Harbour Healthcare Ltd

Devonshire House and Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

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.

The inspection took place on 20 and 21 April 2017 and was unannounced.

Devonshire House and Lodge is a purpose built nursing home providing residential and nursing care for up to 77 people. Devonshire House and Lodge is part of the corporate group Harbour Healthcare. The home is divided into five units, two nursing units and three residential units. On the days of the inspection 52 people were living at the home. Devonshire House and Lodge provides care for older people who may also have mental health needs which includes people living with dementia.

A manager was employed to manage the service who was in the process of registering with Care Quality Commission. 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. The manager had only been employed for three weeks and was in the process of getting to know the service.

Prior to our inspection we received information of concern that there were insufficient staff and equipment to meet people's needs safely. Concerns were also raised that people's dignity was not always respected by

staff, there were no emergency evacuation plans for people, medicines management and administration was unsafe and people's records were often unclear and completed inconsistently.

Following the inspection, we received further concerns from health and social care professionals about the safety of people living at Devonshire House and Lodge.
At our last inspection on 2 and 3 November 2016, we found breaches of regulation. People's care plans were not always easy to understand and were not reviewed regularly. Risks to people's health and safety were not always assessed and actions identified to mitigate risks were not always followed. Records to monitor people's health needs or concerns were not always completed correctly and people's care plans did not contain clear information for staff about how to protect people's rights, if they were assessed as lacking capacity. Staff were not always deployed effectively and did not always have competence, skills and experience to provide safe care and treatment. Equipment used by the service provider was not always assessed as being safe for their individual's needs and people's personal emergency evacuation plans (PEEPs) were not always clear. Audits were in place but these had not always been completed accurately or action taken as a result. Following the inspection they sent us an action plan which said they would meet all these requirements by 28 February 2017. At this inspection we checked whether improvements had been made.

During the inspection, we were informed the police were undertaking an investigation into unexplained bruising sustained by one person. Explanations for the bruising had not been recorded. This is also being investigated under the local authority safeguarding procedures.

We found staff were not always deployed effectively to keep people safe and meet their needs. We observed people who were calling for help receive no response from staff. People told us staff did not always respond to call bells or concerns promptly. People told us there was not always enough to do to occupy their minds and to keep them entertained. Comments included, "It's boring living here, nothing to do is there?" and "There's nothing to do much." People's care plans did not always give clear information about people's preferences or how they wanted their needs to be met.

People were not always protected from risks associated with their care because risk assessments were not always in place; or did not provide clear guidance and direction to staff about how to keep people safe. When guidance was available, this was not always followed by staff. Incidents were not always recorded effectively which meant learning to reduce the risk of future incidents could be lost.

People were at risk of the spread of infection because staff had not all received training on infection control. People's risk assessments and care plans did not contain clear information for staff to follow and appropriate protective clothing was not always readily available. People's needs were not all recorded on a personal evacuation plan to be used in the event of an emergency.

People's medicines were not always managed and administered safely. Staff had not ensured there were always sufficient medicines available for people and that medicines administration records (MARs), were completed accurately. People's changing healthcare needs were not always recorded accurately, identified or acted upon. The provider had not ensured information and recommendations from external professionals had been embedded in practice. Staff were not always available to provide the support people required when eating and drinking. When people had not had enough to drink, records did not always show what action had been taken.

Some staff members understood how the Mental Capacity Act 2005 (MCA) applied to their role but records did not always give clear information about why someone had been assessed as lacking the capacity to

make a certain decision. This meant their human rights may not always have been supported or respected. People's dignity and confidentiality was not always protected and staff did not always show respect for the environment people lived in. The vision and values of the provider were not always reflected in the way staff worked.

It was not always clear who had responsibility for monitoring different aspects of the service and maintaining quality. The provider did not effectively follow systems and processes in place to help monitor the quality of care people received or act upon the results. When quality monitoring activities had identified gaps in the quality of the service, these had not always been acted upon. People's concerns and complaints had not always been reported, recorded or acted upon. For example people and relatives told us they had reported to staff when personal items or clothing had gone missing but action had not always been taken.

People told us they enjoyed the food and said that staff were kind. Comments included, "The food is lovely and the chef is fantastic" and "The food is good, I mean really good." Staff told us they enjoyed providing care and knew people well.

New staff received a thorough induction. Staff had received training and the manager was reviewing all staff training to help ensure all staff training was adequate and up to date.

People told us they felt safe using the service and that staff protected their privacy. Comments included, "I feel safe here because I like the staff." Staff confirmed they knew how to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected.

People had sufficient equipment and aids to meet their individual needs.

Staff told us they had confidence in the new manager and felt able to raise any ideas or concerns.

We asked the provider to respond to the immediate concerns we had about people's safety at Devonshire House and Lodge. They sent us a plan detailing what action they would take to ensure people were safe. This included not admitting anyone to the service until they were confident the service was safely meeting people's needs. This plan will be kept under review.

We found six breaches of the regulations. We are taking further action against this provider and will report on this when it is completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take for two of the breaches at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People's medicines were not always managed safely.

People were not always protected from the risks associated with their care and health conditions.

Staff did not always act to ensure people's needs were met in a safe way. People told us staff did not always respond to call bells promptly.

People were protected by staff who could identify abuse and who would act to protect people.

People had sufficient equipment and aids to meet their individual needs.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not protected always by the Mental Capacity Act 2005 (MCA).

Staff were not always available to support people to eat or drink.

People told us they liked the food.

Staff were receiving more training and their training needs were being reviewed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity or listened to.

Staff did not always treat the environment in a way that showed respect for people's home.

People's confidential information was not always protected.

People said staff protected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have personalised care plans in place which reflected their current needs, however these were beginning to be improved, developed and embedded.

People and staff told us there was not always enough to do to keep people entertained.

People's complaints had not always been recorded or acted upon.

Staff told us they offered people choice.

Is the service well-led?

Inadequate

The service was not well-led.

It was not always clear who held responsibility for different aspects of the service.

The provider did not ensure systems and processes in place to help monitor the quality of care people received were followed and acted upon.

The provider did not ensure advice from external health and social care professionals was understood and followed.

The provider had failed to notify us of all significant events without delay, in line with their legal obligations.

Devonshire House and Lodge

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.

The inspection took place on 20 and 21 April 2017 and was unannounced. The inspection was carried out by two adult social care inspectors, a pharmacist inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who lives with dementia.

Prior to the inspection we reviewed the records held on the service. This included previous inspection reports and notifications and feedback from people, relatives and professionals who know the service. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 11 people and three relatives.

We reviewed records in detail. We also spoke with seven members of staff and reviewed four personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the provider reviewed the quality of the service. This included a range of audits, minutes of meetings and policies and procedures. We were supported during the inspection by the manager and the regional manager.

Whilst carrying out our inspection we left 'Tell us about your care' forms at the reception desk of the home. One relative completed our form and commented on what they thought of the service.

Following the inspection we sought the views of a physiotherapist, a social worker and the local authority

Quality and Service improvement team who know the service well. We also spoke with the local police safeguarding unit and the local authority safeguarding team.

After our inspection, because of identified concerns, we raised a safeguarding alert with the local authority. We also attended a strategy meeting with the local authority safeguarding team.

Inadequate

Is the service safe?

Our findings

At our last inspection on 02 and 03 November 2016, we found people's risk assessments were not always up to date or reflective of their needs, people's personal emergency evacuation plans (PEEPs) were not always clear and some staff were unclear what to do in the event of an emergency, such as a fire. People's hoist slings were not assessed for their individual needs; and people at risk of skin damage were supported by staff who did not have a good understanding of best practice regarding skin care. We also found records to monitor people's health were not always completed and staff were not always deployed in the best way to meet people's needs. We asked the provider to make improvements. Following the inspection they sent us an action plan which said they would meet all these requirements by 28 February 2017. During this inspection we looked to see if improvements had been made. We found that improvements had not always been made or sustained.

Prior to this inspection, the Commission received information of concern that there were insufficient staff and equipment to meet people's needs safely, there were no emergency evacuation plans for people, medicines management and administration was unsafe and people's records were often unclear and completed inconsistently.

People did not always have assessments in place to identify risks to their health or wellbeing. When people did have risk assessments in place these were not always supported by recorded guidance for staff about how to mitigate the risk. We observed one person, who was at risk of choking, have an episode of coughing whilst eating. The staff member took action by patting them on the back. This is not the correct supportive action to take as it can cause the person to choke. A member of staff told us the person was at risk of choking but said the person didn't do this very often. However, there was no guidance in place for staff on what actions they should take to keep the person safe when eating, and what action they should take if the person choked. This information was added to the person's records by the end of the second day and the manager told us they had informed staff of changes to the person's records during handover.

Following the inspection we received information from the manager and the local authority that one person, who required a pureed diet and thickened drinks, had been given a biscuit and an unthickened drink by a new member of staff. The person's relative and another staff member were able to stop the person eating the biscuit before they swallowed. The manager told us they had now put a risk assessment and one to one care in place for the person. They had also ensured information regarding people's dietary requirements was displayed in further places, for example on drinks trolleys.

We looked at the records of four people who had experienced several falls during the month, three did not have clear guidance in place about how staff could mitigate the risk. Three of these people had been admitted to hospital after sustaining injuries following falls. One of these people had experienced six falls in seven days but no assessment of the risk of falls had been completed and there was no guidance for staff about how to reduce the risk to the person. They had then fallen and suffered a head injury and had been admitted to hospital. During the inspection, the manager requested a nurse review the support provided to one person who had experienced falls recently; and a senior member of staff wrote a risk assessment. The

person's relative told us, "I feel my husband is safer, because due to him having a lot of falls recently, they are now doing half hour checks on him."

A procedure was in place to help ensure incidents were recorded, reported and monitored. However, it was not clear from completed incident forms what short or long term actions had been taken to help protect people from future incidents. This meant any learning, to protect people from future incidents, had not taken place. For example, despite some people having several falls, the provider had not identified falls risk assessments or guidance regarding how to reduce risks to people, were not always in place.

Occasionally people became upset, anxious or emotional. A staff member told us, "I know how to calm people down. The information is in people's care plans." However, during lunch, a resident was seen and heard being rude to another resident who was sitting at the same table. Other than advising this person not to use bad language, staff took no further action to help the person calm down or protect the person they were talking to.

People's healthcare needs were not always monitored effectively to help ensure risks relating to their needs were mitigated. Where people were assessed as at risk of skin breakdown, these assessments were not always reviewed regularly to identify any changes to the person's skin health. Where skin breakdown had been identified, actions identified in people's care plans to improve or monitor their skin health had not been followed or recorded accurately. For example, one person had been identified as being at a high risk of skin damage. Their care plan stated they needed to be repositioned every four hours and have prescribed creams administered on a daily basis. However, records showed the person had not regularly been repositioned through the night and records of cream administration were inconsistent. A body map had recorded broken areas of skin in January 2017 but no further record of the person's skin health had been made. This meant it would be difficult for staff to monitor any changes and identify whether the area of skin was improving or needed further action. This demonstrated staff did not understand the importance of regularly monitoring and recording changes to people's health needs in order to mitigate further risk to the person.

Where information recorded by staff showed potential risks to people's health, these had not always been identified. For example, one person's records showed for three days, they had drunk less than was generally recommended. There was no guidance in their records regarding what the ideal amount for the individual would be. However, there was no written information to show whether staff had taken any action to contact the person's GP. We spoke with the manager about this who told us they would take action.

One member of staff told us they thought the completion of health monitoring records had improved since they started working at the home. However, when people were assessed as at high risk of skin damage due to incontinence, records of what personal care had been provided to the person, to mitigate risks to their skin health, were inconsistent. For example, entries were either missing, unclear or recorded on the wrong form. This meant it was unclear whether people had received the care and support they required.

When professionals had been contacted for further advice to keep people safe, staff did not always follow recommendations provided. A healthcare professional explained they had asked at least twice for one person to be supported to be moved by the use of a hoist. Four days after the professionals first request, the person's care plan had been updated with information that they needed two staff to help them stand and transfer. Thirteen days later staff had told the healthcare professional they had still been supporting the person to stand. The person's risk assessment had still not been updated. This meant the person had been put at risk of falling. We alerted the manager to this following the inspection. They told us the risk assessment had now been updated and the staff member who had originally received the information from

the external healthcare professional had received a one to one supervision. The manager told us changes to people's care plans and risk assessments were communicated to staff during handover.

People and staff told us they felt there were always enough staff on duty. One person said "I feel as though there are enough staff on all the time." One staff member told us there were less agency staff used due to recent recruitment and this meant people were receiving care from a more consistent team. However, we observed staff were not always deployed in a way that ensured people's needs were met safely. We observed on two occasions staff not responding to the needs of a one person who was clearly upset and anxious and was calling for help. As staff did not attend, the person tried to move outside their room, and on the second occasion they tried to move to the bathroom, unaided. This resident was assessed as being at a high risk of falls. Attempting to move without staff support increased the risk. We observed that all staff were not occupied supporting other people's needs. We alerted staff to the needs of the person and they responded.

People told us staff members did not always respond to call bells or took a long time to respond. One person, who was in pain, told us they had not used their call bell to alert staff as they, "take too long". A relative confirmed their family members call bell was often not answered within a reasonable time and was often out of reach or disconnected. The manager confirmed there was no current procedure to monitor call bell response times, however they were investigating the possibility of installing a new system which would record response times. This would make it easier to monitor whether people were being responded to promptly.

Staff members received regular evacuation training and were able to describe the evacuation procedures in place. However, people did not always have relevant records in place to help ensure their needs were known in the event of an emergency. Five people did not have a personal evacuation plan in place (PEEP) and some room names and numbers were missing or had more than one number on the door. This meant people's needs and location may not be known in an emergency. Some people had risk assessments in place due smoking; however related actions were not always followed by staff. For example, we observed one person, who had been assessed as lacking the capacity to understand risks related to smoking and who required staff supervision when smoking for their safety; was left alone outside smoking with a lighter. Following our inspection we contacted Devon and Somerset Fire and Rescue service to feedback our inspection findings.

Safe infection control practices were not always followed. Two people, due to a highly contagious infection, required staff to practice barrier nursing to avoid cross infection of other people. Barrier nursing is a set of stringent infection control techniques which includes wearing protective clothing such as gloves and aprons. At the beginning of the inspection there were no gloves and aprons available to staff in one person's room and a staff member had to go to someone else's room to find some. This placed other people at possible risk of infection. Not all staff had received infection control training and the person's continence care plans guided staff to use "universal precautions" with no detail about what this meant. By the end of the inspection the manager had put in place a care plan which detailed what actions staff needed to take to prevent cross infection. They told us changes to care plan were communicated to staff at daily handover meetings.

Staff managed medicines in a way that did not always keep people safe. Staff recorded when medicines had been given on a medicines administration record (MAR). However, we saw that several MARs contained gaps where it was not possible to tell if a person had received the medicine or not. We checked the MARs of 29 people. For fourteen of these people, we found one or more gaps in records where it was not possible to be sure whether medicines had been given as prescribed. We also found two people's MAR had the same type of medicine (but different brand names) recorded twice. There was only one of the brands in stock but this

could have increased the risk of the same medicine being given twice.

Staff did not always ensure medicines were available to people at a time that suited them. One person was prescribed several regular medicines to be given at 9.30pm in the evening. However, their MAR showed that for twelve days the person was asleep when staff tried to administer them, so the medicines were not given. Staff had not contacted the GP to arrange an alternative time for administration.

Medicines were not always ordered in time to make sure that people always had a supply. One person had been without six different medicines, including a medicine to prevent blood clots, for four days as they had not been ordered before the Easter weekend and had run out. Another person had not been given two medicines on the morning of the inspection, because there were none in stock. Staff told us that all these medicines were due to be delivered that day. We checked on the second day of the inspection that these medicines were now available and confirmed they were now in stock. None of these incidents had been reported to the GP or recorded as medicines errors. This meant staff could not be assured there had been no adverse side effects to the person and any learning from the incident could be lost, as it had not been recorded.

One person who was having their medicines given covertly, (without their knowledge, disguised in food or drink), did not have any records to show that a pharmacy assessment had taken place to ensure that medicines were safe and would be effective if crushed and/or mixed with food or drink.

Some additional information was available to staff about when to give medicines that had been prescribed for people to be taken 'when required', for example pain relief. However, this information was not in place for all when required medicines and had not been recently updated. This meant that new staff in particular found it difficult to know when a medicine might be needed, especially for people that could not communicate their needs.

The provider had not acted to keep people safe and mitigate risks to people using the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were stored securely. Medicines requiring cold storage were monitored to check that temperatures were suitable for storing medicines, so that they would be safe and effective. There were suitable storage arrangements and records for some medicines that required additional secure storage. There were suitable arrangements for destruction and disposal of medicines.

One person looked after their own medicines at the time of this inspection. This had been assessed as safe for them and medicines were stored securely in their room. Other people had their medicines given by nurses or care staff, who had received training and had been assessed to make sure they gave medicines safely.
Policies and procedures were available to guide staff. Staff had completed internal medicine audits as a drive for quality improvement. These had not identified some of the concerns raised during this inspection including medicine stock and gaps on MARs.

Recruitment procedures were in place to check new staff were suitable to work with vulnerable adults. However, these procedures had not always been followed in practice. For example, new staff members had not always provided a full employment history and one staff member had no record of a Disclosure and barring service (DBS) check on their file. However, the manager ensured the DBS check was in place by the end of the first day of the inspection.

People told us they felt safe. Comments included, "I feel safe here because I like the staff" and "It's the staff that make it feel safe." Visitors also felt it was a safe place for their family member to live.

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. One member of staff commented, "I would definitely be able to report it to my manger or go to the [local council] safeguarding team."

Staff told us and records showed, people now had sufficient equipment in place, such as hoist slings and continence aids, to meet their individual needs.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 2 and 3 November 2016, we found people's care plans did not contain clear information for staff about how to protect people's rights, if they were assessed as lacking capacity.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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.

Staff told us they had received training on the MCA and one staff member explained, "If someone doesn't have capacity, you can get information from their care plan or their family about what they like. For example, with clothing, we would ask family members what the person is most comfortable wearing. It's important to get it right, even if it's something as simple as always having a hanky or wearing bracers."

Some people's care plans clearly described whether people had the capacity to make certain decisions or not and how to make decisions in their best interests. However, MCA assessments of people's capacity were not always decision specific, as required by the principles of the act. Therefore it was unclear how it had been decided that people didn't have the capacity to make these decisions. Some people's records were contradictory regarding MCA. For example, one person was described in their care plan as having capacity, but their treatment escalation plan (TEP) said they lacked capacity. A TEP is a document that supports early recognition of patient's wishes and needs to support end of life decisions.

A relative confirmed they were involved in making decisions in their family member's best interests. However, one person who was having their medicines given covertly (without their knowledge, disguised in food or drink) had no record to show that medicines given this way were in their best interests. Decisions were made for people without clear evidence that they could not make the decision for themselves. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). The registered manager had applied for DoLS on behalf of people however, some of these were awaiting review by the local authority designated officer.

Staff told us they always asked for people's consent before commencing any care tasks.

Staff told us they helped ensure people had enough to eat and drink. This was observed to happen in two dining rooms. However, during lunch on both days, we observed in one dining room, staff served people's meals to them but then only one staff member remained in the dining room. This member of staff was providing one to one support to someone. This meant other people who needed support or encouragement

to eat, did not receive it. For example, two people were observed as having not eaten their lunch. Staff were not available to support these people as they were no longer in the room. The food was then observed to be removed by a member of staff who came in a little while later. The two people who had not eaten their main course where not then asked whether they were alright or wanted something else. This meant it would be difficult for staff to accurately record how much people were eating and drinking.

In a different dining room we observed a person sitting alone with their lunch, which they had not eaten. There were no staff in the room encouraging or supporting them to eat. This meant the person may not have received the right support to ensure they had sufficient amounts to eat or drink. Two staff members who had observed this did not offer the person support or find other staff to offer them support but commenced vacuuming the room.

During breakfast, we also met one person who was new to the service and told us they had been waiting a long time for their breakfast. A staff member explained the person had been waiting in the wrong room for their breakfast and no-one had known they were there. Staff had not taken care to ensure they knew where the person wanted breakfast and that the person knew where it was served.

The provider had not ensured risks related to not eating and drinking enough were monitored by staff and action taken, where necessary. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records highlighted where risks with eating and drinking had been identified. For example, one person's record evidenced they were at risk of choking and that staff had sought advice and liaised with a speech and language therapist (SLT). Recommendations from the SLT team to thicken the person's drink and to give them pureed food had been recorded and followed.

People told us they liked the food and were able to make choices about what they had to eat. Comments included, "It's a good job the food is good because I'm a good eater", "The food is absolutely lovely", "The food is lovely and the chef is fantastic" and "The food is good, I mean really good." People were encouraged to say what foods they wished to have made available to them and when and where they would like to eat and drink. A staff member told us, "The chef asks people what they like to eat." They added that there was a list of people's likes, dislikes and dietary needs available in the kitchen for staff to refer to. A relative confirmed, "I think the residents eat good healthy food in here."

People were offered hot and cold drinks throughout the day to prevent dehydration. People who were in their room had their drinks within reach and one person confirmed, "They always make sure I have a drink on hand."

New members of staff completed a thorough induction programme, which included being taken through all of the home's policies and procedures, and training to develop their knowledge and skills. Staff then shadowed experienced members of the team, until both parties felt confident they could carry out their role competently. One staff member told us, "I feel I had sufficient support during my induction."

On-going training was planned according to the provider's requirements. There was a clear plan of which training staff needed to attend within the first two weeks and the first six months of their employment. Different training was required according to the staff member's role. Staff told us they had the training and skills they needed to meet people's needs and that this was regularly updated. Comments included, "I've done safeguarding training, first aid, dementia and mental capacity training. I like the training, you learn a lot." The manager told us they were reviewing everyone's training to help ensure all training was in place

and up to date.

People confirmed they thought staff had the correct training and skills to meet their personal needs. However, a healthcare professional told us they had had concerns about staff's manual handling techniques. They had offered advice and guidance but didn't feel this had been communicated to all staff or followed in practice. We shared this information with the manager.

Staff told us supervisions had not been carried out regularly recently, but these were due to start soon. Competency checks had been completed with staff who had nursing responsibilities. This helped ensure they remained competent and effective in their role.

A staff member explained they knew people well and this helped them tell if someone was unwell. They told us if they had concerns about people's health, staff reported it to the nurse on duty who would contact the GP.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection the Commission received information of concern that people's dignity was not always respected by staff.

People were not always treated in a dignified way or listened to. One person had entered someone else's room three times in one day, uninvited. However there was no guidance for staff, following this about how to protect each person's dignity. Another person told us they had been awoken at 5am the morning of the inspection, by staff entering their room to look at their records. They told us this had disturbed their sleep.

A relative provided feedback that their family member was often not dressed properly but were often not wearing items of clothing such as underwear or a jumper. People also told us they had experienced personal items such as dressing gowns, slippers, shoes, underwear and toiletries go missing and staff had not always acted on this information when it was reported. A relative confirmed their family member's clothes were not always returned to them despite them being labelled. Following the inspection, the manager told us a new system had been implemented in the laundry to help ensure people's clothing did not go missing. They also intended to make environmental changes which they believed would reduce the amount of items going missing from people's rooms.

People and their relatives told us that they were treated by respect by all the staff members. However, staff did not always treat the environment in a way that showed respect for the people living there. A relative told us they felt the home was not always clean and tidy, especially at the weekend when their family member's room was not always cleaned or their bin emptied. A small kitchen area had been designed as a place of reminiscence for people living with dementia. However, this was cluttered with equipment and items that didn't belong there. We found throughout the home, items of equipment or odd shoes belonging to service users were left in corridors or lounges. A staff member was also observed using the arm of a comfy chair in the corridor to saw on. This left shavings on the carpet in front of the chair.

The provider had not ensured people's dignity was always respected. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's confidential information was not always respected. During the inspection we found two offices, containing people's care plans, left unlocked and unattended. Another office had some people's confidential information displayed in a way that was clearly visible from the corridor. Staff did not protect the confidentiality of medicines administration records (MARs) whilst administering medicines as they were often unattended during the medicines round. This meant people's confidential information could easily be seen by others.

The provider had not acted to ensure people's confidential information was protected. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the care they received and spoke positively about staff members.

Comments included, "All the people that work here are easy to get on with" and "The staff are wonderful, they do a really good job." A relative confirmed, "Some members of staff are exceptionally attentive to people's needs, caring and sympathetic." Staff members told us they enjoyed meeting people's needs. Comments included, "I get satisfaction from helping people" and "I love it. I love giving care and making people happy."

Staff told us they knew the people they cared for well and gave examples of people's life history, likes and dislikes. Staff told us that people were encouraged to make decisions about their care and to be as independent as possible. One staff member explained, "We encourage people to do as much as they can, for example, combing their hair or putting clothes on."

Staff informed us of various ways people were supported to have the privacy they needed and we observed staff knocking on people's doors before entering. People confirmed that if they were receiving personal care in their room, staff members always made sure the door and curtains were closed to respect privacy and dignity.
Friends and relatives were able to visit without unnecessary restriction. One staff member confirmed, "Visitors are always offered cups of tea or a chair."

People and their relatives were given support when making decisions about their preferences for end of life care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 2 and 3 November 2016, we found care records were not always easy to understand and were not reviewed regularly. This meant staff could not always rely on them to provide guidance on how people wanted their care delivered. We found some action had been taken, but further improvements were still required.

Before people moved into the home, information was gathered about them to help ensure staff had initial information about how to meet their needs. A senior staff member explained that after people had moved in a 'Get to know you tool' would be completed by two different members of staff, to help ensure as much information as possible was collected about the person's needs and preferences.

However, one person who had move into the home the day before the inspection had no information about the care of their catheter recorded in their care plan. This might mean that any care required had not been given.

Some people's care plans now contained detailed information about how they preferred to receive their care. Care plans had recently been rewritten to make them easier to read. One staff member told us, "The care plans are quite easy to understand. I gave them to an agency member of staff who had not worked here before and they understood people's needs from them." However, some care plans still lacked significant information about how they would like to receive their care, treatment and support. For example, a senior staff member told us one man sometimes wore his clothes in bed at night, out of choice. The person's care plan did not reflect this information. This meant staff did not always have up to date information available about how to meet people's needs.

The provider had not ensured accurate, complete and contemporaneous records were maintained in respect of each individual. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and where appropriate, those who mattered to them, were being more actively involved in the care planning process, to help ensure their views and preferences were recorded, known and respected by all staff. Relatives confirmed they were involved in their loved one's care plan and kept well informed about their general welfare.

People had a range of group activities they could be involved in throughout the week. For example, during the inspection, a pet therapy session offered people the opportunity to stroke and pet two dogs if they chose to. However, people told us, "It's boring living here, nothing to do is there?" and "There's nothing to do much." A relative added "My wife just sits in her armchair every day, she's not stimulated enough." Further feedback received from a relative stated that there were no activities at weekends. Staff members explained, "People do get involved in setting the tables and in the laundry but people aren't supported to engage in one to one pastimes that interest them yet. We do try to do puzzles or paint people's nails with them. In some units it feels like we could do more with people" and "There are armchair sports, quizzes, baking and a

coffee morning each week." They added that they thought these activities weren't reflective of the needs or interests of many of the people living at Devonshire House and Lodge. The manager explained they were recruiting a senior activity co-ordinator to help ensure activities were meeting everyone's needs.

People's preferences were not always sought or respected with regard to remaining physically and cognitively active. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy and procedure in place for dealing with any concerns or complaints. Recorded complaints had been investigated and responded to in good time. However, some people had made complaints about their personal clothing that had gone missing and these had not been logged or resolved. One person told us, "I tell the staff that things go missing, but I still don't get any results." Following the inspection the manager told us they had requested staff alert them about missing items and they would ensure these were recorded and resolved for people.

Handover between staff at the start of each shift gave staff time to share important information about people's progress. However, we found that staff did not always have up to date information about people's needs; for example the period of time medicines were to be taken for or recommendations from professionals. One staff member explained, "We write down any concerns and discuss every person. If we have been on annual leave, we ask senior staff to update us about people's needs."

People were offered choice throughout the day and confirmed they were able to get up and got to bed when they pleased. One staff member explained, "We always ask what people want. Even if they prefer the same things every day, we still ask them." People told us they thought their care was focussed on their personal needs and welfare.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 02 and 03 November 2016, we found audits were in place but these had not always been completed accurately or action taken as a result. We also found breaches of regulation. Following the inspection they sent us an action plan which said they would meet all these requirements by 28 February 2017.

At this inspection, we found the provider had failed to ensure the changes made had been sufficient and that audits and processes were effective at driving change.
There was a management structure in the service. A newly appointed manager was in post and was being supported by a regional manager. An acting deputy manager was in post to support the manager until a permanent deputy manager was recruited. The day to day running of each unit was managed by nurses. However individual responsibility and accountability for different aspects of the service was not always clear. For example, at the start of the inspection, the manager was not present and staff members could not confidently tell us exactly which people were residing in the home at that time.

We also found the provider had not ensured staff were fulfilling their roles and responsibilities. This meant staff were not always meeting people's needs in a safe and effective way. For example, we observed times when staff did not respond to people calling for staff to help them; and times when staff did not make themselves available to support people who were eating. Whilst there were senior staff on each unit to monitor staff and ensure they were meeting people's needs, this had not been effective. This demonstrated there was ineffective leadership within the service.

The provider had a comprehensive quality monitoring system in place. This included a range of quality audits as well as residents and relatives meetings and questionnaires to obtain feedback about the service. However, they had not ensured all elements were implemented effectively to provide a clear overview of any gaps in the provision of care or quality. For example, concerns which had been raised in previous years were found to be ongoing. These included lack of sufficient activities, unsafe medicines management and items of clothing going missing. The provider told us they were in the process of reviewing governance documentation.

A range of audits to monitor the quality of the service were in place. However, the provider had not always ensured these were completed according to their policy. This meant the provider was not effectively, monitoring and improving the quality and safety of the service people received. The regional manager told us in the future, unit managers would be responsible for completing audits which would then be checked by the manager of the home. The provider would maintain an overview of these audits and their outcomes.

When audits had been completed they had not always identified the concerns found during the inspection. For example recent audits of people's records and incident forms had not identified that people did not have up to date information about risks relating to their care in place; or that records to monitor changes to people's health had not been completed. Recent medicines audits had not always identified that people's medicines and health monitoring records had not been completed consistently and accurately. For

example, they had not highlighted the gaps in people's MARs or that one person was rarely receiving their medicines due to being asleep.

The provider had also carried out audits of the service. However, where gaps in quality had been identified through audits, action had not always been taken to improve the quality of care people received and learning had not always taken place to reduce the likelihood of future concerns. For example an audit carried out by the provider in August 2016 had identified there had been instances of people's clothes going missing and that activities were not always meeting people's needs. Concerns around the administration and management of medication were also highlighted. The audit stated an action plan was put in place which included retraining staff, auditing medicines and completing staff competency assessments. However, these concerns were found to be ongoing during this inspection.

The manager was required to send a regular report to the provider which included information about people's needs. This enabled them to have an overview of any changes and identify any emerging themes in the service. Information reported on included incidents, weight gain, weight loss and medication errors. Guidance on the report stated, "It is essential that all 12 tabs are completed in full" However, eight areas of the report for the previous month which had been completed by an interim manager had not been completed. This meant the provider would not have had a clear overview of changes to people's needs and any arising concerns.

Feedback from staff had been collected via a questionnaire, the previous year. However, some concerns raised by staff at this time had not been resolved and were identified during this inspection. For example, staff had stated activities weren't meeting people's needs, staff duties and responsibilities were not clearly defined and staff were not always following infection control procedures correctly.

The provider had a vision, mission and values statement describing their aims for the organisation. They told us they monitored whether staff were implementing the organisations vision and values during audits. We observed these had not yet been embedded within the culture of the staff team and that staff were not always meeting Harbour Healthcare's expected values. For example, one value stated staff would be, "Dedicated to teamwork and excellence in care and service delivery." However, we observed one person who told us they were in pain following a dressing being applied by a district nurse. When we alerted staff, they told us the person was always like that after their dressing had been applied and had therefore not acted to help make the person more comfortable.

Where the home was required to work in partnership with other organisations to support care provision this was not always effective. Health and social care professionals who had involvement with the home told us information and guidance provided to senior staff members was not always communicated and shared or followed by staff members.

There were not robust systems in place to identify where quality and safety were being compromised. The provider had not ensured information from other agencies had been used to improve the quality of the service people received. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the end of the inspection, the provider gave assurances that they would provide the new manager with the support and resources they needed to manage the service. This would enable them to deal with the high level of actions required to deal with the concerns identified through the inspection and recruit a new deputy manager. Following the inspection we asked the manager what support they had now been provided. They told us the registered manager from their sister home was coming to support them the next

day. In addition, the provider informed us they had arranged for a senior manager to support the manager at Devonshire House for four days every week and that other senior managers had also been available to support the manager as required.

The regional manager told us they were going to take time with the new manager following the inspection to complete a 'whole home audit'. This would create the base of an action plan for the service. A residents and relative's meeting had also been planned to share information and listen to any ideas or concerns people had.
The provider had not always informed us of significant events in line with their legal obligations, for example we had not been informed that someone had sustained a head injury and been admitted to hospital.

The provider had failed to notify us, without delay, of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff were positive about the new manager and described the management of the home to be approachable, open and supportive. Comments included, "The new manager's really good and approachable. I feel I could talk to them", "Things have felt better with the new manager" and "I'm excited about the new management." The manager told us they aimed to build strong relationships with the staff team as this would be imperative to the success of any changes they intended to implement.
The provider told us the organisation valued staff members who had made a difference. For example, they would write to staff members personally to thank them for their positive contribution and a 'Moments that Matter' award was also available to celebrate good practice.

Staff told us they felt empowered to have a voice and share their opinions and ideas they had. Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice and action had been taken. For example, one staff member commented, "You can suggest things, even if it's as simple as changing a cup to help someone maintain a bit of independence. It's for people's good so senior staff do listen."

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately. Staff member told us, "We raise any concerns with the unit manager and it gets sorted. If you have any issues, they quite quickly sort them out" and "I would feel comfortable raising concerns with the manager."

The provider had implemented a policy regarding the Duty of Candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider told us they had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. They added that staff were due to receive training on the Social Care Commitment and sign up to it themselves.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were always treated with dignity and listened to or that staff treated the environment in a way that showed respect for people's home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always protected by the Mental Capacity Act 2005 (MCA). Records did not clearly show why people had been assessed as lacking the capacity to make certain decisions.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of all significant event, without delay, in line with their legal obligations.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure that they effectively assess, monitor and improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured activities available reflected people's needs and preferences.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure that they effectively assess, monitor and improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not acted to keep people safe. People's medicines were not always managed safely. People were not always protected from the risks associated with their care and health conditions. Incidents were not always recorded effectively. Staff were not deployed in a way that safely met people's needs. People were not always protected from infection control practices to help prevent and control the spread of infection. People did not always have relevant information in place to help ensure they were protected in an emergency evacuation such as a fire.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure that they effectively assess, monitor and

improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured people's records were up to date and reflective of their individual needs. The provider had not acted to ensure people's confidential information was always protected. The provider had not ensured systems and processes in place to help monitor the quality of care people received were followed and acted upon. The provider had not ensured information and advice from other agencies was communicated and acted upon.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure that they effectively assess, monitor and improve the quality and safety of the services provided.