Mr Anthony John Bloom

Devonia House Nursing Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

Devonia House is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury. The service can accommodate a maximum of 32 people. People using this service may have a diagnosis of, or conditions relating to, dementia.

In December 2015 the provider made the decision to stop providing nursing care at the service as they were unable to recruit and retain nursing staff. This came into effect from January 2016.

As a result of the unannounced comprehensive inspection in April 2015 the overall rating for this provider was 'Inadequate'. This meant that it has been placed into 'Special measures' by the Care Quality Commission (CQC).

At the unannounced comprehensive inspection in January 2016 we found improvements had not been achieved and the overall rating for the service remained inadequate. At the inspection in January 2016 we identified nine continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two new breaches. We found people's care plans did not contain person specific mental capacity assessments and applications for the Deprivation of Liberty Safeguards had not been carried out appropriately. Care plans were not updated on a regular basis and some sections were not completed or were inaccurate. There were not enough staff to provide support to people who used the service and recruitment practices were not safe. The provider had not taken steps to ensure staff received on-going or periodic training, supervision and an appraisal to make sure competence was maintained. The management of medicines did not protect people from the risk of unsafe care or treatment. Risks were not fully assessed for the health and safety of people who used the service. The provider had failed to monitor the quality of the service to identify issues. People were at risk of harm because the provider's actions did not sufficiently address the on-going failings.

After the comprehensive inspection in January 2016, the provider wrote to us to say what they would do to meet the legal requirements in relation to the 11 breaches of regulation.

We undertook this unannounced focused inspection on 22 and 23 June 2016 to check that the provider had followed their improvement plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Devonia House Nursing Home on our website at www.cqc.org.uk

As a consequence of the inadequate rating for the service, Devon County Council suspended admissions to the service from 27 July 2015 until 13 May 2016. The suspension of placements was lifted by the local authority on 13 May 2016. However an advisory notice remains in place for social care placements, meaning that any social care funded placements to the service had to be agreed by a senior manager within Devon County Council. The service continues to receive considerable support from the local authority 'quality

assurance and improvement team' and from health and social care professionals. Regular monitoring and support visits had been undertaken by health and social care professionals. We found that despite this support from the local authority the provider was unable to meet the essential requirements and make all of the necessary improvements.

At the time of this inspection the home did not have a registered manager. The service has not had a registered manager since December 2013. However, with the assistance of the local authority, a new manager had been recruited and appointed in January 2016. This manager left the service in March 2016. Another manager was appointed and started working at the service in March 2016 but has since resigned and left the service on 30 June 2016. The provider informed us on that a senior member of the night staff team has been appointed as acting manager temporarily, with responsibility for the day to day running of Devonia House. 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 at the time of the inspection demonstrated that they understood some of the shortfalls at the service and had begun to implement systems and processes to improve the service. However due to the limited time they had managed the service and the difficulties they had experienced the action taken had yet to have a sustained impact upon the overall quality of the service. At times people were exposed to avoidable risk.

People's health, safety and welfare were put at risk because there were not always sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times. Staff did not receive the training they required to be able to fulfil their role effectively. The provider did not have appropriate arrangements in place to manage medicines safely. People were put at risk as a result of poor practice and a lack of staff training in relation to medicines.

People's nutritional needs were not always monitored. Records relating to people's daily dietary and fluid intake were poor. This meant we could not tell in any detail whether people had sufficient amounts to eat and drink.

People were at risk because accurate records were not consistently maintained. There were gaps in people's food and fluid charts, weight, bowel and repositioning charts. We could not be assured that people's care needs were being met.

Systems the provider had in place to monitor and improve the quality of the service had not been embedded and were ineffective.

Some people were happy with the care and support they received. Two health care professionals and two relatives provided positive feedback, especially in relation to staff attitude and caring approach. We witnessed some kind and caring interaction between staff and people who lived at the service.

Some care plans had been improved and contained detailed and personalised information about people's care needs and preferences. However two people did not have care plans or risk assessments in place to ensure staff provided appropriate and safe care and support.

We found improvement in relation to the Mental Capacity Act 2005, which requires providers to ensure safeguards are in place when someone does not have the capacity to make an informed decision about

their care and treatment. Some people's capacity to consent to care and support had been assessed. Applications had been submitted to the local authority in respect of six people where it had been identified that were being deprived of their liberty. However, we found improvement was still needed to ensure everyone's rights were protected.

During the inspection we identified seven continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider's failure to sustain full compliance since 2011. We have made these failings clear to the provider and they have had sufficient time to address them.

Due to the concerns found at this inspection, through our legal processes we have told the provider they cannot admit any new service users without the written consent of CQC.

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. We found not all actions had been taken to ensure the service was safe since the last inspection.

Risks to people were not always identified and action taken to minimise the risk.

There were insufficient suitably trained staff on duty at times to safely meet the needs of people who used the service. Staff recruitment practices did not ensure people were protected from unsuitable staff.

People's medicines were not managed safely.

People were safeguarded from abuse as staff understood safeguarding issues and how to report concerns.

Is the service effective?

Requires Improvement

The service was not effective. We found not all actions had been taken to ensure the service was effective since the last inspection.

People's hydration and nutritional needs were not being effectively monitored which placed them at unnecessary risk.

Staff were not suitably trained and did not always have the skills to undertake the responsibilities expected of them.

The service was applying the principles of the Mental Capacity Act 2005 regarding consent to some people's care and treatment and Deprivation of Liberty Safeguards. However improvements were needed to ensure all people were protected.

People had access to health professionals.

Is the service well-led?

Inadequate

The service was not well led. We found not all actions had been taken to ensure the service was well-led since the last inspection.

There was no registered manager in post. In the absence of a

registered manager, the provider had not ensured prompt and effective action had been taken to address the previous beaches in regulation.

Although there were some new systems to assess and monitor the quality of the service provided, these had not been fully implemented so were ineffective in achieving the necessary improvements.

The provider remains in breach of several regulations of the Health and Social Care Act 2008, which meant people were at risk of receiving care that was unsafe.

Devonia House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This unannounced focused inspection took place on the 22 and 23 June 2016 and was completed by two Care Quality Commission (CQC) inspectors.

The team inspected the service against three of the five questions we ask about services: is the service safe; effective and well-led? This is because the service was not meeting some legal requirements.

Before the inspection we reviewed the information we held about the service, including notifications. Providers are required to submit notifications to the Care Quality Commission about events and incidents that occur including unexpected deaths, any injuries to people receiving care, and any safeguarding matters. This enabled us to ensure we were addressing any potential areas of concern.

There were 17 people living at the home at the time of the inspection. We saw or met with the majority of people using the service and we spoke in detail with five people. We spoke with two relatives, and three health and social care professionals; including a GP, nurse specialist and community nurse. We also spoke with the provider and eight members of staff, including the manager; care staff and ancillary staff. We observed how people were being cared for and how staff attended to their needs.

We looked at six people's care records, people's medicine records, three staff recruitment records, staff training records and a range of other quality monitoring information.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2016 we rated this key question as inadequate. There were not enough staff to meet people's needs; staff recruitment was not robust. Medicines were not managed safely. Not all incidents had been reported appropriately and individual risks had not always been assessed and identified.

The provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches of regulation.

At the last inspection we found a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan following the inspection, which stated weekly reviews of staffing levels would take place by 29 February 2016.

The provider had not organised staffing arrangements to ensure people's needs could be met consistently. As a result there was not always enough qualified, skilled and experienced staff to meet people's needs.

Since the last inspection we have received a concern about staffing levels at the service. We wrote to the provider to request copies of the staff rota and assurance that sufficient staffing levels were maintained.

During this inspection the manager and senior care staff confirmed the preferred staffing level currently needed to meet the needs of the people using the service. These were; one senior carer and four care staff in the morning. One senior and three care staff in the afternoon and evening. At night the preferred staffing was one senior carer and two care staff.

A review of the staff rota from 6 June 2016 to 26 June 2016 showed these preferred staffing levels had not been consistently maintained. For example, there were three staff on duty on the mornings of 18 and 19 June 2016. On the afternoon and evening shifts for these dates there were two care staff with no senior support, for the 17 people using the service at the time. From the review of the rota we found 22 other shifts where staffing levels did not meet the provider's preferred staffing requirements. This had been mainly due to staff sickness. Staff said with staffing levels such as these it was difficult to meet people's needs at times. One said, "It can be hard to get to people when we are short (staffed)…"

People said staff were 'nice, kind and caring', however three people expressed concerns about staffing levels. They described waiting for care and attention. One person explained they had waited 25 minutes for support to use the toilet on the first day of the inspection. They explained due to staff shortages over the previous weekend (18 and 19 June 2016) they had been incontinent as a result of waiting for staff assistance. They were very distressed and embarrassed about this. Another person said, "It is usually alright (staffing) but sometimes they don't come at all." Two people said they often waited for their prescribed medicines; one felt this was down to staffing levels. They said, "There are not enough staff at times…I feel like a nuisance when I ring for help…" Another person commented, "They (staff) are never around…if I need them I have to wait. A lot of money is being made out of us…"

We spoke with the manager and staff about the dependency levels and the care and support needs of people using the service. Staff confirmed that nine people required the assistance of two staff for safe moving and handling and for personal care. Four people required assistance at mealtimes to ensure they ate adequately. A number of people were living with varying forms of dementia, which meant they required a significant amount of support and supervision. One person's behaviour required staff to check them regularly to maintain their safety. The manager explained when staffing levels fell to below the preferred level it was difficult to ensure people received personal care in a timely way, for example baths and showers. The manager said some people had not been able to have a bath for weeks.

A review of the care staff tasks had resulted in some changes. Care staff were no longer responsible for making and serving breakfast. Cleaning staff now undertook this task. A kitchen assistant had been appointed for three and a half hours a day to help prepare, serve and clean up after supper. This enabled care staff to spend more time with people. However cleaning staff said the additional duties meant they had less time for cleaning.

The rota showed an activities person had been employed since the last inspection. They had been contracted to provide 10 hours of activity a week. However, the rota showed this person was also covering night shifts, which meant they were unable to deliver 10 hours of activities as planned. The staff rota from 6 June 2016 to 26 June 2016 showed that two, two hour sessions had been delivered per week and not 10 hours as planned. This meant people had little opportunity for social stimulation and interaction. When asked about activities, one person said, "They (activities) are not very good. We play scrabble sometimes and there is bingo sometimes – I hate bingo!" Another person said they were not aware of any activities at the service.

We spoke with the provider about staffing levels. They said they "did not get involved in the rota" and were unaware that there had been staff shortages due to sickness on 18 and 19 June 2016.

These findings evidence a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

At the inspection in January 2015 we found a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were put at risk of harm because medicines were not safely managed and some risks had not been appropriately assessed and actions taken to minimise the risk.

At the focused inspection conducted on 11 November 2015 we found people's medicines were not managed safely and the planned improvements had not been fully implemented. The provider submitted an action plan which stated they would be fully compliant with medicines safety by 30 April 2016.

At the last inspection in January 2016 we found a continued breach in regulation in relation to medicines management.

During this inspection we found some aspects of medicines management were not safe. Two people said they were concerned about the management of their medicines. Both were concerned about the timing of medicines at times. One person said they were not fully confident in staff's ability and understanding in relation to their medicines. One person had been admitted to the service on 17 June 2016 with a number of prescribed medicines. However there was no record of the medicines administered to them from the 17 June 2016 until 22 June 2016. We spoke with two senior care staff about this and they confirmed that a medicines administration record (MAR) had not been implemented until 22 June 2016. This meant we could

not be sure that the person received their medicine as prescribed.

The service had a medicine's 'procurement' form which recorded the medicines received for each person. However, a procurement form had not been completed for one person to confirm which medicines they had brought to the service on their admission. The medicines for this person had been handwritten on the MAR chart and signed by two care staff to help ensure accuracy. However, staff had transcribed the same medicine twice, which posed a risk of the person receiving the incorrect dose of the medicine. The person told us staff had tried to give them the extra medicine but they had declined it as they recognised it was not their usual medicine. The staff who had hand transcribed these medicines had not received recent or up-dated medicines training. One had not received an up-date since 2012 according to staff training records. According to the guidelines for managing medicines in care homes issued by National Institute for Health and Care Excellence (NICE), "Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines". A senior member of care staff confirmed they would investigate the errors and ensure staff were provided with additional support and training where needed.

People were not always given their medicines when prescribed. One person was prescribed pain relief four times a day. On the first day of the inspection they had requested their pain relief at 1.30pm. They had asked again at 2.15pm. We spoke with them at 3pm and still had not received their pain relief. This meant the person experienced unnecessary pain and discomfort. We found the senior carer on duty and asked that they attend to the person immediately.

In the 'homely remedies' box we found out of date medicines; the expiry date was October 2014. Homely remedies are non-prescription medicines available over the counter in community pharmacies. They are used in care homes for the short term management of minor conditions, such as headaches or constipation.

Staff used a code to indicate when a medicine had not been given because the person had been sleeping at the time. The MAR chart for one person showed this had happened on a number of occasions. However, there was no evidence that staff had tried to administer the medicine again when the person was awake and alert. This meant the person was not receiving their medicines as prescribed on occasions.

The systems in place did not ensure creams and lotions were used as prescribed. There were no clear directions about when creams should be used or where to apply them. There were significant gaps in the 'lotion and cream' charts used to record when these products were used. Records did not confirm creams had been used as prescribed. Two senior members of staff agreed there were significant gaps in the records. This meant the prescriber of the medicine could not be confident creams were used as intended.

The manager had implemented a 'medication error or near miss report and action form', to be used to monitor errors. The manager said there had been five medicines errors since the last inspection however the forms for three errors could not be found. We reviewed the two available forms, which had not been fully completed to show the action taken or the outcome of actions. The sections relating to 'lessons learnt' were missing. This meant possible learning opportunities may have been missed.

Since the last inspection a medicines policy and procedure has been developed to provide guidance for staff. However it referred to older health and social care regulations although it covered some of the basic principles expected of a medicines policy. For example, secure storage; administration and disposal. The policy stated it should be read alongside other medicines policies, including covert medication; homely remedies, 'when required medicines' and use of oxygen. However these polices had not yet been developed

so were not available to guide staff. An advice visit by the supplying pharmacy had taken place on 28 April 2016. They had recommended that the medicines policy be up-dated to include all aspect of safe medicines management. They also recommended staff review the NICE guidelines; although this had not been achieved.

The allergies of two people had not been recorded on the MAR charts or in care records as recommended by the supplying pharmacist. This posed an avoidable risk to people.

There was no monitoring of the room temperature where medicines were stored to ensure they were stored as per the manufacturer's recommendations. This had been a recommendation by the local pharmacist.

At times medicines were not stored securely. The medicines trolley was not attached to the wall in the medicines room and we observed one side was left open.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of staff responsible for the management of medicines had received recent training. However a new senior member of staff had not received training when first employed at the service but had been supported and observed by another senior member of staff when administering medicines. Another member of staff had undertaken training when working in the community but had not received medicines training since starting work at the service, although they were responsible for medicines administration. A senior care staff member said arrangements would be made with the local pharmacy to deliver more training for staff.

The service did not have a copy of the NICE guidance for the management of medicines in care homes. This sets out recommendations for good practice on the systems and processes for managing medicines in care homes. However, staff downloaded the guidance during the inspection to help guide them.

Some recommendations from the supplying pharmacy had been achieved. For example, staff recorded the quantity of medicines received on the MAR chart and also dated creams on opening that had a limited efficacy once open. The medicines fridge temperatures were checked daily with the exception of two days in June 2016. Temperatures were maintained at the recommended level.

Suitable arrangements were in place for storing and recording medicines which needed additional security. Records showed these medicines had been administered as prescribed.

At the last inspection we found people were put at risk of harm because some risks had not been appropriately assessed and actions taken to minimise the risk. The provider submitted an action plan which stated that a new risk analysis form was to be implemented; which would be reviewed and up-dated by staff. They stated they would be compliant with this requirement by 21 March 2016.

Two people had been admitted to Devonia House prior to the inspection; one a week before and the other five days before. Neither person had a full or comprehensive assessment of their needs completed prior to or after admission to the service although both people presented with risks to their health and wellbeing. There was no care plan or risk assessment in place for either person. One person's aggressive behaviour had presented a risk to themselves, staff and others during their first day at the service. However, there was no risk assessment or care plan in place to guide staff about the triggers for the behaviour or how best to support the person. Staff confirmed that the person was 'calmer' after the first day or so and aggressive

behaviour had not been displayed again. The daily notes for the person showed staff had contacted the GP to request sedatives and an assessment of the person's mental capacity. This person also presented a risk in terms of their continence; however, there was no risk assessment or care plan in place to guide staff about how to address these risks and support the person. There was a bowel chart in the care records however there was nothing recorded on this to show how the service was monitoring this aspect of the person's care. This person's bedroom had an overpowering offensive odour. On the second day of the inspection the person was transferred to another room to enable a deep clean to take place.

At the last two inspections we found people were at increased risk of developing pressure damage because pressure relieving mattresses were not used appropriately. At this inspection we found the setting for pressure relieving mattresses was recorded in one of the two care files reviewed. One care plan advised the mattress should be on 'maximum'. However the person using the mattresses weighed 53kgs when last weighed in March 2016. Senior care staff could not confirm this was the correct setting or whether the mattresses should be set according to people's weight. We spoke with a tissue viability nurse (a nurse specialist in skin damage and skin care). The nurse said if the setting was too high this could cause pressure damage. They confirmed best practice when using a pressure mattress was to follow the manufacturer's guidance in relation to settings. They also recommended the settings were checked daily to ensure they were correct. This good practice had not been implemented at the service. Therefore people were at risk.

Four of the six people whose care we reviewed had a high risk of developing pressure damage. For a person recently admitted, the information recorded before their admission stated: 'Help with washing, sore sacrum using derma (barrier cream)'. A 'skin integrity chart' dated 14 June 2016 stated, 'red sacrum grade one sore.' Nothing else was recorded on the chart about whether this had deteriorated or improved. Staff were unable to confirm the current state of the person's skin. Three other people's care plans directed staff to monitor their skin daily. Each person had been prescribed barrier creams to help prevent pressure damage and sore skin. However, records contained significant gaps to demonstrate that daily monitoring and the use of prescribed creams had taken place. One person's records showed they had a 'sore bottom'. There was no record after 9 June 2016 to show whether this was improving or deteriorating and there was no record of barrier creams being used after this date. We found similar shortfalls within two other people's records where their skin had been described as "sore" "slightly broken skin" or "pink skin". This meant it was difficult to assess whether the current interventions had been successful.

Where people were being cared for in bed records showed they were not always supported to change position regularly to prevent the development of pressure damage. The records for one person showed they should be repositioned every four hours. We reviewed the 'turning chart' with senior care staff. There were significant gaps, including from 12 June 2016 to the 17 June 2016 where nothing was recorded to show regular repositioning had taken place.

People's moving and handling needs had been recorded in 'moving and handling plans'. However, they did not contain details of the hoist or slings to be used to ensure people's safety. One member of staff said they were concerned about the equipment being used for one person as the equipment had not been assessed and they were not sure the correct sling was being used. They had been told "We must do it." They had been told to choose a sling that fits the person. This person's moving and handling plan had not been signed or dated making it difficult to assess if the person completing it had the necessary training and experience to do so. We found the label on one hoist sling was illegible as it had faded. This meant staff would not be able to confidently confirm the size of the sling. Concerns had been raised with the manager (on 21 June 2016) about the moving and handling practice of a member of staff. This was to be investigated by the manager or the provider. We have asked for a copy of this investigation, outcome and action taken.

At the past two inspections the provider had failed to ensure there were 'Personal Emergency Evacuation Plans' (PEEPs) in place. These would enable staff to assist with the evacuation of people should there be a fire or another emergency. The provider's initial action plan submitted following the April 2015 inspection stated improvement would be made to ensure PEEPs would be in place by 17 August 2015. However, this had not been achieved at the time of the last inspection in January 2016. At that time there were no PEEPs in place and staff confirmed they had not been given information about PEEPs. The provider's action plan submitted following the January 2016 inspection stated PEEPs would be integrated into care plans by 21 March 2016.

At this inspection the manager confirmed that three PEEPs had been completed. We found one in place out of the six care file records we reviewed. This meant care staff and emergency services staff may not be aware of the safest way to move people quickly should they need to be evacuated in the event of a fire or other emergency.

At the last inspection we found domestic staff were at risk of injury because the service did not have suitable arrangements and guidance in place in relation to Control of Substances Hazardous to Health (COSHH). At this inspection we found a one page guidance chart about COSHH in a storage room on the first floor. However domestic staff said they were unaware of this. At the last inspection domestic staff were using cleaning substances in unlabelled containers. During this inspection we found two cleaning substances in unlabelled bottles and domestic staff were unable to confirm the contents. Domestic staff had not received training related to COSHH or health and safety and had not seen any guidance. This put staff at risk of potential injury. During the inspection we found COSHH products left unattended in a hallway and in an open unoccupied bedroom. This presented a risk to the people using the service, some of whom were living with dementia and may not recognise the risks.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last two inspections the provider had not followed safe recruitment procedures to ensure the risk of employing staff unsuitable for their role were minimised. The provider submitted an action plan which stated a recruitment checklist would be put in place and would be fully completed before new staff commenced work at the service. They stated they would be compliant with this requirement by 30 June 2016.

At this inspection we found staff were being employed at the service before all the necessary checks had been obtained to ensure their suitability.

For example, one member of staff had been working at the service for 19 days before a Disclosure and Barring Service (DBS) identity check had been obtained. This check is undertaken to ensure that staff are not included on the barring list and that they are suitable to work within the service. A reference from their previous employer had been obtained 10 days after their start date. In another personnel file for a new member of staff there was a CRB dated 2013 (CRB was the predecessor of the DBS checks). There was no evidence that a DBS had been applied for.

These findings evidence a breach of Regulation 19 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

The manager had developed a safeguarding policy since the last inspection. Records showed that three staff had signed to say they had read the policy. The manager had also displayed details of how to raise a

safeguarding alert in the office; staff room and kitchen. The manager's training analysis had identified that 27 staff (including ancillary staff) required safeguarding training or an up-date. The manager had arranged for staff to access an on-line safeguarding training course. However records showed that no staff had completed the training to date.

Staff had an understanding of safeguarding issues, for example the type of abuse people may be at risk of. All said they would report any concerns to the manager. Staff were aware of which agencies to contact outside of the service should they have concerns. For example the local authority safeguarding team or CQC.

At the last inspection parts of the building were in need of attention. However the provider did not have a maintenance or improvement plan in place to show how issues were to be addressed. There was a maintenance book, where staff recorded maintenance issues, which the provider dealt with. There was an entry on 20 June 2016 which stated "water pouring in above window in room (room number). Significant leak, needs sealing urgently". The person's whose room it was confirmed there had been a leak from the window. As there was no indication that this had been dealt with we spoke with the provider. They said there were occasional leaks but only when there was heavy rain and a wind in a certain direction. They confirmed they had not undertaken any repairs to the window area and that no further leaks had occurred.

At the last inspection the glass roof over the 'library area' had several cracks and this caused leaks in the wet weather. There was evidence of water damage and damp in this area. Staff confirmed that this area often leaked and they used buckets to catch the water. At the last inspection the provider said quotes had been obtained for the repair work to the library area. However, at this inspection the glass roof had not been repaired. We noticed a wooden beam was soft and disfigured from water damage. Staff confirmed the roof continued to leak when it rained. The provider said it only leaked when "the wind blows in a certain direction". The provider did not have plans to replace or repair the glass roof.

The electrical checks we recommended at the last inspection had been carried out by the provider.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we rated this key question as inadequate. The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) and associated Codes of practice. People were not always supported to ensure they had sufficient amounts to eat and drink. Aspects of people's health care needs had not been monitored effectively. Staff had not received regular training, supervision or appraisals to support them to do their job.

The provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches of regulation. At this inspection we found some improvements had been made in relation to the requirements of the MCA and DoLS and some staff training had been undertaken. However, improvements were still needed.

At the previous two inspections in April 2015 and January 2016 staff had not received regular training, supervision or appraisals to support them to do their job. This had been an outstanding requirement from the inspection in October 2014. The provider submitted an action plan following the last inspection which stated they would be fully compliant with this requirement by 31 March 2016.

At this inspection we found some staff training had been undertaken and the manager had completed a training needs analysis for core training, such as moving and handling, fire safety and medicines. From the records and discussion with the manager and staff we confirmed that nine staff had completed moving and handling training in March 2016. Six staff had not undertaken this training to date. 15 staff had attended fire safety training in April 2016; however, 10 staff had not received fire safety training or up-dates. Apart from the cook and one member of care staff, none of the staff had completed food hygiene training although they were involved in the preparation and serving of food. None of the domestic staff had completed training in relation to Control of Substances Hazardous to Health (COSHH). None of the staff had completed or received up-dated training in relation to infection control. There was no record of which staff had up to date first aid training. Staff could not confirm whether there was always a suitably qualified first aider on duty.

The manager had sourced several free 'on-line' training materials and staff had access to a computer at the service to enable them to complete various training. However, records showed and the manager confirmed that only five staff had completed some of the suggested training. Staff had not received training in respect of people's needs, for example, dementia care; catheter care or skin care. Staff had not received training about the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards to help them understand their responsibilities.

The manager had developed a staff supervision rota. Supervision provides staff with an opportunity to discuss their development or support needs or hear feedback about their performance. The manager had allocated some staff supervisions to senior care staff. However only one member of staff had received supervision since the last inspection. Senior care staff they were waiting for training and guidance as they had not managed staff supervision in the past.

We spoke with two staff who had started working at the service since the last inspection. Both were experienced care staff and had achieved a national qualification in health and social care. They described their induction as one or two days of shadowing senior staff. One said they were confident after this time to work alone with people. The other said, "I just jumped in…"

One inexperienced staff member had been recruited. The manager confirmed this person had not received a 'formal induction' but had spent five shifts shadowing other staff and had completed an on-line moving and handling course. The manager recognised this was not sufficient for a new and inexperienced member of staff. The manager confirmed they had not had the time to set up a formal induction for new staff in line with the Care Certificate (a nationally recognised induction programme for new and inexperienced staff).

These findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

The manager had created a helpful 'staff handbook', which was being circulated to staff at the time of the inspection. It contained important employment information; the expected standards of performance and behaviour at work and information about health and safety issues.

At the previous inspections in April 2015 and January 2016 we found arrangements for ensuring people received an adequate diet put people at risk. The provider submitted an action plan following the last inspection which stated important information relating to food and fluid would be in all care plans by 21 March 2016.

In four of the six care plans there were details of people's dietary needs and preferences, and nutritional assessments had been partially completed. However for two people admitted to the service before the inspection there was no information about their nutritional needs to ensure needs and preferences were met. One person was unwell and during the inspection we noted they had little to eat or drink on the first day of the inspection and nothing to eat on the second day. We visited them on a number of occasions and found untouched cold tea or coffee in front of them. There was a 'daily food chart' for the person to record what diet and fluid they had been taken each day. However there was only one entry on 14 June 2016 which stated '15:40 cake – eaten, sandwich – eaten'. There were no further entries and staff were unable to confirm confidently what the person had to eat or drink.

Three people had been identified as being at risk nutritionally. The care plans stated food and fluid intake was to be monitored and recorded on the fluid and diet charts. However, there were gaps in the records, for up to five days in one case. This made it difficult to assess whether people were receiving sufficient nutrition and fluids to maintain their health. The fluid charts for two people showed they had taken between 100mls and 400mls of fluids on some days. Staff could not be clear what people had to eat and drink because the arrangements for monitoring people's diet were inadequate.

Three people who had been identified as being at risk nutritionally had not been weighed since March 2016. Staff explained it was difficult to weigh one person due to their frail condition. However, no alternative method of monitoring the person's weight, for example using the body mass index (BMI), had been explored. This meant risks to people's health and wellbeing, such as weight loss, were not monitored to ensure the correct action was taken to reduce the risk.

These findings evidence a breach of Regulation14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

People said they enjoyed the food provided. There was a choice of two main courses at lunchtime and choices of hot snacks, soup or sandwiches for tea. The cook also made cakes daily for afternoon tea. One person said, "The food is excellent." Another said, "No complaints about the food…we get enough to eat… lots of vegetables." One person said they had not been told about the choices on the first day of the inspection and staff had arrived with a curry for their lunch. However they did not eat curry. Staff did bring an alternative.

At the previous inspections in April 2015 and January 2016 we found people's health needs were not always managed effectively. At this inspection we found some improvements.

People had access to health care professionals such as GPs and community nurses. During this inspection we received positive feedback from a community nurse who described the improvements they had seen in the past weeks. They said if there were any issues "They (staff) come straight to us now…" They said staff also acted on their recommendations and they confirmed they had no current concerns about the service. They added that improvements had been made "thanks to staff and their determination…" However we found improvements were needed to ensure people's health care needs were monitored. For example their nutrition and hydration needs.

At the previous inspections in April 2015 and January 2016 we found the principles set out in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and associated Codes of practice were not being adhered to. The provider submitted an action plan following the last inspection which stated they would be compliant with this requirement by 4 March 2016.

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

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

We found improvements had been made in relation to the MCA and DoLS at this inspection. The manager had submitted six DoLS applications to the local authority where it had been assessed that people were possibly being deprived of their liberty. The outcome of the applications had yet to be confirmed by the local authority.

People's mental capacity had been assessed in four of the care plans we reviewed. However, one person recently admitted had not had their mental capacity to make decisions assessed. The discharge information from the hospital showed this person had an "undiagnosed dementia" and had been subject to a DoLS during their stay in hospital. However, there was no consideration of whether a DoLS application should be applied for once admitted to Devonia House. The daily records for this person showed they had made an attempt to leave the building when first admitted but staff had intervened for the person's safety. We spoke with the manager and senior care staff about the importance of considering if a DoLS application was required following a full assessment of the person's mental capacity. We discussed ensuring timely contact was made with professionals, including with the DoLS team. In addition, other people were potential deprived of their liberty due to the key code on the front door. On the afternoon of the second day of the inspection, one person had to look for staff to enable them to leave the building. They had full capacity but

could not leave the building freely without the support of staff as they did not have the access code for the door lock.

These findings evidence a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

Inadequate

Is the service well-led?

Our findings

At the last inspection we rated this domain as inadequate. There had been no registered manager at this service since December 2013.The service lacked leadership, guidance and direction and there were not always clear lines of accountability and responsibility. There were no effective systems in place to monitor the quality of service delivered and there was no effective analysis of accidents and incidents to help prevent them in the future.

The provider submitted an action plan following the last inspection. They stated a registered manager would be in post by 25 February 2016 and quality assurance systems would be implemented by 30 June 2016.

This service is registered by an individual provider. The provider did not manage the day to day operation of the service as they had no background or experience to do so. The registered individual had historically delegated responsibilities for the management of the service to a registered manager. The service has had three managers since October 2015. The current manager had started working at the service in March 2016 but had resigned. A relative said there had been lots of changes and described the "lack of management" as a weakness at the service. They added, "I have no idea who people are. There is a lack of communication…I don't know who the manager is but we know the provider."

In light of the manager's resignation, the provider had proposed that that a senior member of the night staff team has been appointed as acting manager temporarily, with responsibility for the day to day running of Devonia House. The provide confirmed the acting manager would take responsibility for ensuring sufficient suitable skilled staff were on duty, and also compile the staff rota. The acting manager would also assess new admissions and decide whether or not the service can meet their needs. The provider confirmed that the acting manager, with their support, would be jointly responsible for staff recruitment, training, induction, supervision, and quality of the service.

During the inspection on 22 and 23 June 2016 we identified two medicines errors, which the acting manager was to investigate. There was also an incident at the service involving issues related to confidentiality and privacy. We received the reports following the acting manager's investigation. However, these did not fully address the concerns; regarding the medicines errors investigation some of the outcome areas were blank, for example, 'action taken as a result'; 'overall outcome' and lessons learnt. In relation to the staff breach of confidentiality, the acting manager sent us copies of staff statements however there was no information about the outcome to the investigation, including any action taken and lessons learnt from the incident. We wrote to the acting manager on 5 July 2016 asking that she send us a full copy of the investigations undertaken along with the outcome. We are concerned that the investigation reports did not identify areas of risks or any improvements to be made to ensure people are safe.

The manager at the time of the inspection had taken steps to improve some aspects of the service. For example issues relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and the development of some policies and procedures to guide staff. Regular staff meetings and briefing up-

dates had taken place since the last inspection to improve communication and joint working between the team. However there remained significant areas where procedures and practices needed to improve further to ensure people received consistently good quality safe care.

'Resident questionnaires' had been distributed in January 2016 to people using the service. Seven completed questionnaires had been returned. These showed areas for improvement, including; involving people more in their care and support; better response times to call bells; more activities, including outings and music sessions, improved communication and better information about how to raise complaints. People did praise the approach of staff, describing most staff as "very friendly" and "excellent staff." An analysis of the responses had not been completed and there was no action plan in place to respond to people's suggestions for improvement. The provider was unaware of the responses and consequently no action had been taken. Other stakeholders' opinion had not been sought about the quality of the service, for example staff and external professionals.

The manager at the time of the inspection had introduced a number of audit templates, for example medicines audits, checklists for the laundry; kitchen and health and safety checks for hot water and window restrictors. The responsibility for completing the audits had been delegated to various staff within the team in April 2016, including domestic staff. However, none of the audits had been completed. The manager confirmed this. This meant there was no systematic review in place to ensure any concerns could be identified and rectified.

Records relating to people's care and support needs were not complete, accurate or current. Two people had no care plan or risk assessment completed. The manager explained once a new person was admitted, they or the senior care staff on duty completed the care plan and risk assessment. They told us "The key information and consent form should be carried out within a few hours of admission, with the remainder completed within 3 days." As the manager was away from the service at the time of the new admissions these important records had not been completed. However, we did see improvements in some people's care records, which were more personalised and detailed, capturing important information about people's needs and preferences. However, records relating to the delivery of daily care were poor, for example food and fluid charts, bowel charts and repositioning charts. The quality and consistency of record keeping meant we could not be confident that people were receiving the care and treatment they required. The gaps in record keeping meant people were at increased risk of weight loss, pressure damage, and medication errors. We could not be assured that the care planned was being delivered. Paperwork relating to one person was found in another person's care records. This showed records were not always stored appropriately.

Analyses of accidents and incidents had not been undertaken to identify patterns or trends that may occur. There had been four recorded accidents/incidents since March 2016. However we not confident that all incidents were being recorded in the accident/incident book as an incident involving a person's behaviour had not been recorded. Without details of accidents and incidents, trends and themes could not be identified to help improve people's safety.

The provider's action plan had not been effective as the service continued to fail to meet the required standards. Systems in place to monitor and improve the service had not delivered the necessary improvements. The provider had failed to ensure that there were always sufficient, suitably trained staff to meet people's needs. The provider had failed to ensure recruitment practices were robust and protected people from unsuitable staff. The provider had failed to ensure people's care and support was managed and delivered in a safe way. The provider had failed to maintained compliance in meeting the regulations over time.

These findings evidence a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

The provider had failed to display the Care Quality Commission (CQC) rating for the service, both on their website and within the service. Prior to this inspection CQC received a concern from a member of the public about the information on the provider's website, which they said was misleading and out of date. We discussed the requirement to display the rating for the service with the manager and provider. The manager was aware of the requirement to display the rating and said they had requested that the provider display it. However, the provider said they were unaware of the requirement to display the rating. Following the inspection the provider contacted us to say the rating was displayed in the home and the website had been taken down until it could be updated.

The provider had failed to notify CQC of events which stopped the service running safely and properly. For example, where staffing fell below the safe and preferred levels set by the provider. On two occasions in June 2016 there were only two members of care staff on duty, which put people at risk of not receiving safe effective care. The CQC had not been notified about a death at the service. This meant we were unable to monitor the service.

These findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 CQC (Registration) Regulations 2009. This is a continued breach of regulation.

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
Treatment of disease, disorder or injury	The provider had failed to notify CQC of events which stopped the service running safely and properly. They had failed to notify us of deaths.

The enforcement action we took:

NOD to resrtict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were put at risk of harm because medicines were not safely managed and some risks had not been appropriately assessed and actions taken to minimise the risk.

The enforcement action we took:

NOD under section 31 to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The principles set out in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and associated Codes of practice were not being adhered to.

The enforcement action we took:

NOD unders section 31 to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	Staff had not received regular training, supervision or appraisals to support them to do their job.

The enforcement action we took:

NOD under section 31 to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems in place to monitor the quality of service delivered and there was no effective analysis of accidents and incidents to help prevent them in the future.

The enforcement action we took:

NOD under section 31 to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not followed safe recruitment procedures to ensure the risk of employing staff unsuitable for their role were minimised.

The enforcement action we took:

NOD under section 31 to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not organised staffing arrangements to ensure people's needs could be met consistently. As a result there was not always enough qualified, skilled and experienced staff to meet people's needs.

The enforcement action we took:

NOD under section 31 to restrict admissions