

Devonshire House Care Limited

Devonshire House

Inspection report

The Green
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Tel: 01388833795

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Devonshire House provides accommodation and personal care for up to 25 people, some of whom were living with dementia or learning disabilities. On the day of our visit there were 22 people using the service.

People's experience of using this service:

People's risk assessments did not consistently cover all potential areas of risk, such as the risk of pressure damage and aggression and did not consistently mitigate risks. We looked at the systems in place for medicines management and found they did not always keep people safe. People felt safe in the care of staff members and were happy with staffing levels. However, staff were not utilised effectively. The provider had appropriate systems in place to support staff to raise any safeguarding concerns. Staff had access to appropriate personal protective equipment (PPE) to help prevent the spread of infection. Premises continued to need work to become safe.

People told us they received effective support. Systems were in place to ensure that staff received appropriate supervision to support them in their roles. Staff felt they were trained to the right level to effectively work with people. Checks were made on the ongoing competency of staff. People were supported to eat meals of their choosing and were supported to access health professionals when necessary. Where people wanted to remain independent with personal care the lack of a shower prevented this.

People told us care staff were caring and kind. People's privacy and dignity needs were not always maintained by staff members caring for them. We could not evidence people were receiving regular baths.

Care plans contained lots of information on people's life history, likes and dislikes. However, every person had the same index of which care plan was included whether this was needed or not. Activities were taking place but needed more work to either involve people as a group or on a one to one basis.

The providers systems and processes in place to monitor and audit the service continued to require improvement. Records management needed improvements regarding medicines, risk assessments and quality monitoring of the service.

The service continued to meet the characteristics of requires improvement but had deteriorated to inadequate in well led.

More information in the full report.

Rating at last inspection: Requires improvement, (published March 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection. At the last inspection in January 2018, we asked the provider to take action to make improvements. Some action had

been completed however further improvements were required. This is the second consecutive time the service has been rated Requires Improvement.

Follow up: We will request an action plan from the provider to understand what immediate action they will take to improve the quality and safety of care provided to people. We will also meet with the provider to discuss this action plan.

This service has received a rating of 'Inadequate' in one or more domains 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.

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 always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Inadequate ●

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 as part of our regulatory functions. This inspection checked 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.

Inspection team:

The inspection team consisted of an inspector, a pharmacy inspector, an assistant inspector and an expert 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.

Service and service type

Devonshire House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection

The inspection was unannounced.

What we did:

We used the information we held about the service to formulate our inspection plan. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. These include information such as safeguarding concerns, serious injuries and deaths that had occurred at the service. 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. We also sought feedback from commissioners of the service.

During the inspection, we spoke with nine people who used the service and three relatives. We did this to gain their views about the care and to check that standards of care were being met. Some people who used the service were not able to speak to us about their care experiences, so we observed how the staff interacted with people in communal areas and we looked at the care records of three people who used the service, to see if their records were accurate and up to date.

We spoke with four members of care staff, the cook, the activity coordinator, the deputy manager and the registered manager. We also spoke with one visiting professional and contacted two staff members via the telephone after the inspection. We looked at records relating to the management of the service. These included accident and incident records, meeting minutes and quality assurance records.

Is the service safe?

Our findings

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

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.

Assessing risk, safety monitoring and management

- At the last inspection in January 2018 we found that risk assessments were not all in place. For example, one person was receiving care from the district nurse about pressure damage, but there was no risk assessment in place. Another person was receiving a soft diet and thickened fluids but there was no risk assessment in place to support staff. We also found that people's safety in the event of a fire had not been fully managed, there were no risk assessments for the outdoor areas of the service and the electrical safety certificate highlighted the electrics were unsatisfactory.
- At this inspection we found that people's safety in the event of a fire and using the out door areas had been assessed and improved and work needed to the electrics had been completed. However, there was further improvement needed with personal risk assessments. As was highlighted at the last inspection, one person was receiving care from the district nurse for skin integrity but still had no risk assessment in place.
- Another person was on thickened fluids, and a minced and moist diet. There was information from the speech and language therapist (SALT), however, there was nothing in the care plan to support staff on how to present this, what foods to avoid and what to do in the event of a choking episode.
- Although we found some improvement with environmental risk and fire safety risks, work was still needed. For example, we saw a commode propping open a fire door, when we removed the commode the fire door was not working. The registered manager said they would investigate this straight away.
- The fridge which stored food in the kitchen was showing a high temperature. We asked to see the daily recording of the temperatures and found they were photocopies of past recordings. This evidenced that no one was checking food was stored at the correct and safe temperature.

This was a continued breach of regulations in relation to safe care and treatment

Using medicines safely

- At the last inspection in January 2018 we found medicines were not administered safely. There were gaps on medication administration records (MAR) charts, staff had little knowledge of what was a 'when required' medicines, patch application records showed the patch had not been applied correctly, and topical MAR charts to show the application of creams were not fully completed.
- At this inspection we found improvements were still needed to medicine management.
- Medicine patches were not fully rotated and applied to different areas of the body. This could lead to the lack of effectiveness of the patch or skin irritation.
- People who self-administrated creams and inhalers had no risk assessments in place to ensure this was safe.

- Although controlled drugs were overall correct, weekly counts were not taking place regularly as per their own medicine policy and on one occasion there was a discrepancy with a controlled drug count. We followed this up after inspection and we were told this was a recording error.
- Two people were prescribed a medicine used for anxiety and agitation, we found both people consistently had this medicine administered at 10pm each night despite daily records showing that both these people were settled or asleep showing no signs of agitation or anxiety. The registered manager completed an investigation and found that daily records were not being completed correctly. Following our inspection, we were told the doctor had discontinued this medicine.
- One person was prescribed five different medicines to be used when required for constipation. There was no guidance for staff to follow regarding which medicine to use and when. We followed this up after inspection and were told three of these medicines had now been discontinued.

This was a breach of regulations in relation to safe care and treatment

Staffing and recruitment

- At the last inspection we found there was enough staff, but many were stood around just watching. We said they could be deployed more effectively. The registered manager agreed to investigate this.
- At this inspection there were five care workers, a senior, the deputy, the registered manager, two kitchen staff, one laundry staff, two domestic staff and an activity coordinator for 22 people. We found they were still not deployed effectively. We saw all staff sitting round a dining table, the registered manager said they would be on their break, but we questioned whether they would all go together for a break. We saw very little interaction other than care needs, with people. This meant opportunities had been lost to engage people in stimulating activities to meet their social and emotional needs.
- People we spoke with said there were enough staff. Comments included, "There are enough staff, they are not stretched, and there are no problems through the night" and "I think there are enough staff, they don't seem pushed, you can see them walking around."

We recommend the registered manager looks at ways staff can support people to be more engaged.

- We saw staff had been recruited safely by the provider.

Preventing and controlling infection

- At the last inspection we found staff were not following infection control guidelines and the laundry did not have a sink in place.
- At this inspection we found staff understood the importance of infection control and we observed them following best practice and using personal protective equipment (PPE) when required. The provider had also fitted a sink into the laundry area.
- All people we spoke with commented on how clean their rooms were and how good the laundry was.

Systems and processes

- The provider had a safeguarding procedure to follow and staff had been trained to understand the signs of abuse and how to report incidents.
- People we spoke with said they felt secure. Comments included, "Yes I do feel safe and secure," "I do indeed feel safe" and "Oh yes, I am safe I can stick up for myself no problem."

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Adapting service, design, decoration to meet people's needs

- At the last inspection in January 2018 we found there was no dementia friendly signage or stimulus, two out of three bath hoists were out of order, and two further bathrooms were out of order one being a building site but left open for people to gain entry.
- At this inspection we found some improvement. However further improvements were needed.
- People living with dementia did not have sufficient adaptations to the service to help them to orientate themselves, such as clear signage of doors and use of colours in areas to prevent falls. There continued to be areas of the service that did not meet people's needs and required improvement.
- One of the bath hoists had been fixed. However, one was still broken, this bath hoist allowed you to insert a person into the bath, yet it would not lift to support getting out of the bath. Although the registered manager advised no one who required a hoist used that bathroom, there was no system in place to stop the hoist being used. The registered manager then put a sign on the bath explaining the hoist should not be used. We were told after the inspection that the bath hoist had been decommissioned.
- We found the bathroom mentioned at the last inspection described as being a building site, still resembled a building site, all tiles had been taken off, bags of cement and construction items laid about and it was unusable as a bathroom, yet the door was wide open. This meant people had access to an unsafe area. The registered manager said a padlock should be on the door. This was in place the day after inspection.
- A radiator in one room was broken and the person in that room was using a standalone radiator. Although a basic risk assessment was in place, this put the person at risk of harm.
- Some people's rooms required decoration.
- Secondary double-glazing windows were broken in one room. We were informed the day after inspection these had been fixed.
- One person's radiator's steel edging was broken and jutting out which could cause harm to someone. The registered manager said they would arrange for a plumber to visit.
- We reported that bath temperatures were too low at the last inspection and this inspection we found they were still reading too low. For one person their bath temperature read at 36 degrees. Hot water temperature should be within the 39 degrees lowest and 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014).
- We asked to see a refurbishment plan. However, one was not available. We were sent one after the inspection.

This was a breach of regulations in relation to premises and equipment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- We saw people had their needs assessed prior to moving into the service.
- The pre-admission assessment looked at how people preferred to communicate, their day and night routines, what support would be needed and their likes and dislikes.

Staff skills, knowledge and experience

- We saw that staff training was up to date. We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the basic requirements of their posts.
- Staff received support through supervision and a yearly appraisal.

Supporting people to eat and drink enough with choice in a balanced diet

- People were happy with the food that was provided. Comments included, "Lovely food, home-cooked, too good even. Sometimes you get a choice, at tea-time you do. At lunch-time you take what's there. You get fruit and veg, fresh, not frozen. They vary the veg as much as they can. It's hot drinks mostly, I have my own juice. There's always plenty of tea and coffee. I don't have late snacks as I go to bed early", "Food is okay, there is nothing that I would say needs improving", "I can't complain about the food, it is sandwiches or a meal and there are always plenty of drinks" and "The food is alright."
- Where people were a known choking risk and required food that was minced and moist plus thickened fluids, these were provided. However, further guidance for staff to follow, such as which foods to avoid was needed.
- People were provided with choice at meal times, and there were plenty of drinks and snacks throughout the day.
- The provider used the GULP dehydration risk screening tool to assess people's hydration needs.
- We found that food and fluid charts were not being completed for people who had these. The registered manager said they were looking at introducing new charts.

Staff working with other agencies to provide consistent, effective, timely care

- We saw evidence of staff working with external healthcare professionals such as the district nurse and pharmacist. However, recommendations were not always documented but staff could explain what they did in each circumstance. For example, one person was cared for by the district nurse for skin integrity. There was nothing documented for staff to follow but one staff member explained how they place cushions around this person to support them.
- People we spoke with said, "They [staff] arrange appointments and are pretty good, probably quicker here than it happened at home" and "Yes they sort out medical appointments. The optician came in, I had my eyes tested and got some new glasses. The Chiropodist also comes in, she is very good."

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- At the time of the inspection four people had a DoLS in place.
- We could not find evidence of consent for all people who were using bed rails.
- For one person who was deemed to have capacity the family had consented to them having bed rails. Staff told us they did not believe this person had capacity to make this decision, however, capacity assessments were not in place to make decisions in this person's best interests. We were told these were under development.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At the last inspection in January 2018 we found the staff caring but due to issues we found the provider was not ensuring the service was caring overall. At this inspection we found work was still needed by the provider to ensure caring was good.

Ensuring people are well treated and supported

- Staff knew people well and knew what support each person needed.
- Staff were task orientated and provided care for people as and when needed. However, there was little interaction with people between care tasks.
- We saw little evidence of people receiving baths. We were told baths and bathing temperatures were documented in people's daily notes and people were offered two baths a week or more if they wanted them. We looked through four people's daily notes and for three people we could find no evidence of baths. For one person they had a bath on the 19 December 2018 and the next bath recorded was not until the 5 January 2019, therefore 17 days without a bath.
- We asked the registered manager to do an analysis of everyone's bath times. We were provided evidence of a few people receiving more regular baths. However, further work was needed to ensure people were having regular baths or staff were accurately recording when people had baths.
- Although we found some concerns people commented on how kind the staff are. Comments included, "They are very good staff, kind and compassionate", "There are some lovely girls, but you always get the odd one. It doesn't matter who you are or where you are" and "Staff show kindness, compassion, privacy and dignity, all those things I think are good, I really do."
- A relative we spoke with said, "I am always welcome here, the staff are kind and they take me out to the taxi when I leave."

Supporting people to express their views and be involved in making decisions about their care

- We saw people were offered choice in everyday situations such as where would you like to sit, what would you like to eat.
- People were supported to continue in their faith. One person said, "The Church of England come once every one or two weeks and we have communion together and that's nice."

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always upheld. We observed one staff member applying cream to a person's

knees in the entrance hall. The staff member did not ask the person's permission to do this or provide the person with the opportunity to go to a private place.

- One person said, "I wash and dress myself, it is no problem. They [staff] encourage you to keep doing what you can. I don't want to be useless, I like to be able to potter."
- The premises did not support everyone to be independent. For example, one person said they preferred to complete all personal care tasks themselves. Due to circumstances the person was unable to use a bath and stated they would love a shower as they could do this themselves. The service did not have a shower, we asked the registered manager if a shower was to be installed and we were told they were thinking about it, but it was down to money.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

People's needs were not always met. Regulations may or may not have been met.

Personalised care

- People's assessments and care plans considered people's values, beliefs and communication needs.
- Care plans detailed people's life history, people who were important to them, how they liked to spend their day and their usual preferred routines.
- Care plans needed to provide more clear instructions for staff on how to provide care. For example, one person was prone to anxiety and aggression but there was no detail to support staff on how to manage this.
- We saw people had signed to say they agreed with what was written in the care plan. However, there was little evidence to show they had been involved.
- Activities needed improvement to be more creative and person centred.
- On the inspection day baking was an activity. However, when we observed this it was the activity coordinator baking cupcakes and some people watching.
- We asked people if they were happy with the activities on offer. Comments included, "The staff are kind, but residents are silent as there is nothing to talk about", "They have trips out locally, but no bus rides, I was out yesterday actually. There was a lot of activity and nice to be in the fresh air, but it was nothing exciting" and "I watch TV and go to the quiz now and then."
- We were told that people had access to a tablet. One person used this to talk to family abroad via Skype.

Improving care quality in response to complaints or concerns

- People's concerns were listened to and recorded, fully investigated with satisfactory outcomes reached.
- People we spoke with said, "If I needed to make a complaint, I'd go straight to the Manager.", "If I had a complaint, I'd mention it to one of the girls. If that didn't work, I'd take it further. There is a leaflet telling you about that" and "If there was a complaint, I'd go to one of them and raise it. On the whole I'm quite happy with her care; it's not posh but the food is good and it's very clean"
- The complaints procedure was detailed around the building. However, this was not in easy read format for people who may need it.

End of life care and support

- At the last inspection in January 2018 we found there were no end of life wishes and preferences recorded.
- At this inspection we saw advanced wishes were in place for each person, these detailed how someone wished to be cared for in the event they got ill or deteriorated in health. However, details about people's end of life wishes were lacking, with no information regarding funeral plans, religious preferences or emergency contacts in the event of death.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection the registered manager was only working two mornings a week and a senior care worker was overseeing the management side. At this inspection the registered manager was now working four days a week and the senior care worker was now a deputy manager.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- At the last inspection the registered manager and provider did not have effective systems in place to check the quality and safety of the services people received and to drive continuous improvements. At this inspection, we found that improvements were still required and there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Systems were not operated robustly and effectively to ensure issues were identified and action taken to make improvements. Management and staff did not understand the principles of good quality improvement and the service lacked drivers for improvement. We found several issues during the inspection that had not been picked up by audits. For example, medicines audits did not consider topical creams administration. Therefore, no action had been taken to make improvements in this area and the provider could not be sure people were receiving their topical creams as prescribed.
- The registered manager/deputy manager daily walk around had not highlighted concerns we raised. For example, trailing wires, broken windows, fire doors being propped open and the bathroom door that should be locked, being wide open and the padlock missing.
- Risks to people were not fully assessed and provided little or no information to support staff to mitigate the risk.
- The premises continued to need work to make it safe and effective for people using the service.
- There was a high level of staff that were not deployed effectively.
- This was the second inspection in a row where the service has been rated as requires improvement. We found little or no evidence of learning, reflective practice and service improvement. This demonstrated that the provider has been unable to implement effective systems to monitor and improve the safety and quality of care provided to people.

This was a continued breach of regulations in relation to good governance.

- The provider was responsive to our feedback and told us about some changes they were going to implement following the inspection. However, we were unable to assess whether the planned

improvements would be successful at addressing the shortfalls we identified. We will check that their plan has been implemented effectively during our next inspection.

Engaging and involving people using the service, the public and staff

- People and relatives knew the registered manager and provider and felt they were approachable. Comments included, "The manager is very friendly and approachable" and "The manager is very good."

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 The provider was not doing all that was reasonably practicable to mitigate risks. Medicines were not managed safely. Reg 12 (2)(a)(b)(g) |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider was not ensuring premises and equipment was secure, suitable and properly maintained. Reg 15 (1) |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess or monitor and improve the quality and safety of the service. Reg 17(2)(a)(b) |