staff to keep people safe, however one unit did not have staff as available as other units.

Medicines were administered in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always completed training in line with the providers policy.

People were involved in the care planning process.

People were supported with their nutritional needs.

Staff had a good understand of the Mental Capacity Act 2005) and Deprivation of Liberty Safeguards were referred appropriately.

Is the service caring?

Good

The service was caring.

People were supported with their choice and treated with respect and dignity.

People were supported with their preferred method of communication.

People and staff told us staff were caring in their attitude.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always sufficient activities for people in all units.

People knew how to complain and complaints were monitored and investigated.

Care plans reflected people current needs and detailed their preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits had identified areas for improvement but action had not always been taken to improve these areas.

People and relatives told us they had confidence in the management and board of trustees.

The culture in the service was mostly positive but some feedback indicated staff were not motivated and happy.

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 comprehensive inspection took place on 9 and 28 August and 4 September 2018 and was unannounced. The inspection was carried out by one inspector, one bank inspector, one assistant inspector, a governance specialist advisor and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit, we spent some time observing staff delivering care and support to people, to help us understand people's experiences of using the service. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We also looked at records, including care plans for eight people, six staff records and records relating to the management of the service. We spoke with 12 people who used the service, 10 relatives and 15 staff including the registered manager, the project manager, two staff nurses, chairman of the board of trustees, two activities staff and eight care staff. We also spoke with a healthcare professional who was visiting at the time of our inspection.

Good

Is the service safe?

Our findings

At the last inspection we rated the service as requires improvement. At this inspection we found improvements had been made and we now rated this domain as good.

People we spoke with indicated they felt safe living at Donisthorpe Hall. One person told us, "'Feel very safe here, never had reason not to feel safe." Relatives agreed and one said, "I know everyone is safe here. I have no concerns with that. Its lovely."

The provider had a health and safety policy in place, and this was made accessible to staff and people living at the service. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. We saw evidence that all areas were regularly checked and any requirements were actioned appropriately. There were regular safety checks of equipment which included kitchen equipment such as extraction fans and moving and handling equipment such as hoists, slings and weighing scales. However, two of the seven electrical safety certificates for different areas of the building had been rated unsatisfactory. We raised this with the registered manager who agreed such documents should be in place and they would ensure they were introduced as soon as possible. They told us work had been undertaken to improve the systems and new certificates had been issued. People were protected from the risk of infection and staff used appropriate protective equipment. All areas of the home were odour-free, clean and tidy and free of any hazards, and all cleaning products were safely locked away.

Incidents and accidents were recorded and analysed by the registered manager and included an action plan to address any issues or trends identified. We saw evidence that incidents and accidents were responded to appropriately and care plans and risk assessments were updated accordingly. Lessons were learned and appropriate action was taken to prevent reoccurrence. For example, when a person had fallen from their bed and had sustained an injury, we saw that the provider had put a sensor mat and crash mattress in the person's room and had updated the person's risk assessment. We saw that there had been no further incident following this action. However, one of the four units post analysis audit from the provider showed an increase of accidents and incidents. We mentioned this to the registered manager who was aware of the increase and was investigating the problem.

People and relatives told us at times staffing levels could be better. The staffing records we viewed confirmed there were always sufficient staff on duty at any one time to provide care and support to people. However, we observed during busier times of the day such as meal times, staff were task orientated and sometimes rushed. One staff member told us, "It's always nice to have more staff but its ok where it is." We mentioned this to the registered manager who told us they had many changes of staff recently and appropriate deployment of remaining staff was still being worked towards.

The service had taken steps to protect people in the event of a fire, and we saw that a general fire risk assessment was in place. We saw evidence that checks of all fire safety equipment were carried out regularly. These included the fire alarm system and fire extinguishers. The service carried out regular fire drills and fire alarm tests and staff were aware of the fire procedure. People's records contained personal

emergency evacuation plans (PEEPS). These included appropriate action to be taken in the event of a fire according to people's abilities and needs.

Arrangements were in place for the management of people's medicines. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). This assured us that medicines were available at the point of need and stored securely.

Medicines were administered by nurses who had been trained in medicines administration and there were regular medicines audits. People received their medicines as prescribed, including controlled drugs. However, we looked at 20 MAR charts and found two gaps in the recording of medicines administered. We discussed this with the nurse in charge and the registered manager who could provide us with evidence that the two medicines had been administered and this was a recording error. The registered manager told us they would speak with the members of staff responsible and take appropriate action.

Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example, one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the person.

Historically, we recommended the service review its documentation around 'when required' medicines. At the last inspection we found this recommendation had not been met. At this inspection we observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. We saw PRN protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. This also included information such as risk assessments with certain medicines that had a sedating effect.

Staff said they received training in safeguarding adults and training records confirmed this. The service had safeguarding and whistleblowing policies and procedures in place and staff had access to these. Staff had a good knowledge of how to report any concerns they had.

Staff were recruited in a safe way. We reviewed recruitment records for eight staff who were working at the time of inspection. We found staff had applied for a post, been interviewed and had their documents checked. The provider completed a Disclosure and Barring Service (DBS) check on staff. This is a check completed of people's backgrounds for any cautions, convictions and barring lists to help employers make better recruitment decisions. All staff records we reviewed had DBS details in place.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified, either at the point of initial assessment or during a review. Risks identified included manual handling, falls and nutrition. Each risk was analysed and included guidelines for staff to understand how to support the person effectively. For example, for a person at risk of falls, we saw, "[Person's name] needs to be monitored closely to reduce the risk of falls."

There were protocols in place to respond to any medical emergencies or significant changes in a person's wellbeing. Emergency contact numbers were accessible. Nursing and senior staff were available to help and support the staff and people using the service in case of an emergency.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we rated the service requires improvement. At this inspection we found although improvements had been made, further improvements were still needed. We rated this domain requires improvement.

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that where possible, people had been involved in discussions about their care and support. Assessments included background information which helped staff understand each person and their individual needs. Relatives thought that the staff team provided a service that met people's individual needs.

People were supported by staff who had appropriate skills and experience. All staff undertook training the provider considered mandatory such as health and safety, safeguarding, fire safety and infection control. They also undertook training specific to the needs of the people who used the service which included end of life care, dementia and nutritional supplements training. All staff employed at the service had achieved or were undertaking the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. However, we reviewed the training records of the service and found 27 staff had manual handling training that had expired. We mentioned this to the registered manager who was aware of the concern and were applying for more courses. We found no accidents or incidents had occurred as a result of the lack of manual handling training.

People were cared for by staff who were suitably supervised and appraised. The staff we spoke with told us that they received regular supervision and records we viewed confirmed this. They said that this had provided an opportunity for them to address any issues and to receive feedback on good practice and areas requiring improvement.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider understood the principles of the MCA and had followed its requirements. The registered manager had identified people for whom restrictions had to be put in place and had taken appropriate action to make sure that where the

restrictions amounted to a deprivation of liberty these were in people's best interests. This included people who required the use of bedrails to prevent them falling out of bed, and the use of locked doors to prevent people at risk going outside by themselves.

Care records we checked contained 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms. These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if they stopped breathing. These were authorised by the relevant healthcare professionals with evidence of consultation with the relatives where the person who used the service lacked capacity. This meant that people were being appropriately supported when decisions about their care were made. Where family or friends had Power of Attorney (LPA) in place, the service maintained a copy of these records. This meant that the decision-making process could be followed clearly.

All staff employed at the service had received training in MCA and DoLS. Staff we spoke with demonstrated a good understanding of the MCA and DoLS. They could provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interest if they lacked capacity. We saw information and posters in various areas of the home about the MCA.

The staff recognised the importance of food, nutrition and a healthy diet for people's wellbeing, and as an important aspect of their daily life. People's individual nutritional needs, likes and dislikes were assessed and recorded in an 'eating and drinking' care plan. Where people struggled with their intake of nutrition and hydration, they were monitored on a Malnutrition Universal Screening Tool (MUST). We found MUST were completed and updated monthly with people's weight and Body Mass Index. We observed the lunch time experience and saw people who required a soft food or pureed diet received it in-line with their care records.

People received the support they needed to stay healthy. Records showed that people's health needs were monitored and any concerns were recorded and followed up. There was evidence that people were referred to the relevant healthcare professionals when needed to ensure they received appropriate treatment. We saw nutrition and hydration records that indicated someone had lost weight over several months had been referred to a dietician and supplied with supplement drinks to increase their calorie intake. Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This showed that the service was meeting people's health needs effectively.

The environment was designed to meet people's needs, in particular those living with dementia. For example, corridors and people's bedroom doors were painted in contrasting colours and there were photographs and pictures on bedroom doors if people had agreed to this. There were signs and pictures to help people find their way to their bedrooms, bathrooms or other communal areas. Notice boards displayed photographs of events that had taken place at the home.

The registered manager was familiar with the accessible information standard. This is information provided in a format to people so that they can understand it. For example, we saw the complaints policy had been completed in an 'easy read' version to make it easier to understand for some people. Other documents had been completed is an easy read version and we observed staff reading the menu to people to support them to make their choices.

Good

Is the service caring?

Our findings

At the last inspection we rated the service requires Improvement. At this inspection we found improvements had been made and we now rated this domain good.

People and relatives told us, and we saw people were treated with kindness, compassion and dignity. One person said, "Staff are kind and very respectful. They listen to me, they are very accommodating." Relatives' comments included, "Staff here are kind and compassionate even under extreme provocation" and "Staff are kind, some kinder than others."

Advocacy services were available and encouraged by the service. We saw people used advocacy services in the past and details were easy for people to contact staff support if required. The staff team recognised if someone had no immediate family, then an advocacy service would be appropriate to help make big decisions.

Staff demonstrated a good level of engagement with people. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day. There was music playing throughout the morning, and we saw that people enjoyed singing along to songs. One person commented, "That's my favourite song," to which staff engaged in a conversation with them about it. However, some people who used the service told us staff had complained to them about issues they had with the service. We mentioned this to the registered manager who agreed staff should not mention any concerns they had to people who used the service and would investigate to find out what happened.

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. It was clear from all the staff we spoke with that respect, dignity and personal choice were values they all shared and which they were proud of. The service had a compliments book which contained thank you cards and letters from friends and relatives. Staff also told us about the importance of confidentiality. They said people's private documents should be locked away. We observed staff when talking about one person's medical needs, they did so in a private area.

Staff displayed a gentle and patient approach throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. For example, we observed staff encouraging a person to do their exercises. Throughout the session, the staff member explained the benefit of exercises and said, "This will make you stronger." We witnessed the person responding to this by fully participating. This was rewarded by praise and kind words. Staff were attentive when people needed assistance and responded promptly to their needs. They also encouraged people to remain as independent as they could be, for example one person used a spoon to eat as they found it difficult to use a knife and fork to maintain independence. We observed staff taking time and showing patience for a person who had expressed the wish to mobilise independently and their effort was met with praise and encouragement.

People told us that staff respected their privacy and dignity. One person said, "They always ask permission to enter my room." People were well presented, in clean clothing and with clean hair and nails. There was a hairdressing salon and a hairdresser visited regularly to attend to people's hair.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated the service Requires Improvement. At this inspection we found although improvements had been made, further improvements were still needed. We rated this domain Requires Improvement.

The provider employed two activity coordinators to help ensure that a range of activities were provided seven days a week. There was a record of activities available for each person to see what was happening. Activities included baking sessions, trips out, reminiscence and games. The service benefitted from a holiday room where a picture of a location could be projected onto a wall and lights could mimic the sunshine and heat. The activity coordinators told us they spoke with people to see what they liked to do and accommodated this when they could. Staff told us that this enabled them to support people with activities of their choice.

People's care documentation covered social isolation. One person's care records included details on how they liked to get involved, with whom, and what kind of activities. This allowed staff to support them in social inclusion. Staff told us they ensured there were opportunities to provide activities outside the service environment and within the community whenever possible. For example, they described taking a group of people to a local town and using the garden. They also added that they celebrated religious events throughout the year. However, staff felt it was difficult at times to engage everyone daily. We observed in one-unit people had very little activity during the day. We mentioned this to the registered manager who told us they were trying different methods to make sure everyone had opportunities to participate.

Staff told us they wanted to ensure that the home felt like a home and family environment. They described how, for some people, a hug gained a positive response. One staff member told us their favourite aspect of their job was to 'pamper' people, for example helping people choose hair and make-up styles and painting nails. We observed the same staff member later talking to a person about nail colours. The person was smiling and laughing during this interaction. During our observations, on one unit, staff did not have as much time to engage with people. We mentioned this to the registered manager who told us they would look into this unit to see what additional support was required.

We toured the premises and found the service had an on-site synagogue to support the members of the Jewish community. The kitchen operated as a full Kosher kitchen to meet the needs of people who followed the Jewish faith. People of other faiths were welcomed into the service and supported with their beliefs. People told us they were supported with their religious and cultural beliefs.

Care plans were comprehensive and contained detailed information about the care needs for each person and how to meet these. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. For example, what time people wanted to go to bed or have their meals. Care plans included a 'one-page profile' document. This detailed how best to support a person, what is important to them, what they don't like and who was important to them. Care records also contained information in 'My care passport'. This contained brief information about how to support the person. For example, how to support

them with getting dressed, eating and drinking and taking their medication. This made it clear to staff who were not familiar with the person, how to support them in a person-centred way. We saw care records were reviewed monthly and reflected people's personal needs. Relatives of people who did not have capacity told us they had been consulted about their family member's care plans and had agreed to these. They said they were well informed by the staff about the care their relatives received. We found care records on one unit lacked some personalised detail.

The service had a complaints procedure in place and this was available to people who used the service and relatives. A record was kept of all the complaints received. Each record included the date, nature of the complaint, action taken and outcome. Where complaints had been received, we saw that they had been investigated and the complainants responded to in line with the complaints procedure. At the time of the inspection, over the previous three months there had been 12 complaints received. These varied from complaints of an overflowing bin outside, to concerns of residents arriving for breakfast but no one was serving before 9am.

People's end of life wishes was recorded in their care plan and they had advanced care plans in place. We saw evidence that people were supported to remain at the home until the end of their lives if they had expressed this wish. At the time of our inspection, some people were receiving end of life care. We saw that they were comfortable and well cared for and staff attended to their needs throughout the day. Staff on duty told us they followed advice from the palliative care team who was involved in the person's care. Staff received training on this area of their work.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we rated the service requires Improvement. At this inspection we found although improvements had been made, further improvements were still needed. We rated this domain requires Improvement.

People and relatives we spoke with were complimentary about the staff and the registered manager. They said they were approachable and provided a culture of openness. Comments included, "Home is well managed", "Manager comes around regularly. I can't say anything negative" and "Usually see the manager on a regular basis, most of the time, the home is well managed."

The provider had put in place or changed several different types of audits to review the quality of the care provided since our last inspection. At this inspection we found improvements had been made, but there were still some areas for improvement. Audit types included medicines audits, environmental checks, health and safety checks and care records. Audits also included people's weights, bed rails, tissue viability documentation and nutritional care plans. Audits were evaluated and where necessary, action plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were thorough and regular. Other audits identified areas of concern which the provider and registered manager were already aware of and acting against. For example, high use of agency staff reducing consistency, increase of accidents and incidents on one unit and one unit had not completed the target number of care plan reviews. Audits had not always identified all the concerns we raised during inspection. When audits had identified any concerns we had, action had not always been taken at the point of inspection. We mentioned this to the registered manager who told us, they had a lot of areas to work on to improve the service and they could not all be done at once.

The registered manager was experienced in management but had worked at the service for six months at the time of inspection. They had knowledge of the service, each person's needs and the areas of improvements needed. They kept themselves abreast of developments within the social care sector by attending seminars organised by the local authority, as well as reading publications and consulting relevant websites. The registered manager told us that they felt supported by the provider and board of trustees.

Some staff we spoke with commented that there was an open and positive culture at the home. They felt that the clinical leads and the registered manager were visible and hands on. However, other staff told us there had been a lot of changes recently and felt they did not know what was going on and they had concerns. We asked if they had fed this back to any line management and we were told "no". We mentioned this to the registered manager who said they would approach staff in team meetings. Staff added that there was a shared responsibility across different staff groups and everyone, "Mucked in."

Staff told us they had regular meetings and records confirmed this. The items discussed included care plans, audits, environment updates, ideas for improvements and communication. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any

lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. There were also regular senior staff meetings, and meetings for people who used the service and their relatives. Some of the subjects discussed included complaints and concerns, improvements planned and ideas, mealtime and activities. This indicated that people, relatives and staff were involved in the development of the home and felt valued.

People and their relatives were encouraged and supported to feedback about the service through quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. We saw that the results indicated that overall people were happy with the service and the care provided.

The provider produced a quarterly newsletter which was distributed to people and relatives to keep them informed about the service. This detailed information about events and activities undertaken, any improvements made to the environment, outcomes of inspections, staff news, fundraising and activities.