Mr Anthony John Bloom

Devonia House Nursing Home

Inspection report

Leg O'mutton Corner, Yelverton, PL20 6DJ
Tel: 01822852081
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Devonia House is a nursing home for older people registered to accommodate a maximum of 32 people. People using this service may have a diagnosis of, or conditions relating to, dementia. Prior to this inspection we inspected this service three times between February and October 2014. On 21 February 2014 we inspected the service and found the provider was not meeting regulations in relation to the safety and suitability of premises; supporting workers and assessing and monitoring the quality of service provision.

We carried out an inspection on 18 June 2014 to check whether Devonia House Nursing Home had taken action to meet the breaches found on 21 February 2014. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations, including continued breaches in relation to supporting workers and assessing and monitoring the quality of service provision. We issued two warning notices, one in relation to the care and welfare of people using the service and one relating to assessing and monitoring the quality of service provision. Two compliance actions were issued relating

Summary of findings

to management of medicines and supporting workers. The provider submitted written representations in relation to the warning notices, which were not up-held by CQC.

We carried out an inspection over two days on 24 September and 7 October 2014 in order to check that the provider had complied with the requirements of the warning notices issued in June 2014. We found improvement had been made to comply with the warning notice in relation to the care and welfare of people using the service. Some improvements were found in relation to assessing and monitoring the quality of service provision; the management of medicines and supporting workers. However improvement was still required in all three of these outcomes. Therefore the enforcement actions remained in place in relation to these outcomes.

There has been on-going evidence of an inability of the provider to sustain full compliance since August 2011. Devon County Council implemented a safeguarding process in June 2014 following the CQC inspection and other concerns raised with them. Placements to the home had been suspended as a result of the safeguarding concerns.

During the safeguarding process the service had been monitored through a combination of visits by social services staff, the community nurse team, the local mental health team, as well as multidisciplinary safeguarding strategy meetings. The suspension of placements was lifted by the local authority in March 2015. However an advisory notice remains in place for social care and nursing care placements, meaning that any health or social care funded placements to the service had to be agreed by a senior manager within Devon County Council or the local Clinical Commissioning Group (CCG).

The safeguarding process was closed in March 2015 as the multidisciplinary safeguarding meeting concluded that improvements had been made at the service to keep people safe.

This service is registered by an individual provider. The provider does not manage the day to day operation of the service as they have no clinical background or experience. The registered individual has delegated responsibilities for the oversight of management of the service to a registered manager.

The service has not had a registered manager since December 2013. There is an acting manager in post and recruitment for a registered manager is on-going. Since March 2015, the provider has used a recruitment agency and advertisements had been placed in local newspapers in order to recruit a suitable registered manager. 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.

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.

People could not be confident the staff had the knowledge and skills to carry out their roles and responsibilities because training was not up to date. There was no formal plan for on going training and there were no systems for appraising and supervising staff to ensure they understood their role and their competencies were being reviewed regularly.

The service was not safe because people were not always protected against the risks associated with medicines. The provider did not have appropriate arrangements in place to manage medicines safely.

People's nutritional needs were not always identified and monitored. Nutritional care plans lacked detail or clear instructions for staff about how to support people in relation to eating and drinking. Records relating to people's daily dietary intake were poor. This meant we could not tell in any detail what people had to eat each day, or whether they were being offered alternative snack or food supplements, when they declined meals.

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

Care records did not reflect the needs and preference of people using the service. They were disorganised, incomplete and contradictory in places. Care plans are a

Summary of findings

tool used to inform and direct staff about people's health and social care needs. Lack of detailed and accurate care plans meant care and support may not be given consistently.

The care planned and delivered was not personalised to reflect people's likes, dislikes and preferences. There was a risk that the task orientated approach to care may impact on people's individual preferences and wishes.

People's care needs were not effectively communicated to staff. Some staff had not seen people's care plans and relied on a verbal handover for information. As a result people did not always receive care in accordance with their care plans. For example some people were not appropriately supported with moving and handling.

The Mental Capacity Act 2005 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. People's capacity to consent had not been assessed. The provider had not taken appropriate action in line with legislation and guidance to ensure people's rights were protected.

There was a lack of stimulation for people using the service. Several people said they would like to see improvements in this area. Very few activities were offered and those that were did not always take into account individual interests and preferences or consider individual's abilities.

There was a lack of quality monitoring systems at the home, which meant some risks were not being identified or responded to. Staff said concerns about staffing levels were not being adequately responded to. People continued to be at risk of harm because the provider's actions did not sufficiently address the on-going failings and breaches of regulations. This was despite the significant amount of support provided by the multi-agency team to address those failings.

We received mixed comments about the attitude and approach of some staff. Some people said staff were kind and friendly comments included, "I do feel well cared for, they do look after me. Staff are polite, caring and friendly…" and "…they (staff) go out of their way to treat us well." Others felt staff could be abrupt and inconsiderate. Comments included, "Some carers are more caring than others" and "Staff are very impersonal and don't have time to stop and talk but they are always polite."

Relatives and visiting professionals said they found staff to be kind and caring in their approach. Comments included, "The girls are as good as gold"; "Staff are very friendly here" and "The staff I have met seem very caring."

Some people were positive about the food provided at the service. Comments included, "The food is very nice…"; "Plain home cooked food. I can't complain about it" and "The food is alright but no choice." Other people commented on the lack of choice and one person described the supper menu as "repetitive."

During the inspection we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider to sustain full compliance since 2011. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Services placed in special measures will be inspected again within six months.
- The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

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.

Risks to people's health and welfare were not always well managed.

People's health, safety and welfare were put at risk because there were not sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times.

Medicines were not managed in a safe way to ensure people were protected from risks associated with unsafe management of medicines.

People were at risk because recruitment checks were not always completed before staff worked at the home.

Is the service effective?

Inadequate

The service was not effective.

People's health and welfare needs were not always met.

People were being cared for by staff who had not received the training and information they needed to make sure they had the necessary skills and knowledge to meet people's needs.

The provider was not meeting the requirements under the Mental Capacity Act 2005. People's capacity to consent had not been assessed and the provider had failed to follow appropriate legislation and guidance to ensure that decisions were made in people's best interests.

People's nutritional needs were not always being met and they did not have a choice or a varied diet.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some people gave positive comments about staff and how they were cared for, this was not consistent.

People's privacy and dignity was not always respected or maintained.

People were not always given the information they needed to make choices about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive. Not all individual needs had been assessed or met. People's emotional and social needs had not been identified and their preferences and individual interests were not considered when planning care and treatment.

Summary of findings

People and/or their representatives were not involved in the assessment and care planning process.

There was a lack of stimulation and interaction available for people. Care was provided in a task based approach as opposed to meeting the personalised needs of people.

There were limited opportunities to obtain feedback from people using the service.

People were able to raise concerns; however complaints about the service were not managed in a consistent way.

Is the service well-led?

Inadequate 

The service was not well-led.

People were at risk because of the lack of consistent leadership at the home. The acting manager was not empowered to manage the service and make the necessary decisions to ensure people received a consistently good service.

There were divisions within the staff team and the provider had failed to ensure a healthy, open and inclusive culture at the service, where all team members were valued and listened to.

The provider had not developed systems for monitoring the quality of the service.

There was no analysis of accidents, incidents, concerns and other significant events so the provider could not evidence they had learnt from these.

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.

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. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

A Provider Information Return (PIR) had not been requested prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 15 17 and 29 April 2015 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an expert- by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, they had experience of services for older people with dementia.

There were 22 people living at the home at the time of the inspection. 11 people required nursing care. We spoke with 12 people using the service and six relatives. We spoke with 14 health and social care professionals, including two social care professionals; a community matron; a community nurse; a tissue viability specialist; two GPs; an occupational therapist, speech and language therapist and a mental health professional. We also spoke with 11 members of staff, including the provider; acting manager; nursing staff; care staff and ancillary staff.

We observed how people were being cared for and how staff attended to their needs. We joined some people whilst they were having lunch to discuss and observe their experiences.

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

Inadequate

Is the service safe?

Our findings

Since the last inspection in October 2014 the service had experienced a problem ensuring nursing shifts had been covered. Over Christmas 2014 there had been an incident where the service was unable to provide sufficient nursing staff cover for a shift. With the help and support of the local Clinical Commissioning Group (CCG) they were able to cover the situation. There had been no reoccurrence of this incident since.

There were not always enough qualified, skilled and experienced staff to meet people's needs. The provider had failed to demonstrate they had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels.

We spoke with the acting manager and eight members of nursing and care staff about people's needs and staffing levels. Staff said 11 people required the assistance of two staff for safe moving and handling and personal care took at least 20 minutes per person. 19 people were living with varying forms of dementia, which meant they required a significant amount of support and supervision. A number of people also required assistance or encouragement at mealtimes. Staff, including the acting manager, said in order to delivery care in a safe and effective way the preferred safe staffing levels were five care staff and one registered nurse from 8am until 2pm; and four care staff and one registered nurse from 2pm until 8pm.

The duty rota from 23 March 2015 until 19 April 2015 showed out of the 28 day period the preferred safe staffing levels had been met for the early shift on six occasions and not at all for the afternoon/evening shifts. On three occasions on the early shift three care staff and one registered nurse were on duty, this was due to sickness. We asked staff how this impacted on the care delivered. Staff said they were unable to delivery personal care in a timely way, that they had no time to spend with people chatting or engaging them with activities to enhance their social care. They said that at times people had to wait for assistance especially if they required two members of staff to deliver care safely.

Staff said on occasion's people had not received personal care until 12.50pm. One said, "It is sometimes very hard. Some people are having lunch when others are just having their personal care." Another said they did not always get their breaks, and they had worked from 8am until 2.30pm without a break. They said staff were feeling exhausted and that "it gets disheartening" as staff did not have time to spend with people. They said, "We go from one job (task) to another."

Staff said they felt they were frequently short staffed on shifts. The acting manager and staff said agency staff had been used on occasions, for example when the service had been unable to maintain staffing at three care staff for shifts. However, the acting manager said they had to contact the provider's wife to get permission to use agency staff, which they felt was a constraint on their ability to ensure suitable staffing levels were maintained.

In the afternoons one member of the care staff team was deployed into the kitchen to prepare afternoon teas and make supper, which took them 'off the floor' for up to three hours. This meant there were two care staff and one registered nurse on the floor for significant periods in the afternoon. On the first day of the inspection we heard one person calling out throughout the day, this increased for a two hour period during the late afternoon. Staff did not have the time to intervene to reduce the person's anxiety for any length of time. When they did go to the person they stopped calling out and said, "Thank you dear." However as staff only stayed for a few minutes, the person became distressed and started to call out again. Some staff did not acknowledge the person's calling at all as they were busy with other tasks.

One person had experienced 17 falls within a two month period according to the accident records. The risk assessment showed, in order to reduce the risk, "adequate numbers of staff" where needed to ensure the person was safe. The "action to be taken" to reduce the risk was to discuss the possibility of extra staff with social services and the provider to monitor this person. However there was no further information recorded about whether this had been achieved. The acting manager said they had discussed the possibility of additional staff with the provider but this had not been agreed and there was no change to the number of staff on duty. A senor mat had been put in place to alert staff to the person's movements to help reduce the risk. However, as the person or their relative removed the senor mat on occasions it was not a reliable way of staff monitoring the person's movements.

During our visit on 29 April 2015, a visitor alerted the acting manager that this person had fallen in the lounge. There

Is the service safe?

were no care staff present on the ground floor at this time. Initially the acting manager and home's secretary were unable to find care staff as they were delivering care within a bedroom. The emergency call bell was sounded but it took over 10 minutes to find the care staff to assist the person from the floor. Care staff said they were dealing with a person who required two staff for safe care. They were also unable to hear the emergency call bell in certain parts of the home so were unaware of the emergency.

We received mixed feedback from people about whether there were enough staff on duty. Several people said they felt the home was sometimes short of staff. We asked them how this impacted on them. Comments included, "Staff listen to me and treat me routinely, but we do not have lengthy conversations, they don't have time"; "There are not enough staff, they are always moaning that they have too much to do, I feel my care is jeopardised as a result. Staff don't have much time to sit and talk to us", and "You can wait for 10 to 15 minutes to go to the loo sometimes." One person said they missed having conversations, and felt that the staff just didn't have the time. Two people said they thought there were enough staff on duty and staff responded quickly when assistance was requested.

One visitor said on occasions when medication was late the nurse would explain that this was due to being busy. They added that they thought the home was understaffed and that staff discouraged their relative from leaving their room due to a risk of falling. They said therefore this person was left alone, out of sight and forgotten. Over the course of the inspection we observed this person spent long periods in their room alone. They told us they felt isolated in their room and that they didn't get out or see staff very often. Another relative said, "Weekends seem short staffed". Other relatives said they thought there were usually enough staff on duty.

During the inspection we saw no lengthy interactions between people using the service and staff. Interactions were brisk but polite as staff appeared to be rushing with no time for conversation.

Not all staff had the right skills to deliver safe care. On the second day of the inspection we witnessed staff using unsafe moving and handling techniques, which increased the risk of injury. The members of staff involved were new staff, they said they had not received moving and handling training (this was confirmed by reviewing their personnel files) and they were not aware of the person's moving and handling needs. This showed that consideration had not been given to the skill mix on the shift in order to protect people from unsafe care.

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

People's medicines were not managed safely. For example most medicines were supplied in weekly blister packs, with several medicines in one blister. Safe systems were not in place for updating the packs when a prescribed medicine was changed. This increased the risk of mistakes. Staff had not noticed a very recent change in dose of two medicines and a person had received the wrong dose of these medicines.

The pharmacy provided printed medicines administration record sheets for staff to complete when they had given people their medicines. These were not always completed appropriately. For example staff had made handwritten additions or changes to some record sheets, if a medicine had been added, stopped or the dose changed. Staff had not signed or dated these records to show who had made the change and when. There was no record of who had authorised any changes made to a prescription. This increased the risk of mistakes being made so people would not receive their medicines correctly. One person's medicines administration records had a large number of gaps. Records did not show this person had received their medicines correctly. Staff had not recorded the reason, if the medicine had not been given.

Oxygen cylinders were not stored securely so there was a risk they could fall over causing injury. Daily records of the temperature of the medicines refrigerator did not show these were in the safe range for storing medicines.

The home's medicines policy was not available for staff as nursing staff were unable to find it during the first day of the inspection. When we were shown a policy it was hand written, dated April 2015 and it was not in line with current good practice. For example it did not include information about how staff should order medicines or the checks and records they should make to ensure the correct medicines were available for people. Staff were not able to check they were following safe procedures for managing medicines

A relative and visiting professional raised concerns with us about the management of medicines, in particular the

timing of administration of medicines. A visitor said their relative's time critical medicines were sometimes late, which affected the person's condition. A visiting professional said they had visited a person who required medicines at 12.00 but they were not given until 3pm and only after prompting and reminding staff.

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

People's medicines were available for them. Two people told us they were happy with how staff looked after their medicines. Suitable arrangements were in place for looking after medicines which needed additional security. Records showed these medicines had been looked after safely.

Risks to people's health and wellbeing were not always identified through risk assessments. Measures to meet people's individual needs and reduce risks were not always clear in people's care plans. One person's weight record showed they had lost a considerable amount of weight over a period of four months. There was no nutritional assessment or care plan in place to guide staff about the care and support the person required. We were concerned about the lack of information about how this person was being supported to maintain their weight. The nurse on duty on the first day of the inspection was unable to confirm if the GP had been alerted to the weight loss. We contacted the GP who confirmed the service had alerted them to the weight loss. However, a visiting social worker said the weight loss had been reported to them by staff at the service and they had

prompted staff to contact the GP. They had been so concerned about the weight loss they had also contacted the GP themselves. Staff had monitored the steady weight loss but had not taken a proactive approach by referring the concerns to the GP in a timely way.

The daily notes for another person showed they had developed minor pressure damage. A pressure damage risk assessment had been completed which showed the person was 'at risk'. However this had not been reviewed since December 2014 and since that time the person had lost a considerable amount of weight, which had increased their risk. The daily records showed they had a sore sacral area, and that they were 'nursed in bed' initially to relieve the pressure on this area. The person had a pressure relieving mattress on their bed and a pressure relieving cushion for their chair. However, there was no risk assessment or care plan in place to direct staff about the actions to be taken to reduce the risk of further pressure damage. During the first day of the inspection this person spent from 10.30am until after 5pm sitting in a wheelchair. Although sitting on a pressure cushion their position was not changed for over six hours, which increased the risk of skin damage. We discussed our concerns with the nurse in charge at the time and with the acting manager.

One person had been identified as being at risk of choking and they required a soft diet and assistance with meals. This person was nursed in bed at all times. We were concerned that the position this person was in whilst eating posed a choking risk. The 'eating/drinking/weight care plan stated the person should be in a "sitting position" when having food. However staff assisted the person to eat as they lay on their side. Staff said the person was unable to maintain a sitting position due to their frail physical condition. However one GP told us during the inspection the person could be supported to sit in bed. The care plan and risk assessment had not been up-dated to show staff were having difficulty maintaining the person's position during meal times. No advice had been sought from a speech and language therapist to ensure current practice was safe. A speech and language therapist said staff should be able to recognise the risk associated with positioning people when assisting them with meals.

People were at increased risk of developing pressure damage because pressure relieving mattresses were not used appropriately. Two people's care records stated mattresses were to be set to 'medium'. There were no records for appropriate settings in the other care records to ensure the effectiveness of the equipment.

We looked at the setting on six pressure mattresses. They were all set to firm or maximum. One person's mattress was set for person weighing 160kgs although they weighed 60kgs. The acting manager was unaware of the mattress settings. A tissue viability nurse said if mattresses were not set correctly, according to people's weights, and if they were 'too hard', people would not receive the therapeutic effect intended. They added that a hard pressure relieving mattress could cause pressure and potentially more damage. A district nurse was concerned that nurses were not always aware of the correct mattress to use and said they had to prompt staff in the past to ensure the correct pressure relieving equipment was used.

Inadequate

Is the service safe?

Other risks associated with people's health and care needs had not been identified or addressed. For example how people's behaviour impacted on their safety and wellbeing.

Although accidents and incidents were reported and recorded, the level of accidents reported for some people showed high ongoing risks remained. This demonstrated the actions being taken were not reducing risks to an acceptable level. Two staff were not aware of the process for reporting and recording accidents and incidents, which could result in under reporting.

Many people would rely on staff or external professionals such as the fire service to assist them in the event of a fire. However, there were no individual personal emergency evacuation plans which took account of people's mobility, sensory and communication needs. Also, some of the corridors were narrow, winding and had uneven floors, which could impact on the equipment needed to evacuate people or the route to be taken. This meant emergency services staff would not be aware of the safest way to move people quickly should they need to be evacuated in the event of a fire. We discussed this with the acting manager, who was unaware of these fire safety obligations.

These findings evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk because the provider's recruitment checks did not ensure information was available about staff's good character, qualifications and skills. We reviewed the recruitment records of five staff appointed since the last inspection. The application form was one page and did not include information about the candidate's qualifications, experience or competencies. This information was not recorded elsewhere in the file to assure the provider the candidate had the necessary qualifications and experience required for the post.

The files did not contain the information required to show the right checks and references had been obtained to ensure new staff were suitable to work with vulnerable people.

Disclosure and Barring Service (DBS) checks (previously Criminal Record Bureau Checks) had been obtained and were on file in four of the five recruitment files.

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

Most people said they felt safe living at the service. Comments included, "I think I am safe. No harm has come to me so far"; "No-one is unkind or rude…", "I never feel threatened by anyone" and "I feel safe here, I have not experienced verbal or physical abuse…" Relatives said they thought the service was safe. One said, "I have never seen concerning practice".

Four staff appointed since the last inspection had not received training relating to safeguarding adults and two of them said they had not seen the safeguarding policies and procedures at the service. However, all said they would report any concerns about possible abuse or poor practice to the manager. They were aware of organisations outside of the service they could contact should they feel their concerns were not being taken seriously. There was a poster displayed in the staff office with the contact details for the local safeguarding team, which staff were aware of. The acting manager said they were in the process of sourcing safeguarding training for new staff.

The acting manager and nursing staff were aware of the responsibility to report any safeguarding concerns to the local authority. The acting manager and the provider had co-operated with the recent safeguarding investigations.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 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.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

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.

Records showed and staff confirmed that the majority had not received training relating to the MCA (2005) and the DoLS to help them understand their responsibilities. Staff did not have an understanding of the legislation or how this related to their practice. One said, "I haven't heard of that"; another said they thought it meant people should be treated 'nice, kind and gentle'. One member of staff said they remembered having training some time ago but they could not recall the principles of the MCA or DoLS. We spoke with the acting manager about this, who told us they were still in the process of sourcing training for all staff on this subject.

The service did not have a policy or procedure in place to guide staff about the MCA or DoLS. There was a 'framework' entitled 'safeguarding from Deprivation of Liberties' in a policy file in the main office but staff were unaware of this and had not seen or read the 'framework'.

The care records did not contain up-to-date or valid mental capacity assessments. For example, one person had a generic, non-specific mental capacity assessment which was completed in 2011 which showed the person did not have capacity. However a 'general' consent form had been signed in 2011 by the person, indicating their capacity to consent to treatment, investigation, support and care whilst living at the service. This information was conflicting and had not been up-dated since 2011.

Some files contained 'resident consent forms', although not all had been signed. These forms were not specific. They asked people to consent to staff at Devonia House carrying out "treatment, investigation, support and care." There was no accompanying documentation to show whether the person had capacity to make the decisions for themselves and no evidence that it was in the person's best interests.

Some people with a dementia type condition did not have mental capacity assessments completed to ensure decisions made were in their best interests. There was no evidence in the care records to show relatives and professionals had been appropriately consulted with as part of any 'best interest' decision. There was no information in care plans to guide staff about how they could assist people to make some decisions for themselves.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At least one person was being deprived of their liberty at the time of the inspection. Staff said one person was unable to leave the building unless accompanied by another person or staff member. We heard this person asking to go out and staff explaining they would have to wait for their friend to come. Staff also said this person had 'escaped' on occasion, which was a risk to their health and safety. These restrictions had been discussed and agreed with the person's family. However, there was no mental capacity assessment in place specific to this decision; no best interest meeting decision or DoLS authorisation in place for this person. This meant the home did not have relevant assessments and authorisations in place to restrict this person's freedom, and were doing so unlawfully.

None of the staff knew that they were restricting the person's freedom. We spoke with the acting manager about this, who told us they would ensure a mental capacity assessment was carried out for the person and, an urgent DoLS application would be sent for authorisation as soon as possible. When we visited the service on 29 April 2015 the DoLS application had still not been submitted.

This demonstrated that the principals set out in the MCA code of practice were not being adhered to.

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

Some people were able to confirm that staff sought their agreement before carrying out any day to day care or

treatment. One person said staff asked them if they were ready before assisting them with their personal care needs. Another said when staff assisted them with moving they explained what they needed to do and sought the person's involvement and cooperation.

People were not always supported to ensure they had sufficient amounts to eat and drink and to maintain a balanced diet. Two had lost significant amounts of weight over a four month period.

One person's care records did not contain a care plan in relation to how to manage and support the person's nutrition and hydration. The daily notes from January 2015 showed the GP had been contacted about the weight loss. Recommendations within the daily notes included, to monitor weight weekly, encourage and supervise food and fluid, food supplements required on a daily basis and a strict food and fluid chart to be kept. This information had not been used to develop a nutritional care plan but was 'lost' within the daily notes. The weight book showed this person was not weighed weekly in February, March or April. The food and diet chart contained gaps; sometimes nothing was recorded for a whole day, other times information about certain mealtimes was missing. This meant we could not tell what the person had to eat each day, or whether they were being offered alternative snacks or food supplements, if they declined meals. Two care staff were unaware that supplements had been recommended for the person. The daily food and fluid records did not confirm if supplements had been offered. The acting manager and a nurse said the person was reluctant to take supplements. This information had not been recorded and alternative ways of increasing the person's intake had not been explored although they continued to lose weight. A social care professional said they had visited this person one lunchtime. They found the person's food was untouched on a table in their room but the food and fluid chart had been completed to show the lunch had been eaten. There were no staff present to supervise the person or offer support and encouragement with the meal.

The food and diet charts for two other people at risk of weight loss were poorly completed; with days where no entries were made or entries were incomplete or minimum information was recorded, for example, "lunch, pudding".

Food supplements were recommended for another person but a note in their records showed the person did not like them. However, when asked, the person and their relative said the person did like the supplements and would take them if offered, but staff had not offered the supplements for some time. We discussed this with the acting manager and nurse on duty. They said the person had declined the supplements in the past and so were no longer offered. This contradicted what the person and their relative told us. Following feedback the acting deputy manager agreed this person's nutritional care plan needed to be reviewed.

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

We asked people their views of the food and responses were mixed. Some people were positive, with comments including, "The food is very nice. There is always enough to eat. I have a nice breakfast every day", "Plain home cooked food. I can't complain about it" and "The food is alright but no choice." Some people expressed dissatisfaction. One person said, "The food is sometimes good, sometimes rubbish." A second person said, "The food is routine but good, I would like to have some Chinese food, I enjoy savoury rice." This type of food was not available on the menu. Another person said the menu especially the supper menu was "repetitive". We observed this person brought their plate of supper downstairs uneaten shortly after supper was served. They were not offered an alternative. At tea time meals were plated up and carried upstairs three plates to a tray. The plates were not covered in order to protect the food. Following the inspection the provider informed us that staff had been instructed to only deliver food that had been covered.

The cook prepared meals from a four week menu planner, which was created by the provider's wife. People using the service were not involved in reviewing or planning menus. People did not know what the main meal of the day was or whether there was an alternative. Staff said there used to be a menu board for people to refer to but this had been removed. On the second day of the inspection the menu was displayed on a board but in a part of the building where few people could see it. On the third day of the inspection the menu board was in the dining room for people to see. No choice was advertised for the main lunchtime meal. The majority of people spent the day in their room and there was no information about the daily

meal provided to them. People said they were not aware of menu choices for the main meal of the day at lunchtime. One person said, "We have a choice of 'take it or leave it'". Another said, "They (staff) just put it in front of you."

The cook had a list of people's dietary needs and preferences, although individual care plans did not contain information about people's likes, dislikes, allergies and preferences. The cook prepared soft and purred diets for six people, which were well presented. The cook said people were told the day before what the main meal was for the following day and that alternatives were available. However people said they were not aware of a choice of main meal or alternatives.

Body maps were used for some people to show reddened areas, sores or wound. One person's body map had been completed on 09/12/2014 and showed the person's skin was intact. However the daily records, the acting manager and staff confirmed this person had developed soreness on their sacral area. The body map had not been up-dated and there was no care plan in place to direct staff about how to reduce the risk of further pressure damage. A nurse said staff delivered regular pressure area care to this person, including using barrier creams to protect the skin. As the person did not have a care plan none of these instructions were recorded. Two staff said they were unaware of this person's skin condition and would speak to other staff if they had any concerns. This meant this person may be at risk of inconsistent care.

Some people required regular repositioning to reduce the risk of pressure damage. However records showed people were not always repositioned as often as required. For example one person required a position change every two hours. We found gaps in records, which showed their position may not have been changed for several hours. Where people are not repositioned for extended periods they are at increased risk of skin damage. A tissue viability specialist nurse said care plans had been an issue at the service as they did not always define what should be done to prevent skin damage.

The acting manager said three people required regular dressings for wound care. Records were kept in a 'dressing folder' in the treatment room. However, not all nursing staff were aware of the dressing folder. One nurse said they were unaware of the dressing folder which contained wound care plans. They said would either follow the dressing already in place or use their clinical knowledge to decide on an appropriate dressing/ treatment. This meant there was a risk that treatment was not consistent.

The 'dressing folder instructed staff to 'up-date the care plan and risk assessment for each dressing on a monthly basis or 'as when necessary'. However, none of the care plans or risk assessments had been up-dated. The information on the 'dressing and wound care plan' was inadequate as it did not provide a description or size of the wound; there were no clear directions about how often the dressing should be renewed or the dressing to be used. For example one person had been having a dressing renewed every two days; however there was a gap in the records of 11 days where the dressing appeared not to have been renewed. Records showed a marked deterioration in the wound between the two entries. There was no information or evaluation about how the wounds were progressing to show if the treatment was effective.

A tissue viability specialist nurse said the service had contacted them recently for advice about one person's wound, which was deteriorating. They said the wound had not been swabbed although information indicated the wound could have an infection. They said although the service did not have a history of major problems with pressure damage or other wounds, in the past the service had been "slow to put recommendations into practice". For example, there had been delays in ensuring equipment and recommended dressings were in place. The specialist nurse added that staff were "kind hearted but needed structures in place to evidence what they were doing."

In the staff room there was an exercise chart for one person pinned onto the staff notice board. We drew this to the attention of one member of staff who said that they had not noticed it before. We did not see any other reference to this exercise regime in the person's care plan, nor could the person tell us anything about the recommended exercise regime. This meant the person may not be receiving the care and support they required.

Other basic health charts were not always completed. For example one person's bowel movement chart indicated that they had not had a bowel movement for the whole of April and only five times in March. This person said they were constipated and had last had their bowels opened four days before the inspection. There was no additional information within care records to show how this was being

addressed or treated. Another person's bowel movement chart had not been completed for April 2015 and there were only two entries for March 2015. Again, there was no additional information within care records to show how this was being addressed or treated.

These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health professionals in order to meet their health care needs although referrals made by the service were not always made in a timely way. GPs, community nurses, mental health professionals and speech and language therapist had been involved in people's

care when required. One health professional said "some staff were better than others at being able to give information and up-dates to them." Another felt the continuity of care and information was impacted as there was a lack of consistency within the nursing team. Two GPs said referrals made to them were appropriate. One said they were called "at the first signs of deterioration." A community nurse said staff required prompting at times to ensure their recommendations were followed, however they added overall their instructions were usually followed. Another community professional said that when they visited the service, there was not always a senior staff member available to assist them and provide information.

Staff had not received regular training, supervision or appraisals to support them to do their job. This was a requirement at the last inspection. Two newly appointed staff said they had not received a comprehensive induction. One said, "I didn't get an induction"; the other said induction was "not great". Both said they worked with a permanent member of staff for one shift; and then the following shift they were "chucked in". One added, "I was shocked to be honest." We asked to look at the induction training record for two new care staff and a registered nurse. The induction checklist for one new care staff could not be found. This member of staff said they did not remember being given an induction training record to complete.

The current induction process was inadequate and did not ensure staff were able to demonstrate a sound understanding of their role. Records showed there were significant gaps in the induction process for new staff. This meant that suitable arrangements were not in place to ensure that staff were properly supported and trained by providing a comprehensive induction.

The service had not developed appropriate methods to monitor and manage the training needs of the staff. There were no systems in place to indicate what staff training was needed and what training had been completed.

Four members of staff appointed since the last inspection had not received training to ensure they worked safely with people. For example, moving and handling; safeguarding adults; Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLs) or infection control. Staff involved with the preparation of food had not completed food hygiene training to ensure adequate standards were maintained. One member of staff said they had not had a food hygiene up-date for 10 years. The acting manager could not confirm a date for food hygiene training. Staff had not received training or up-dates in relation to dementia; diabetes, skin care, catheter care or managing behaviour which may challenge the service. Two staff said they had watched a DVD and completed a dementia questionnaire 'five or six years ago'.

Most staff had not undertaken training about how to support people with swallowing difficulties. A speech and language therapist said they felt "there was not always an appropriate view of the value of modified diets" within the staff team. They added that staff appeared to be confused at times about when a pureed or soft forkable meal was required. This meant staff lacked knowledge and understanding about the types of food and drink that was safe for some people.

At the last inspection the acting manager said she had hoped to introduce supervision for staff in October 2014. However at this inspection the acting manager said due to a lack of management time staff had not received supervision or an annual appraisal. Records showed staff had last received supervision and appraisal in 2013. Supervision enables staff to discuss their role, performance and training needs with their manager.

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

Staff had attended a fire safety session in February 2015 and four staff had attended a moving and handling session

Is the service effective?

at the beginning of April 2015, with another session booked for late April 2015. During our visit on 29 April the acting manager confirmed that all staff had received moving and handling training. Infection control training was booked for April 2015. Continence training had been booked for 3 May 2015. A training provided by the Parkinson's nurse specialist was arranged for June 2015.

During the inspection two people said the home, in particular their bedroom, was sometimes cold. One person had a heater in their room and extra blankets as they were cold. They said their radiator did not get hot enough to warm the room. Another person, who had since left the service, said they had been "freezing" during their stay. They were given extra blankets, which they found heavy. A free standing heating was also provided for a short while but then taken away. This resulted in the person staying in bed rather than engaging with their rehabilitation programme.

We spoke with the provider about the heating. The provider was not aware of people's concerns about the heating. However the issue of cold bedrooms was discussed at a staff meeting in February 2015. The minutes of the meeting showed people 'found this weather (cold weather) distressing'. Staff were asked to ensure radiators were turned on, extra blankets were available for people and that windows were closed. The minutes also showed the provider would be asked for a thermometer for bedrooms to monitor temperatures. However, the provider confirmed that monitoring of room temperatures was not undertaken to ensure people were warm and comfortable.

Records showed the two central heating boilers had been serviced and maintained and a Gas Safety Record had been issued in August 2014. Staff said they had access to the two thermostats which controlled the heating and they could adjust this as and when necessary. The acting manager confirmed there were no restrictions about using the central heating.

Maintenance issues were recorded in a maintenance book. Staff said the provider checked this regularly and ensured issues were dealt with. We checked some of the records against what had been completed and saw that action had been taken to mend the minor repairs listed in the book.

Requires Improvement

Is the service caring?

Our findings

We received mixed comments about the attitude and approach of some staff. Some people said staff were kind and friendly others felt staff could be abrupt and inconsiderate.

One person said they had been "horrified with the lack of dignity" shown to them on the second morning of the inspection. They said, "To my horror they (staff) started to dress me when I was in the process of having a bowel movement, I had told them this was about to happen but they just went on dressing me. They wipe me very briskly, it is not comfortable." Another person "Some carers are more caring than others. Staff don't have much time to sit and talk to us." A third person said "The staff have an impersonality, I guess from their training." Another said, "Staff are very impersonal and don't have time to stop and talk but they are always polite." A fifth person commented, "…sometimes carers are not very pleasant." We asked what they meant by this and they said staff were sometimes a "little brusque" as they were rushing around with not enough time to stand and talk.

Some interactions that did not demonstrate a caring approach. For example, other staff continually walked past one person's room even though they were calling out and were obviously distressed. On one occasion staff did not explain to a person how they planned to assist them to move from a wheel chair to a comfortable chair in the lounge. The person was not given clear instructions or time to understand what staff were planning to do. Staff were rushed and they used unsafe techniques when assisting the person. We spoke with the person once they were settled in their chair. They said they often felt rushed by staff and they did not feel some staff understood their needs. They said, "some are better than others."

The call bells in some people's rooms were out of reach, which meant they could not alert staff if needed. One call bell lead was too short and it did not stretch to where the person was sitting in their chair. Two other people's call bells were out of reach. One person said when this happened they waited for staff to pass their room and called out to them.

The majority of people spent the day in their bedroom and we found they were only visited by staff when delivering care and support or when serving meals. There was very little social interaction between people using the service and staff.

Not all staff had a good knowledge of people at the home. Some staff employed since the last inspection said they were given no information about people's likes, interests, hobbies or past life. They said they had not been shown care plans and did not have time to read care plans in any event. This meant staff were unable to engage with people about things which were important to them.

These findings evidence a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people had a more positive experience of staff. One person said, "I do feel well cared for, they do look after me. Staff are polite, caring and friendly. Life here is satisfactory as it is." Another person said, "Staff do listen to what I say, they go out of their way to treat us well." A third person said, "Staff ask me if I'm happy, the staff here are so good, no problems with them at all, I've never had an angry word in 6 years." Another said "Staff ask if I need help and say let us know if you need us. Overall, care is excellent and I would recommend this home to anybody."

We witnessed several caring interactions between staff and people, for example, staff greeted people with smiles, saying 'morning, how are you'. Two staff were particularly patient and kind when one person became anxious and distressed. They spent time with the person providing reassurance and refocusing them onto positive topics. Staff also spoke with four people at the dining table, bending down to their eye level and explaining about a planned activity at the local church. This member of staff was informative and responded to people questions in a friendly manner.

Relatives said they found staff to be kind and caring in their approach. Comments included, "The girls are as good as gold"; "Staff are very friendly here" and "The staff I have met seem very caring." Visiting professionals also said staff were caring. One said the service had "hard working care staff who seem to care for people", they added they had not witnessed practice or behaviours from staff which would concern them. Another professional said "Staff appear to be caring and approachable, trying to do their best."

Requires Improvement

Is the service caring?

People and their relatives said personal care was well attended to. One relative said, "Mum always looks well cared for and well presented." Another said, "I have no concerns on that score. Mum's clothes are coordinated. She was always smart so this is important to her." Most people said they were happy with laundry service and that their clothes were looked after. One person said, "The laundry is perfect, I always get my own clothes back." However a relative explained that often items of clothing, particularly socks and underwear, went missing in the laundry, which was frustrating.

Most people said staff were respectful of their privacy and dignity. One person said, "They're very good at pulling curtains while they wash and dress me." Most bedroom doors had signs which said 'please do not disturb. Personal care being given'. These could be flipped over as required. This was a good way of protecting people's dignity and privacy.

Some people said they were able to make choices about what time they went to bed and rose in the morning and whether they wanted to spend time in their bedrooms. One person said, "I have a choice of what I want to do but I choose to stay in my room to read and watch documentaries." Other people were not able to verbally express preferences or choices and there was no detailed information in care records about people's preferred routines. Many people stayed in their room but it was unclear if this was their choice.

One relative said their family member was "very independent" and "doesn't want to be told…" They said staff respected the person's choices and decisions.

Relatives and friends were made welcome and visited regularly throughout the two days we spent there. Visitors said they received a warm welcome from staff at the home and were offered refreshments. One said, "They are all very friendly here." Another said they always got a "nice welcome."

People were not always supported to express their views. The acting manager confirmed that 'resident and family meetings' had not been held since she had been in post. No records could be found of when the last meeting had been held. People said they were not aware that meetings were held to discuss the service or share comments or ideas. One person said, "I don't know of any resident or family meetings but there are no major changes to be made…" Another person said, "To my knowledge they have not had residents meetings." This meant opportunities for feedback were limited which restricted how much influence people could potentially have in how the service was run.

Requires Improvement

Is the service responsive?

Our findings

Admissions to the service were not always managed in accordance with the policy of the service. The home's admission policy stated prior to admission individuals would be visited to discuss their needs, routines and preferences. However, the admission of two people had been arranged by the provider's wife. This meant the acting manager had not had an opportunity to meet the people and complete a pre-admission assessment to ensure the service could meet people's needs and expectations. Other pre-admission assessments were brief and did not contained sufficient information to develop a comprehensive plan of care.

The quality of people's care records was variable and lacked detail about people's nursing, care and support needs and about actions to be taken to address any concerns. One person who moved to the service in December 2014 did not have a care plan at all for staff to follow. An initial assessment had been completed by staff from the local authority which provided information about the person's health and support needs but not how best to meet those needs. This person was at risk of skin damage, they had lost weight; they needed assistance with moving and they had a catheter. Two staff were unaware of the person's support needs in relation to skin care, moving and handling and the support required to maintain a healthy diet.

Another care plan for a person who moved to the service in February 2015 had several blank pages in relation to mobility; eating and drinking, mouth care and sensory needs. This person said their experience of care varied depending on who was assisting them. They said, "Some (staff) know more and understand better than others." Without effective care planning people were at risk of receiving inconsistent and ineffective care.

Care plans were not person centred and did not reflect people's needs, preferences, interests, hobbies or past lives. This meant staff would have limited knowledge about people and events that were important to them, and would limit what staff could talk to people about.

Changes to people's needs were not always identified, for example weight loss or risk of pressure damage, and care plans were not reviewed regularly. One person's care plan stated their religion but stated they were non practicing. Records showed this person, who lacked capacity, was given food which would have contravened their religion. The acting manager said this had been discussed and agreed with a relative. However, there was no record to confirm this.

People did not have an opportunity to contribute to the planning of their care. The acting manager said people using the service and their relatives were not involved in the development of care plans or when/if care plans were reviewed. The acting manager or nursing staff wrote and reviewed care plans. None of people we spoke with were aware of their care plan. One person said they would like to see it and be more involved.

People were at risk of receiving inappropriate care. This was because some staff did not know what people's care needs were or how to meet them. Staff said they had not seen care plans and relied on information from handover or other staff when delivering care. Two staff were unaware of people's moving and handling needs and dietary needs, which potentially presented a risk.

These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's social needs were not met. There were limited opportunities for social activities or occupation. Activities offered were not always based on people's individual likes or interests or targeted at an appropriate level to accommodate people's varying abilities.

Where activities were organised these were mainly aimed at groups of people rather than people's individual preferences. Three people said they were not inclined to join in with group activities. One person said they would appreciate the opportunity to go out more often. Another person said it would be nice to have someone to talk with sometimes. A visitor said as their relative spent most of their time in their room, they wondered how much time staff had to spend just having a chat to relieve the social isolation.

The statement of purpose for the service stated there was an 'activities programme' which was "tailored to suit the needs of the individual." It went onto say that activities such as slide shows; arts and crafts sessions; exercise

Requires Improvement

Is the service responsive?

sessions; outings, concerns, sing a longs and local events were offered. There was no evidence to show people had regular opportunities to take part in these types of activities.

Several people said activities was an area they would like to see improve. Comments included, "I'm bored because of my lack of mobility."; "Staff don't have much time to sit and talk to us…I would like to do activities during the day, maybe gardening but all they do is play scrabble several times a week"; "We play scrabble and that's it really. I do get bored at times but I have made friends" and "If I go out I have to be accompanied, no one from the home would come with me, I would like to see my hair dresser in Tavistock." This showed that opportunities for social interaction and stimulation were lacking.

A member of care staff team was allocated four hours per week to deliver activities. They confirmed activities had been limited. They said they got to spend "some time" on a one to one basis with people but "not very often." This meant people could become socially isolated in their rooms as few people used the communal areas.

People living with dementia would benefit from activities based on current good practice guidance for dementia care. For example, the use of sensory items, rummage boxes and comfort items, which help to prompt meaningful conversations, social interactions and recollections for people. **We recommend that the service seek advice and guidance on developing activities for people living with dementia.**

There were some planned activities for May 2015, for example a local Church group had invited people to attend a tea party. A table top and craft sale was planned for early May to raise some funds for Summer outings and a sing a long was organised for the month of May. A scrabble game was organised twice a week, but staff said this was attended by the same four or five people.

The provider had a complaints procedure. Everyone we asked said they were able to speak with the provider or acting manager if they had a concern or complaint. People said they felt their concerns would be listened to. Comments included, "I have no complaints"; "I would speak to any of the staff if I had any worries or complaints" and "If I had complaints I would speak to the sister but I've had no complaints since I've been here."

Relatives also said they would speak with the provider, acting manager or other staff if they had any concerns or complaints. They too felt their concerns would be listened to and acted on. One relative said they had raised concerns in the past, which had been dealt with.

The acting manager said if people using the service or relatives raised any concerns, these were normally resolved informally. She said she would record and investigate complaints formally when required. However, without a way of monitoring informal complaints or concerns the provider may miss an opportunity to identify trends or areas of risk that may need to be addressed.

A record of complaints was kept. Two had been received since January 2015; both related to the quality of food/ mealtimes. There was a brief description of the complaint along with a brief description of proposed action. However there were no records of whether the concerns had been resolved satisfactorily, although the acting manager assured both were resolved.

There were a number of compliment cards on display expressing thanks to staff at the service.

Inadequate

Is the service well-led?

Our findings

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 clinical background or experience. The registered individual had historically delegated responsibilities for the oversight of management of the service to a registered manager.

At the time of our inspection the provider did not have a registered manager in post. There had been no registered manager at this service since December 2013. The provider had appointed an acting manager, who took up the post in August 2014. However, the acting manager said they had been unable to concentrate on their management role as they spent the majority of time working as a registered nurse in the home. The acting manager said she was allocated one day a week to focus on the management of the service. The duty rota confirmed this. The provider said they had attempted to recruit additional trained nursing staff to enable the acting manager to focus on their managerial responsibilities. Two part time nurses had been recruited since the last inspection but this did not appear to enable the acting manager additional time to manage the service.

The provider and acting manager were not familiar with the Health and Social Care 2008 (Regulated Activities) Regulations 2014. A copy of the guidance for providers on meeting the regulations had not been obtained to ensure the service was following and meeting the regulations.

The service had not maintained compliance in meeting regulations over time. The home was last inspected on 7 October 2014 and was not meeting the requirements of the regulations we checked at that time. At our previous inspection on 18 June 2014 two warning notices were issued. Since 2011, CQC has inspected the service ten times. Only one of these ten inspections was judged as being fully compliant in all the outcome areas that were inspected.

There were not always clear lines of accountability and responsibility. The service lacked leadership, guidance and direction. The acting manager was unsupported by the provider and said they felt "constrained" and unable to make decisions. For example any increase in staffing levels or the use of agency staff had to be agreed with the provider's wife. The acting manager said they did not have any control over budgets or decisions, which made the day to day management of service difficult.

The local authority commissioning team and other health and social care professionals had concerns about the management of the home. Three visiting professionals express concerns about the provider's approach. Although it was recognised the provider took pride in the home, visiting professionals were concerned about the provider's failure to 'allow managers to manager the service independently'. One professional said the acting manager knew what needed to be done, that they had a "heart of gold and oodles of commitment" but they were not given the support, time or resources to manage the service. One health professional described the service as "a bit old fashioned". Another professional said they found one member of staff 'hostile and rude' at times. Two others said non clinical staff were involved in conversations with professionals about people's health needs, which they felt was inappropriate and a breach of confidentiality at times. Other professionals said staff were hard working, and they also recognised the work undertaken by the acting manager to make improvements.

The atmosphere within the staff team was strained, especially during our visit on 29 April 2015. Two staff were reduced to tears following an interaction with the provider. One of them, an agency staff member, said they had "never been spoken to in such a way". They said staff at the service were "stressed and swearing" at each other. They asked to leave the service. This would have meant two care staff and one registered nurse on duty for the late shift. The acting manager persuaded the agency staff to stay for the shift. A permanent member of staff was also tearful and distressed about their interaction with the provider. The provider did apologise to both staff but the incident caused disruption to the staff team and took them away from their role while the acting manager calmed and reassured. Staff said this type of disruptive interaction was not uncommon.

Staff meetings were held approximately three monthly according to records. These meetings provided an opportunity for staff to be kept informed about issues relating to their roles and the service. However, two staff said they did not feel able to contribute to the staff meetings, which they said could be dominated by just one or two staff. One said they did not feel able to express their

Inadequate

Is the service well-led?

opinion or ideas as there was a culture of long serving staff "know best". The staff member said some staff had set ways of doing things and they had been told, "We have always done it like this." This showed the culture within the staff team was not open to new ideas or suggestions, which may benefit people using the service.

The acting manager and two staff members said there were 'divisions and clicks' within the staff team, which caused problems for team working. The acting manager said "the culture within the team is not working, there are divisions, and some are working their own way, not supportive of the team as a whole." The acting manager said it was their intention to try to 'build team spirit'. They planned a team meeting for April 2015 but no date was confirmed.

The service did not have effective governance systems in place to ensure continuous improvement. There were no effective quality assurance systems to make sure that areas for improvement were identified and addressed and the service took account of good practice guidelines. For example medication, care plan and falls audits were not carried out to ensure consistent quality care. We found inconsistencies and gaps in record keeping throughout the inspection. The variability in the quality and consistency of record keeping meant we could not be confident that people were receiving the care and treatment they required. These gaps in record keeping meant people were at increased risk of weight loss, falls, pressure damage, and medication errors.

The lack of information for staff in relation to meeting people's needs had not been identified through a quality monitoring systems. This meant that appropriate action was not always being taken to prevent harm to people who had needs relating to nutrition, hydration and pressure damage. Staff at the service were often responding to concerns identified by visiting health professionals rather than proactively identifying and escalating concerns or risks themselves.

There was inadequate analysis of incidents and accidents in order to learn from these, and therefore to help prevent further accidents and incidents in the future. There was no analysis of concerns from people using the service. Therefore people living at the home could not be confident that the provider had taken the necessary steps to protect them from the risks of unsafe and unsuitable care and treatment because systems to monitor the quality of the service were inadequate.

Staff training was not monitored to ensure staff received training relevant to their roles. We identified that staff had not received the relevant induction and training to help them to work safely and understand the needs of some people living in the home. There was no formal system for monitoring and assessing staff performance or for supporting professional development.

People who used the service, their representatives and staff were not asked for their views about their care and treatment provided. None of the people we spoke with could remember being asked for their feedback or opinion about the service they received. No surveys seeking views of people using the service or their relatives had been carried out and the acting manager and provider were unable to say when the last satisfaction survey had been completed. This meant that the provider was unable to come to an informed view in relation to the standards of care and treatment provided.

The home did not have policies and procedures in place which covered all aspects of the service. The policies and procedures we reviewed were not comprehensive and had not been updated and reviewed as necessary, for example, when legislation changed. This meant changes in current practices were not reflected in the home's policies. Some staff said policies and procedures were not available for them to read and they were unsure of where to find them. A folder in the staff room contained some policies and a notice on the folder instructed all staff to read the policies and sign a confirmation sheet when they had done so. The confirmation sheet had been signed by two members of staff.

There were no information technology facilities in the home. We discussed with staff how they accessed current guidance and information on best practice in care. The acting manager said if they needed to access information from the internet this had to be done from their own homes.

People were not protected from varying staffing levels as the provider did not monitor staffing levels. A needs analysis and risk assessment had not been carried out as the basis for deciding sufficient staffing levels. Staffing levels varied considerably, for example from five care staff and a registered nurse for an early shift to three care staff and a registered nurse for other early shifts. This was regardless of the fact that the number of people living at the service remained static.

Inadequate

Is the service well-led?

The rotas did not show the ancillary staff on duty, for example the cook, cleaning staff and secretary. This meant there was no accurate record of who was on duty. The provider said ancillary staff managed their own shifts and they were not included on the rota. It was unclear who was responsible for managing ancillary staff. The provider said 'they tended to get on with things themselves'. On the third day of the inspection a kitchen assistant failed to turn up for their evening shift. Staff did not know who had been booked to cover the shift so they had to contact the provider's wife to get this information. They then spent time calling both kitchen assistants to find neither could cover the shift. One of three care staff on the late shift had to spend an hour in the kitchen cleaning and washing up after supper. This meant there were two care staff and one registered nurse on the floor to assist people with their evening routine. Staff said it was a struggle to manage with just two care staff.

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

During previous inspections we had identified issues in relation to the staff rota. In the past the staff rota was developed by the homes secretary and did not account for the different skills of individual members of staff. In addition issues with the staff rota had exposed people who used the service to unnecessary risk in the past. The acting manager and other staff confirmed at this inspection that nursing staff and senior care were now responsible for the rota. The acting manager said this was working well.