Donness Nursing Home Limited

# Donness Nursing Home

## Inspection report

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## Ratings

| Overall rating for this service | Inadequate |
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|---|---|
| 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** |

# Summary of findings

## Overall summary

Donness Nursing Home is a residential care home that was providing personal and nursing care to 20 people aged 65 and over at the time of the inspection. The home is registered to support 34 people.

In 2017, the service was rated as 'good' by CQC. The appointment of a second registered manager had helped improve the standard of care and the management of staff. A team of multi-disciplinary health and social care professionals had also provided intensive support to the service to address a previous lack of staff training, poor record keeping and poor management. This high level of support had been instigated when the service was rated as 'inadequate' and 'requires improvement' following CQC inspections in 2016. The second registered manager left shortly after the inspection in 2017.

In July 2018, there was a further inspection and the service was rated as 'inadequate'. This showed the provider was unable to sustain the improvements made. A team of multi-disciplinary health and social care professionals provided further input to support the provider. The provider chose to employ an interim management team to help them make improvements. When we inspected in February 2019, the service was rated as Requires Improvement in all key areas of care. The interim management team withdrew their services in September 2019 and a proposed sale of the home to a new provider did not happen.

At the time of our inspection the local authority adult safeguarding team were investigating allegations of poor care, and the service was being supported by the local authority quality and improvement team. Following our inspection and the number of concerns identified, the provider decided to voluntarily suspend all new placements to the service until improvements were made.

People's experience of using this service and what we found
The systems to help identify where improvements were required had been ineffective. The systemic failings found at this inspection demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of potential and continued harm.

Since our last inspection, the ratings for all key questions had either stayed at Requires Improvement or deteriorated to Inadequate.

People told us they felt safe living at the service. However, practices were not safe. Poor monitoring of

people's fluid and nutritional intake put people at risk of dehydration and malnutrition. This risk was increased by poor monitoring of weight loss. Changes to people's health needs were not routinely addressed in a timely way.

People received or experienced unsafe or inconsistent care. Risks associated with people's care were not always documented and/or monitored effectively by staff. People were not effectively protected from abuse because some staff did not recognise their responsibilities to ensure people were safe.

Communal areas were clean but there were bedrooms that had an unpleasant odour. The environment had been assessed for safety. Fire training did not take place regularly which put people at risk in the event of a fire as staff may not be competent and confident to respond appropriately. The staff training matrix showed some staff had undertaken little training. Staff competency in using a person-centred approach was variable.

The level and standard of activities and meaningful occupation did not meet the social needs and wellbeing of everyone living at the home.

People were not involved in planning their care and support; people's care was not effectively reviewed and changes to their health needs were poorly managed.

Concerns were not routinely responded to in a consistent manner, so some people lost trust in the staff because their complaints had not been handled appropriately. When the manager was made aware of complaints, they followed the formal process and took steps to address issues and reassure people.

People and relatives said staff were kind and caring. And overall, people's privacy and dignity was respected. People's medicines were generally managed safely.
Rating at last inspection The last rating for this service was requires improvement (published 26 April 2019) and there were multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating and in part due to safeguarding concerns for one person. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We judged five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been repeated. These linked to safe care and treatment, staff recruitment, the cleanliness of the environment, staff training and supervision and good governance.

On this inspection there were a further five new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These linked to staffing arrangements, safeguarding, person centred care, meeting nutritional and hydration needs and need for consent.

We recommended the provider improved some areas of medicine practice and improved the range of activities.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider, safeguarding team and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any further concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. The provider voluntarily decided to close Donness Nursing Home. It will be closed by the end of March 2020.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** ● |
| **Is the service effective?**<br>The service was not effective.<br>Details are in our effective findings below. | **Inadequate** ● |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** ● |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** ● |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-Led findings below. | **Inadequate** ● |

# Donness Nursing Home

## Detailed findings

## Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by an inspector, a member of the medicines team, an assistant inspector, a specialist nursing advisor 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. Their area of expertise is dementia care.

Service and service type:
Donness Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, who was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager chose to retain only a few managerial duties, such as meeting with the new manager.

Notice of inspection:
The inspection was unannounced on 30 October 2019 and 1 November 2019.

What we did:
Prior to the inspection we reviewed the information we held about the service. We reviewed notifications we

had received from the service. A notification is information about important events which the service is required to send us by law. We sought feedback from the local authority and professionals who work with the service.

Prior to the inspection, we liaised with health and social care professionals and the safeguarding team in relation to a safeguarding concern linked to an individual. We used all of this information to plan our inspection.

Some people using the service were living with dementia or illnesses that limited their ability to communicate and tell us about their experience of living there. We would normally use the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us and share their experience fully. However, due to a carpet being laid in one communal room, there was not enough space for us to spend time with people in the lounge or dining room.

During the inspection we met with nine people using the service, including people in their rooms, and spoke with them about their views on the care at the service. We also spoke with eight relatives, the management team and staff, including nursing and care staff.

We reviewed four people's care files, recruitment and training files, meeting minutes, rotas and audits. We looked around the premises. We reviewed medicine administration records.

The provider did not participate in this inspection but was provided with detailed written feedback.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Inadequate

# Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● There were systems and nationally recognised assessment tools to assess the individual risks for each person, but these were not consistently completed. This included risks in relation to malnutrition and pressure damage. Falls risk assessments were not regularly reviewed; action was not taken promptly to reduce the risk.
● People's care plans did not consistently contain information on pressure relieving equipment. For example, this was the case for one person assessed as at high risk of pressure damage. We saw pressure equipment was in place but following the inspection health care professionals have raised concerns regarding pressure care management when people's skin became damaged.
● Fire drills did not take place on a regular basis, which potentially put people's safety at risk. This was highlighted at out last inspection. A fire officer visited during our inspection and addressed this issue with the provider.

At our last inspection the provider had not addressed and audited identified risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Despite the above concerns, people said they felt safe. For example, "You have no worries here, you feel safe, but you want to be at home." A relative said they felt reassured their spouse was well cared for.
● Systems were in place to ensure that all equipment was maintained and serviced. A regular programme of safety checks was carried out. For example, in respect of gas safety, fire systems, electrical safety and building safety.
● People had a personal emergency evacuation plan (PEEP). The evacuation plans set out the specific physical and communication requirements for each person to ensure they could be safely evacuated from

the service in the event of an emergency. Agency staff said on their first shift they were shown fire exits as part of their introduction to the service.

Staffing and recruitment

● Checks were in place before new staff started work at the home, such as police checks and identification documents. However, one new member of staff had not provided a document to confirm their current address, training qualifications and a second reference had not been obtained.
● There was no record of a process within the service to check all nursing staff had current registration. We checked the Nursing and Midwifery Council website and saw newly appointed nurses were registered but there was nothing to show this check had been carried out by anyone at the service.

At our last inspection the provider had failed to demonstrate that the recruitment process was robust. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Most people said staffing levels met their needs. One person said, "There always seems to be enough staff, I am never left waiting." However, another person said, "Sometimes there are not enough staff especially at meal times, I sometimes have to wait for my meal."
● Staffing levels were assessed at five care staff and a nurse in the morning and four care staff in the afternoon and evening with a nurse. Night staff consisted of two care staff and a nurse. They were supported by a clinical lead, deputy manager and manager five days a week and a housekeeping team, including cooks and domestic staff every day of the week.
The number of people living at the home had reduced. However, some people said staff were busy and therefore contact with them was mainly linked to support rather than time to sit and chat with them. This was particularly the case for people in their rooms, either through choice or because of their health care needs. For example, people commented, "They haven't got a lot of time, they always seem to be rushing around or are being called on their intercom…If you ring your bell you don't have to wait too long. 20 minutes is the longest, that was last night during handover."
● On previous inspections, communal areas were not always effectively staffed in the evening. On our last inspection, there had been improvement in how this was managed. However, on this inspection, staff completing incident reports recorded people had falls in the evening in communal areas. They stated in these reports staff were not available to cover communal areas at these times due to supporting people in their bedrooms. Discussions in August 2019 around creating a regular additional twilight shift had not progressed.
● The provider has not addressed this issue with the staff team or analysed the number of incidents. Staff said the amount of people needing two staff members to assist them to move had risen which meant staff were away from communal areas, particularly when people needed assistance to bed. Ten people required the support of two staff members to assist them to move and two other people had variable support needs and sometimes required two care staff to mobilise. This left only eight people who could mobilise independently.

The provider had not ensured people were supported by staffing arrangements. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was regular reliance on agency staff for both nursing and care shifts to supplement the existing staff team. For example, records showed for a fortnight in November 2019, agency staff were requested for at

least one shift per day. They were advertising for more staff and a new care worker had recently started working at the home.

Preventing and controlling infection

● Improvements were still needed to address offensive odours in several bedrooms, which undermined people's dignity. Cleaning records showed there was variability regarding how often mattresses were cleaned, despite a system being in place to give timescales when this should be done.

At our last inspection the provider had failed to ensure the environment was free from odours, which was a breach of Regulation 15 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● The laundry area was well managed with systems in place to manage the risk of cross infection. People were happy with how their clothes were washed. One person said, "Every night they take off my clothes and take them to be washed, they are always returned. They change my bed once a week."

Systems and processes to safeguard people from the risk of abuse

● People were not effectively protected from abuse because some staff did not recognise their responsibilities to ensure people were safe. They did not take action to report allegations or concerns in a timely and effective way. This was despite training in 2019. During the inspection, we shared concerns with commissioners and the safeguarding team relating to how risks to people's health and safety were being monitored and managed. There were there examples of safeguarding issues that had not been reported appropriately to keep people safe.

● Visitors shared their concerns regarding the actions and comments of some staff, which indicated a lack of compassion and understanding of the vulnerability of the people living at the home. They said this meant they were not confident staff had an awareness of their impact on people's well-being. They did not feel reassured by the response of some staff that lessons had been learnt and practice would change, because they said their attitude belittled their concerns.

● One person was sexually inappropriate towards staff in their comments and actions. A risk assessment had not been completed to consider if people living or visiting at the home were also at risk. This was despite an incident with another person living at Donness; there was no updated risk assessment to show action had been taken to reduce the risk of this happening again. A chart was in place to record incidents, but this was poorly completed. Staff said this had negatively impacted on a subsequent assessment by health professionals because the information to assess the risk was not available.

● A recorded complaint raised concerns that a person had been hit by another person living at the home. This had happened in an unsupervised communal area; there was a delay in telling the victim's family. This person had already been hit on a previous occasion by another person living at the home. A safeguarding alert had not been made by staff.

● Two people said other people living at the home sometimes entered their room uninvited. One person said, "One resident keeps coming in but not regularly." Another person said, "People have been in my room, about once a month, I tell them to get out." No preventative actions had been taken.

The provider had not ensured people were safeguarded from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Several staff members said the atmosphere was calmer in the lounge now the activities staff member

spent more time in the area during the week.

Using medicines safely

● There were suitable arrangements for storing and disposal of medicines, including those needing cold storage and extra security. Medicines were administered using a safe method. There were systems in place to report any medicines errors or incidents.
● There were protocols for some medicines prescribed to be taken 'when required', to guide staff as to when it would be appropriate to give a dose. However, we found that these were not completed for all medicines prescribed this way. For example, we found one person prescribed a sedative medicine with no protocol or guidance for staff. For another person prescribed a sedative medicine we were told that the dose had changed and so the medicine chart and the protocol did not match. This put people at risk of not receiving medicines safely or as prescribed.
● Most medicines records appeared well completed and doses signed as administered in accordance with the prescription. Some hand-written medicines charts entries were not signed and dated or checked for accuracy by a second member of staff, in line with good practice guidance.
● One person's records showed that two of their medicines had been out of stock. Three doses of a pain-relieving medicine had been missed and a cream preparation had been recorded as out of stock for four days. This person told us they were still waiting for the cream to be supplied. For a second person, three doses of a preventative medicine had been missed due to uncertainty over whether it was to be continued, as staff had not followed this up with the GP in a timely way.
● There were systems in place to record the application of topical creams and other external preparations, and guidance was available for staff on how to apply these. However, the completion of these charts was variable in quality, with gaps over a period of days for some people, so it was not possible to be sure these were being applied when needed.
● Regular medicines audits were completed, and we saw that some issues were identified, and actions for improvement recorded. However, the areas for improvement that we found had not been identified and addressed.

We recommend that the provider update their policy and practice in relation to medicines management to incorporate current best practice. This is a repeated recommendation.

Inadequate

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The quality of staff inductions was variable, and records showed some staff, including nurses and the new manager had not completed an induction.
- Competency checks did not take place in a timely manner to check the safety of staff practice. For example, one staff member who worked on nights administered medicine, but their competency was not assessed until approximately a month after their appointment.
- Records showed training or updates for different topics were overdue for a number of staff, including nursing staff and night staff. For example, medication awareness.
- There was an inconsistent approach to ensuring the staff group had the skills to meet people's care needs. The training matrix showed a number of gaps in staff training and some staff members either had not received key training or their training had not been updated. For example, food hygiene and end of life care.
- Staff records showed some staff had not attended training relevant to the people they supported, such as dementia awareness. Some staff practice showed further training was needed in this area of care. For example, how their intonation, tone of voice and their body language could potentially negatively impact on people living with dementia. A relative said some staff lacked awareness and understanding, for example by not considering their role in maintaining people's quality of life, such enabling them to watch the television.
- Staff had been reminded in team meetings to abide by safe moving and handling techniques. Training had taken place in May 2019, but staff said it was of poor quality. Alternative training to address this issue was not booked to happen until November 2019.
- Staff attempted to help a person stand up from a chair but after several unsuccessful attempts, staff decided to leave them to eat their meal where they were sitting. Staff said, "He can get up but he'd rather not, he knows we can't pull him up." The person's moving and handling plan said they had variable ability to move independently but did not provide clear guidance to staff. However, another person said, "I feel safe when they are moving me, the staff are always pleasant."
- Supervision sessions had progressed since our last inspection, but this was not consistent across the staff

group. Supervision provides an opportunity for staff to discuss their work and training needs and to receive feedback about their performance.

At our last inspection, the provider had not ensured staff were suitably trained, which was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

Supporting people to eat and drink enough to maintain a balanced diet
● Risks linked to malnutrition and dehydration were poorly managed for some people. For example, a fluid monitoring chart for one day only had two entries, which showed a person had drunk approximately 100mls over 24 hours. The average recommended average fluid intake is 1500 mls per day. The chart had been put in place because the person was at risk of dehydration.
● One group of staff had the responsibility to total and monitor some people's fluid intake on a daily basis to ensure people drank appropriate amounts, and if not, take action. These reviews had not happened and so there was no effective oversight of how much people were drinking.
● Records lacked detail and amounts were described in general and subjective terms, such as ate 'a fair amount but needs to drink a bit more'. There was a lack of oversight to react to increased risk. The poor quality of recording meant it was unclear what action had been taken to increase people's food and fluid intake
● Kitchen staff did not know when people had lost weight so had not taken steps to increase people's calorie intake. This was addressed during the inspection.
● One person, who was unwell, had not been effectively assisted with their meal; we met them in their room. We raised our concern with staff. Staff had not considered that the meal was cold, which was still untouched by the person's bed 50 minutes after it had been served. There was a lack of oversight of how mealtimes were managed which meant specific staff were not deployed to check, encourage or assist people who were unwell. Despite the person losing weight, there was no record of food being provided after 1pm on one day and after 5pm on three other days.
● A visitor said they were not confident their relative was kept hydrated and therefore felt compelled to visit regularly so they could assist the person to have a drink.
● People's weight was recorded. However, records showed this was a task rather than a meaningful health intervention. For example, some people were weighed weekly, but their weights were stable. Or were due to be weighed weekly but records stated they had been 'missed'.  Other people were regularly losing weight but were only weighed monthly.
● On the first day of our inspection, the flooring was being changed in one communal room. Lunch was served in a small room, which was crowded. There was not enough space in this room to accommodate people who wished to eat their meal in the dining room. One person's wheelchair would not fit in and so they had to eat their meal in the lounge. There was lack of planning to ensure meals were served in a suitable setting.
● The improvements to the mealtime experience that had taken place at the last inspection had not been sustained. The daily menu was not made available to everyone living at the home and condiments had been removed from the tables.

The provider had not ensured people's nutritional and hydration needs were met, which was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities).

● People said they enjoyed the food served to them and staff knew their preferences. One person said, "I

don't like gravy, so they never put it on my meals." Another person said, "Sometimes the food is very appetising" and another said, "The food is not too bad, well cooked, a few options. I have to be careful… there is always sandwiches, cheese on toast, egg on toast, if they can find anything else they will."

Assessing people's needs and choices; Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Applications for DoLS had been made to the supervisory body when necessary. However, these did not include restrictive measures such as the use of bed rails and sensor mats, which they should have done.
● Daily handover sheets recorded information regarding people's decisions linked to resuscitation. However, they no longer showed if a DoLS application had been requested or authorised. For example, there was no information regarding the authorisation of an application for one person. This meant agency staff were not supplied with crucial information in a suitable format.
● People, or where appropriate, another person of their choice, were not routinely asked to read, and agree the content of their care plan.

The provider had not ensured consent was gained from the relevant person which was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

● Prior to moving to the service, peoples' needs and choices were assessed, to ensure the service was suitable for them. Records showed people's capacity to consent to various aspect of care or treatment had been assessed.
● Work had taken place to ensure appropriate documentation was in place to protect some aspects of people's rights. For example, requesting copies of legal documents, such as Lasting Power of Attorney.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to health professionals to meet their health care needs but referrals were not always made in a timely way. For example, a staff member recorded that one person was having difficulty swallowing their medicines but there had been no referral to the speech and language team.
● When people's health deteriorated, there was not effective communication between staff to ensure everyone on the shift was aware. For example, handover sheets were not routinely updated with key information, such as a person being placed on a fluid chart due to their risk of dehydration or now needing prompting and encouragement to eat their meals. Care plans were not consistently updated with key changes to people's health.
● Communication books were used by nursing and care staff but there was no system to show staff had read them at the start of their shift.
● Staff logged concerns in people's daily records and the staff communication book but there was no log to

show if they had been addressed. For example, a referral to a health professional.
● Staff said the lack of a mobile phone meant there were delays in receiving and making calls to health professionals as staff could only use the landline in the ground floor office, if it was available. Staff said this was particularly time consuming when people's care needs were changing rapidly, for example end of life care.
● People said their health needs were met. One person said, "It's not too bad, better than in hospital." One relative said they were reassured by nurses always being available.

Adapting service, design, decoration to meet people's needs
● Best practice in terms of design and decoration were not followed for people living with dementia. For example, colour and signage was not used to define areas to assist people's independence and orientation.
● Some carpets were patterned. Patterned flooring can result in an increased risk of falls for people living with dementia. However, work had started to replace flooring in communal areas and armchairs in a contrasting colour were delivered on the day of our inspection. This contrast can reduce the amounts of falls as people can clearly see the edge of the chair when they sit down.

We recommend that the provider should seek advice from a reputable source regarding the design of buildings for people living with dementia.

Requires Improvement

# Our findings

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

At the last inspection this key question was rated as Requires Improvement At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Some relatives shared incidents where a staff member had shown a lack of compassion. For example, leaving them feeling dismissed after raising concerns or treated in a way they described as "flippant." We passed on these concerns to the new manager. Therefore, some staff did not provide strong role models to less experienced or less confident staff members.
- Personal care records for people were poorly completed. For example, one person's records had gaps for several days linked to washing their face, hands and body despite them experiencing incontinence. Therefore, staff would not know for certain that care had been provided or that the person's dignity had been maintained.
- A relative expressed concern that when they visited late in the morning, their relative still had not received personal care, for example a shave. On one of these days, they returned mid-afternoon and their relative had still not received personal care support. However, other relatives praised how their relatives were supported to maintain their appearance.
- One person's pre-admission assessment stated they held a religious belief. However, this information had not been included in their care plan, so it was unclear if staff had considered if they were meeting or supporting the person to continue to practice their religion.
- Several relatives said there were problems with how laundry was managed at the home. For example, finding other people's clothes in their relative's wardrobe and occasionally clothing going missing. One said, "They get the clothes mixed up, the clothes are clean but not ironed. I plan to take his washing home and wash and iron it myself."
- People living at the home said staff were kind, compassionate and treated them with respect. Staff supported people back to their rooms to change their clothing, for example due to incontinence, to help them maintain their dignity. A relative said, "The staff are more like friends now, I feel part of a family, that's the atmosphere, very kind."

● People said they were treated with dignity when they were supported with personal care. For example, one person said, "They cover you up with a towel, do a bit at a time, they don't strip you off and leave you naked. They are not rough, they are fairly gentle." And other people commented, "There are always two staff to wash me, they make sure the door is locked, I ask to wash my own face. It's very good care, they always speak pleasantly. I like the way they dress and undress me, they are gentle. It's nice to be looked after, to know you are always clean" and
"Staff always knock on the door, they are very good, they don't throw you around."

Supporting people to express their views and be involved in making decisions about their care
● Some staff were particularly responsive to people's individual needs and recognised what topics of conversation met their personal interests and emotional needs. Staff interacted with people in a kind and compassionate way whilst providing physical care and support. However, these interactions were normally linked to a task, such as assisting people to move. Social interactions were mainly by the staff member who organised activities.

## Requires Improvement

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- People said they had not been involved in care planning and records did not show they had been involved or given consent.
- Some people's care plans showed they had been consulted about the content but were not involved in reviews. Reviews were sporadic and did not capture changes to people's health and well-being. Reviews were not meaningful. Despite one person experiencing a high number of falls and weight loss since their move to the home five months previously, there had only been two care plan reviews. The reviews did not provide an overview of their experience in that time, for example emotional well-being, and contained minimal information.
- Care plans contained specific aims to aid people's health and well-being, but staff did not always address these goals in the way they supported people. For example, an aim of one person's care plan was to help them remain continent. Their care plan said they could get restless and agitated if they needed to access the toilet. The person displayed this behaviour, but staff encouraged them to sit back down, despite them continually standing up.
- Some care plans contained people's individual interests but despite this personalised information their emotional and mental health needs were not met. For example, one person's religion could influence the way they lived their life. There was no care plan to show if this had been taken into consideration as to how their care was delivered or how their spiritual needs would be met.

The provider had not ensured people were provided with person-centred care which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

Improving care quality in response to complaints or concerns
- Despite some written complaints information containing the wrong name for the manager, some people said they felt confident about raising complaints and concerns verbally. For example, "If I had a complaint I

would walk to the office and say I wanted to complain to the Head." Another person had made a written complaint and received an apology and said things had improved but they worried about being seen to complain too much.
● Since our last inspection, the new manager had kept a record of complaints, which were well documented. They had shown a commitment to addressing and resolving concerns when they were made aware of them. For example, meeting with people and responding in writing. However, other staff were less diligent in logging or responding appropriately to people's concerns and complaints, which meant some people were left feeling dissatisfied and were not reassured by the attitude of some staff.

End of life care and support
● At the time of the inspection, there was no one actively receiving end of life care. However, end of life care planning was not comprehensive. For one person, there were no plans to show how their faith would be supported, or if, at the end of their life, they would need a specific approach in line with their beliefs.
● The family of one person recognised the person's health was deteriorating and expressed concern that no staff member had discussed the person's end of life wishes, which the person could not express for themselves. They had also not been asked to be involved in the person's care plan to cover this aspect of their care.
● Some staff expressed concern there was not enough time for them to meet the needs of everyone in the home when people required end of life care. Some staff had identified they needed further training in this area of care to keep their practice up to date.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Some people, who either due to preference or because of their health needs stayed in their bedroom, said they could feel isolated. One person said, "Staff don't come and socialise, only when delivering food or personal care. It gets a bit lonely, but I've got my telly and a good view out of the window." Another said, "Staff haven't got time to come and sit with me, no one has." Comfort checks by staff were recorded but these were task orientated rather than meeting people's emotional needs.
● Several relatives expressed concern about the lack of stimulation for people staying in their rooms. One said, "They don't tend to bother to get him out of his room, he is in bed all the time, no reason is given."
● In contrast, other relatives praised the impact of the social events held in the lounge had upon their relative's well-being and enjoyment of life. Staff commented how one person had become more alert and responded well to the activities person, which was confirmed by the person's spouse.
● Activities were the responsibility of one staff member who worked five days a week. The new manager said the appointment of a staff member to the new role of organising activities such as quizzes and singing had been beneficial to people living at the home. They were looking at ways to support the staff member to record how people responded to activities and social events. There was not a system in place to judge if people's individual social needs and interests were being met or that everyone had equal access to social opportunities.

We recommend the service seeks further advice and guidance on developing activities and social interactions for people who choose to stay in their own room and/or are living with dementia.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Some people's care plans included a section about how staff should communicate with people who experienced communication difficulties. However, not all staff recognised effective communication as an important way of supporting people to aid their general wellbeing.
- Previous plans to provide pictorial menus so people living with dementia could make an informed choice at mealtimes had not progressed.

Inadequate

# Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The systemic failings as cited in the safe, effective, caring and responsive key questions demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of potential and continued harm.

● Since our last inspection, the ratings for three key questions had deteriorated.

● Shifts were not well run, there was a lack of leadership and delegation. There was poor communication between the management team, so issues were not addressed. During the inspection, the provider said they were unaware of an individual safeguarding concern linked to a person using day care. This was despite some staff having attended a safeguarding meeting.

● When people's health deteriorated, the staff on shift did not work as a team to monitor peoples' well-being. On the second day of inspection, two staff had been allocated to work on a floor where one person was unwell. One was a new member of staff and the other was an agency member of staff, who did not work regularly at the service. This showed a lack of planning when there were other staff available who knew the person.

● Some staff did not take responsibility to address risk. For example, staff did not always make safeguarding referrals or refer to health professionals in a timely way.

● Changes to people's health were not addressed in a timely way. For example, when one person's health deteriorated, neither the management team or the nursing staff reviewed the type of support they were offered or monitored how staff were supporting the person despite them losing weight and sleeping more.

Continuous learning and improving care

● Staff did not challenge each other's practice. They did not question why records were incomplete and did not recognise their purpose. For example, fluid charts were poorly completed by care staff and then were not audited by nurses, making the records meaningless and ineffective.
● Not everyone benefited from meaningful ways to spend their time. Despite this being highlighted in previous inspections as an on-going area for improvement.
● Records showed the poor performance of some staff had not been addressed in a timely or robust manner. Concerns linked to poor practice had not been addressed thoroughly so we were not reassured similar events would not happen again.
● There was an inconsistent approach to concerns or complaints as some staff did not follow the appropriate process. This left some relatives feeling worried about the well-being and health of their relative.
● There was a weekly audit tool for the manager and clinical lead to complete, which had 12 areas to check, such as residents' weights, wound care audit and mattress audit, but these were poorly completed. For example, for one week's audit there was only nine entries.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● At the last inspection, the provider had arranged for an interim management team to manage Donness Nursing Home. Their aim was for another provider to buy the home and continue to manage the service. However, the interim management company withdrew their services in September 2019. The provider said this was unexpected.
● The provider is also the registered manager but delegates managerial duties at the home to the new manager, who was appointed in May 2019. They remain legally responsible for the quality and safety of care at the home. Induction and supervision records were not kept for the new manager; the new manager had only received one supervision session since their appointment.
● Since the withdrawal of the interim management company, the provider said they were in regular contact with the new manager, but this was on an informal basis rather than formally recorded. They provided us with a retrospective list of their visits to the service, for example dates of tours of the home, which focussed on the environment, and meetings with the manager.
● The provider is no longer registered as a nurse; a clinical lead works at the service whose role included supervising clinical practice at the home and the supervision of the nursing staff. During the inspection, concerns were raised regarding the competency of some staff to keep people safe and the level of supervision when concerns were identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● Feedback from people living at and visiting the home was gathered informally during general conversation with staff. However, other feedback systems, such as through regular one to one reviews and residents' meetings were not part of the home's culture.
●The new manager met with staff to gather views and share information, including areas to improve. These meetings were minuted for those that could not attend. Common themes included better record keeping. Some staff raised concerns about a night and day shift divide, including people's incontinence not being managed well in the evenings. The new manager had begun to address this by clarifying roles and expectations.
● Staff also expressed concern how dominant staff members could impact on how successfully shifts were run; including not taking instructions from nurses. On our last inspection in February 2019, plans were in place to address this issue and increase people's confidence to lead shifts, but this had not been achieved. In contrast, other staff said there was a good atmosphere amongst the team. One staff member said, "The reason I am here is because there is a good team here and I really care about the residents. I do like the job

and the team…I do see ways in which we could improve if we were allowed to."

At our last inspection, the provider had not ensured there were robust governance systems, which was a breach of Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

CQC had not been notified of events in the home, which linked to safeguarding concerns. Staff had not recognised events as being a safeguarding concern.

The provider had not notified CQC of notifiable events, which was a breach of Regulation 18 of the Care Quality Commission (Registration ) Regulations 2009 (Part 4).

Working in partnership with others

● The local quality assurance and improvement team had been welcomed by the provider and management team to assist them in improving the service, but work was still on-going. A nurse educator who visited the service to address training deficits said staff had responded well to training. Staff who attended training were now paid for their time.

# 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<br><br>The provider had not notified the Commission of notifiable events in the home relating to safeguarding incidents. |

**The enforcement action we took:**

Requirement

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had not ensured people were provided with person-centred care. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not ensured consent was gained from the relevant person. |

**The enforcement action we took:**

Requirement

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not addressed and audited identified risks. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured people were safeguarded from abuse and improper treatment. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider had not ensured people's nutritional and hydration needs were met. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had failed to ensure the environment was free from odours. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured there were robust governance systems. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to demonstrate that the recruitment process was robust. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured staff were suitably trained and competent. |

**The enforcement action we took:**

Planned action not taken - service voluntarily closing.