Downside House Limited

Downside House

Inspection report

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Date of inspection visit:
09 October 2018
11 October 2018

Date of publication:
21 December 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Downside House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 21 people, including people living with dementia care needs. There were 17 people living at the home when we visited. Accommodation is spread over three floors, connected by a passenger lift and stairwells. All rooms had en-suite toilet and washing facilities. There is a lounge/dining room on the ground floor and bathrooms on each of the floors.

This inspection took place on 9 and 11 October 2018 and was unannounced.

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. At the time of the inspection there was not a registered manager in place. The previous registered manager had left the service in June 2018. At this inspection there was a manager in place who had taken over the overall running of the service, with support from the directors of the provider's company. The manager had commenced the registration process with the Care Quality Commission (CQC).

Risks posed by equipment which could result in significant injury or harm to people had not been assessed or considered. Personal evacuation and escape plans which aimed to keep people safe in the event of a fire were not up to date.

People felt safe living at Downside House and staff knew how to identify, prevent and report abuse and had received training in this area. However, some staff had failed to ensure people were protected from receiving improper treatment.

Oral medicines were managed safely and administered in line with the prescribing instructions. However, systems in place to ensure topical creams were used safety were not effective and clear guidance in relation to when 'as required' medicines should be provided was not in place.

The principles of the Mental Capacity Act 2005 were not being followed to ensure people were only cared for with consent; capacity assessments had not always been completed and best interest decisions were not in place for all people that required them.

The systems and processes in place to monitor the quality and safety of the service, were not always robust. There were a number of audits in place to check the quality and safety of the service, however, some of these were not always effective in identifying concerns. People, their families and staff had the opportunity to become involved in developing the service. However, actions were not always taken in a timely way when themes for improvements had been identified.

Staff supported people to be independent; however, changes to the environment had not been implemented to help people further increase their abilities to complete tasks without full support.

There were enough staff to meet people's needs in a timely way and staff were able to support people in a relaxed and unhurried way. People received care from staff who had received an induction into their role, who were competent and suitably trained. However, staff were not consistently supported in their roles as per the provider's policy.

There was not always a person-centred approach to care and for some people their views and wishes had not always been considered. People's care files contained individual information about their physical and psychological needs and provided staff with guidance on how people should be supported and what they could do for themselves. However, we found that information for some people about their preferences, likes and dislikes and life history was insufficient.

People were supported to have enough to eat and drink and had access to health professionals and other specialists if they needed them. Procedures were in place to help ensure that people received consistent support when they moved between services.

Staff worked in partnership with health and social care professionals to provide them with the opportunity to share knowledge and ideas with others to aid the delivery of effective care.

People and their families were positive about the care received. Staff had developed caring and positive relationships with people. Staff protected people's privacy and responded promptly when people's needs changed.

People received mental and physical stimulation and had access to a range of activities. Staff supported people to meet their cultural and religious needs.

The directors of the provider's company were fully engaged in running the service and their vision and values were clear and understood by staff. There were processes in place to deal with any complaints or concerns.

The home was clean and there were systems in place to protect people from the risk of infection.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always managed effectively and risks posed by equipment had not always been considered.

There were plans in place to deal with foreseeable emergencies, However, personal evacuation and escape plans were not up to date.

Staff had received safeguarding training; however, some staff had failed to ensure people were protected from receiving improper treatment.

Oral medicines were managed safely and administered in line with the prescribing instructions. However, systems in place to ensure topical creams were used safety were not effective.

There were enough staff to meet people's needs and recruiting practices helped ensure that all appropriate checks had been completed.

The home was clean and there were systems in place to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Best interest decisions had not always been made in accordance with The Mental Capacity Act 2005. This meant that staff could be providing care and support to people without lawful consent.

Changes to the environment had not been implemented to help people to maintain their independence.

People received care from staff who had received an induction into their role, who were competent and suitably trained. However, staff had not received regular one-to-one sessions of supervision in line with the provider's staff supervision policy.

People were supported to have enough to eat and drink.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

Staff supported people to meet their cultural and religious needs where required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At times there was a task focused approach to care, which could amount to abusive, improper treatment.

People were not always provided with person-centred care that had considered their views or wishes.

Staff responded promptly when peoples' needs or preferences changed.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

People knew how to raise a complaint and the management team had a process in place to deal with any complaints or concerns.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems and processes in place to monitor the quality and safety of the service, were not always robust or effective.

People, their families and staff had the opportunity to become involved in developing the service. However actions were not

always taken in a timely way when themes for improvements had been identified.

There was a clear management structure in place. Staff were happy in their work, felt supported by management and worked well as a team.

The providers were fully engaged in running the service.

Downside House

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 11 October 2018 by two inspectors and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed this and other information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are information about specific important events the service is legally required to tell us about.

During the inspection we spoke with six people who use the service and five family members. We observed care and support being delivered in communal area of the home. We also spoke with the manager, two deputy managers, the cook and five care staff. We received feedback from three social care professionals and a visiting professional who had contact with the service.

We looked at care plans and associated records for nine people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints, accidents and incidents and quality assurance records.

The home was last inspected in July 2016 when it was rated as 'Good' overall.

Requires Improvement

Is the service safe?

Our findings

People, their family members and social care professionals told us they felt the service was safe. A person said, "I feel safe, I don't need to worry." A family member said, "[My relative] is very safe here, we don't need to worry." Another family member told us, "I'm confident that [my relative] is safe."

Although people told us they felt safe, we found risks to people were not always managed effectively and risks posed by equipment had not to always been considered. For example, some people required bedrails to keep them safe while in bed; however, no risk assessments had been completed which detailed the risks posed in relation to there use; such as limb entrapment and people making attempts to climb over these. We also found that not all upstairs windows had window restrictors in place. This posed a risk that people could fall from the windows. This was discussed with the manager who told us they had previously noted this and had asked for these to be fitted. However, this had not been done. The manager agreed to address the all the issues highlighted.

Personal evacuation and escape plans (PEEPs) had been completed for people. However, we found that these were not all up to date. This meant that if people needed to be supported to evacuate the building in an emergency written information passed to emergency responders would not always be accurate, placing people at risk of harm. This was discussed with the manager who was aware that this information was not up to date. They said it was on their 'action plan' to do; but had not completed all changes required. The inspector highlighted the urgency of this task and by the completion of the inspection PEEPs for all people had been completed and were up to date.

Other risks were managed effectively and risk assessments had been completed which identified possible triggers and actions staff needed to take to reduce the risks. For example, for people who behaved in a way that might present a risk to the person or others, the behaviours and triggers to these behaviours had been identified and these were clearly understood by staff. People who were at risk of malnutrition and dehydration had clear and up to date information within their risk assessments of how this should be monitored and managed by staff. Actions taken to monitor this risk also included the implementation of food and fluid charts and regular weight checks. Other risks were monitored and managed and risk assessments in place included moving and positioning, seizure activity, skin integrity and medicines management.

Equipment such as hoists and lifts were serviced and checked regularly. There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly.

The manager reviewed any accidents and incidents that occurred in the home to identify any patterns or trends and they described the action they would take if a common theme emerged. For example, the home's falls audit had highlighted that one person had experienced an increased number falls by slipping out of their chair; this had resulted in staff considering preventative measures, which were implemented.

Staff had received safeguarding training and explained how they would to identify, prevent and report abuse. Staff told us they would report any concerns to a member of the management team and were aware of external organisations, including CQC, if additional support was required. One staff member told us, "I have had safeguarding training; if I had concerns I would be confident enough to speak out, I would speak to [name of manager] if I have any concerns, or go higher". The manager explained the action they would take when a safeguarding concern was raised with them and records confirmed appropriate action had been taken. However, on reviewing people's daily records it was noted that people were being provided with personal care very early in the morning. Staff had not considered that the waking of some people and the provision of more than essential care at a very early time in the morning could amount to abusive, improper treatment and did not respect the person's right to have a good night's sleep. This is further explained within the Responsive section of this report.

We found that where people were prescribed topical creams this was not always managed safely. For example, there was not individual guidance available to staff as to when, where and how these creams should be applied. We saw that one person had three different creams used on one area of their body regularly and a staff member was unable to confirm which of these three creams should be used. Systems were not in place to ensure that people's prescribed topical creams were labelled with their name and not used beyond the manufacturer's use-by date. This meant staff were not aware of the expiration date of the item and when the cream would no longer be safe to use. This was discussed with the deputy manager who agreed to review the current practices in relation to the management and administration of topical creams.

People were provided with 'as required' (PRN) medicines when needed. People also told us that they could access pain relief when required. However, people's PRN plans did not support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved lacked detail. This was discussed with the deputy manager who agreed to update these forms.

All other medicines were managed safety. There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly. Stock checks of medicines were completed monthly to help ensure they were always available to people. We checked the Medicine Administration Records (MAR) for six people and no gaps were identified. This demonstrated that people had received their medicines as prescribed. Medicines were administered by staff who had received appropriate training and staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were sufficient numbers of staff on duty to meet people's needs. People and their families told us that they felt there were enough staff available to meet their needs. One person said, "There is enough staff." Another person told us, "The staff come quickly if I need them." The manager told us that staffing levels were based on the needs of the people using the service. They also said that they met with the deputy managers once a week to discuss the staffing levels and that more staff would be put in place if required. There was a duty roster system, which detailed the planned cover for the home. Staff absence were usually covered by existing staff working additional hours.

During the inspection staff were visible and responded quickly to people's needs. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. All the staff we spoke with felt that the staffing levels were suitable to meet the needs of the people.

There were safe recruitment procedures in place, which included seeking references, obtaining a full

employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed appropriately before new staff started working with people.

There were processes in place to manage the risk of infection and personal protective equipment (PPE) was available throughout all areas of the home. Staff were seen to be wearing gloves and aprons when appropriate. The laundry room was clean and organised and measures had been taken to mitigate the risk of infection. Colour coded mops, buckets and cleaning cloths were available for different areas of the home which helped to prevent cross contamination. Cleaning schedules were in place for each area of the home and staff completed check sheets to show they had undertaken cleaning in accordance with the schedules, which we saw were up to date.

Requires Improvement

Is the service effective?

Our findings

People, their families, healthcare professionals and social care professionals told us they felt the service was effective. A person said, "If I can't be at home this is the second place I would want to be, it's very good." A family member told us, "I'm very happy with the care, [my relative] is definitely in the right place." Another family member said, "Since [my relative] has been at the home, they have really improved; they are back on their feet and much brighter." A social care professional told us, "People appear happy." Another social care professional described improvements in a person's abilities and wellbeing since being at Downside House.

Although people were happy with the care they received, we found the provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005. Some people living at the home had a cognitive impairment and were not able to give valid consent for certain decisions. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Capacity assessments had not been completed for people as required. We also found that records of best interest decisions made were not always recorded to demonstrate why, how, or when the decision had been made, who had been involved in making the decision and what else had been considered. For example, we identified that care was being provided to a person who could be resistive to personal care; although staff may be acting in the person's best interest to provide personal care without the person's consent, they had not formally assessed this person's capacity or recorded a best interest decision following the principles of the MCA Code of practice. Furthermore, staff were using bedrails to prevent people, including people living with dementia from falling out of bed. Where people had not been able to consent to the use of bedrails, capacity assessments and best interest decisions were not recorded in relation to why these bedrails were required and why they were the least restrictive option to keep the person safe. This shows staff were protecting people's rights and following the principles of the MCA.

The failure to ensure that capacity assessments and best interest decisions were made in accordance with the Mental Capacity Act 2005 was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff sought verbal consent from people who were able to provide it. One person said, "They [staff] will always ask first, they wouldn't just do something." Another person told us, "Staff always explain to me what they are doing to do and why; if I didn't want them to do something I only have to say." Additionally, for one person who required their medicine to be given covertly a full best interest assessment had been completed and documented which demonstrated full involvement from healthcare professionals and family members.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found

that the service was not following the principles of the MCA as DoLS applications made had not been followed up in a timely manner. For example, we found that seven DoLS applications had been made in total, two of these applications had been made over two years ago and two were over one year ago; no action had been taken by the home to follow these up. For one person a DoLS assessment had been undertaken in June 2018 although no other information had been provided. Therefore, staff were unaware of the outcome of this assessment; if the person could be lawfully deprived of their liberty or if any conditions had been put in place. This was discussed with the manager who confirmed that this should have been followed up and agreed to make contact with the supervisory body for updates on the seven applications made. Following the inspection information was received that demonstrated that contact had been made.

The provider did not have an effective system in place to ensure staff were support appropriately in their work. The providers' staff supervision policy stated that: 'Staff will be provided with formal supervision at two monthly intervals'. Staff had not received regular one-to-one sessions of supervision consistently with a member of the management team as per the providers' policy. Supervisions provide an opportunity for the management team to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The manager was unable to provide us will a copy of a comprehensive supervision record at the time of the inspection. They told us that staff had commented in staff meetings they didn't always get 1:1 supervisions and this had resulted in them making changes in the way supervision was organised. However, they did not yet have a robust system in place to help ensure this would happen consistently. Although staff did not receive formal supervisions the staff we spoke to during the inspection did say that they felt that the manager was approachable and supportive.

People and their families felt that the staff were well trained. A person said, "The staff are very good, they know what they are doing." Another person told us, "I have lots of confidence in the staff." A family member said, "The staff are well trained." Staff completed regular training depending on their role and were given the opportunity to participate in extra training where necessary. For example, blood glucose training had recently been arranged to allow staff to better monitor the health of people with diabetes. The training staff had received included safeguarding, diet and nutrition, moving and handling, infection control and end of life care. Training was delivered via online 'e-learning', practical learning sessions and classroom settings depending on the area of learning.

All the staff we spoke with felt that they received effective and appropriate training. Staff comments included, "I have just done my first aid training and am also completing training so that I can be a fire marshal"; "I have loads of training arranged" and "We seem to be having a lot more training now the new manager is here."

People were supported by staff who had received an induction into their role, which enabled them to meet the needs of the people they were supporting. This included a period of shadowing a more experienced member of staff and the completion of essential training. Staff confirmed that they had received induction when they started work at the service. Staff that were new to care were supported to complete training that followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life and aims to ensure workers have the necessary introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. When we asked people if they enjoyed their food their comments included, "Oh yes, the food is very good"; "The food is excellent" and "I get plenty to eat; if I'm hungry I only have to ask and they [staff] will

bring me something, any time of day." People were provided with a choice of food and alternatives were offered if they did not want what was on the menu. We observed lunch and saw that people had different meals according to their choice and dietary needs. Staff were aware of which people needed soft or pureed food or special diets such as diabetic diets.

People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. Where people required support to eat and drink this was done in a kind and unhurried way. A family member told us, "I'm very impressed with the way staff help [my relative] to eat, they are so kind and patient." People's nutritional needs were monitored and assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Care records showed referrals were made appropriately and advice from healthcare professionals was followed.

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. Information in relation to people's health needs and how these should be managed was documented within people's care files. Staff knew people's health needs well and were able to describe the action they would take in medical emergency.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. The manager told us that new services were provided with up to date information about the person and if required the person would be accompanied by a member of staff.

Downside House is an older style building with accommodation spread over three floors, connected by a passenger lift and stairwells. All rooms had en-suite toilets and washing facilities. There is a lounge/dining room on the ground floor and bathrooms on each of the floors. The manager told us consideration was given to the environment when pre- admission assessments were completed due to the stairs and building lay out. People's bedrooms were personalised with personal items, photos and ornaments to reflect people's interests. Although the environment was clean, well-kept, calm and relaxed limited attempts had been made to help support the people living there; including those with cognitive impairments and limited sight. For example, areas of the home, including the communal area and corridors were painted one colour and rooms including people's bedroom, bathrooms and the communal room were not always signposted which meant that areas were not easily identifiable to help people to find their way around. Handrails were in place in corridors to provide extra support to people, however these were of a similar colour to the walls and did not stand out and a heavily patterned carpet was in place which can be confusing to people with visual or mental impairments. This was discussed with the manager who told us that this was something they had picked up on when they started at the service in July 2018 and were currently in the process of planning to make the environment more supportive of people's needs.

Good

Is the service caring?

Our findings

People and their families said that the staff were kind and caring. People's comments included; "The staff are wonderful, lovely; I can't fault them"; "You only have to ask and they will help you" and "They are all so very nice to us." A family member told us, "I am really satisfied with how [my relative] is treated." Another family member said they were, "very, very happy with the care."

Throughout the inspection, we observed positive interactions between staff and people. People were listened to by staff who gave them the time they needed to communicate their views and wishes. Staff were seen to kneel down to people's eye level when communicating and listened to them with interest. We heard good natured and friendly conversations between people and staff which demonstrated that staff knew people well. One person told us, "They [staff] always listen to me." Where people had specific communication needs, these were recorded in their care plans and known by staff. One care plan provided information to staff about how to best communicate with a person who found it difficult to be understood. Information in this care plan stated that staff were to 'be patient; give [person] time to respond and repeat any questions if required.' For another person whose first language was not English staff had completed a short training session on how to better communicate with them.

People told us that staff treated them with dignity and respect. A person said, "I'm respected by staff; they always talk to me nicely." Another person told us, "This home is the best or one of the best; I'm treated very well and can't grumble at all." A visiting professional stated, "The quality of the care provided to people is excellent; I often see the staff stopping and chatting to people, the staff are wonderful."

Staff understood the importance of protecting people's privacy and dignity and people confirmed that staff considered their privacy when providing personal care by closing doors and curtains. A person said, "They [staff] knock on my door every time." Another person said that they were asked by the staff if they would like curtains closed. A staff member told us, "I would close people's curtains and door and keep the person covered as much as possible when helping them with personal care."

Information regarding confidentiality, dignity and respect formed a key part of the induction training for staff. Confidential information, such as care records, were kept in the staff office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. Throughout the inspection we saw staff encouraging people to be independent. For example, specific cutlery and walking aids, such as frames and sticks were provided when required and ongoing encouragement, support and reassurance was given to people when needed. A person said, "If I need any extra help I only have to ask." Details of what people could do for themselves was documented within peoples care records. One person's care record stated, '[Name of person] can manage to wash their hands and face but requires support from staff to wash other areas.'

The manager told us they explored people's cultural and diversity needs by talking to them and their families and by getting to know them and their backgrounds and any information gained from this would then be recorded in people's care plans. The manager told us that if a person followed a particular faith that they and the staff lacked knowledge of, they would research this by looking for information on the internet and by speaking to followers of that faith to help ensure that people could be effectively supported.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who were important to the person. All the families we spoke with confirmed that the manager and staff supported their loved ones to maintain their relationships and that when they visited they felt welcome.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "The staff are very good, they know what I need." However, on reviewing people's daily records we found that for some people; particularly those with cognitive impairments, staff sometimes took a task focused approach to care. For example, the daily records for two people with dementia and high-level care needs showed that night staff regularly assisted these people to wash, dress and get out of bed as early as 4.30am. The manager was unable to provide any records that evidenced it was these people's preference for getting up at this time or provide us with documentation that these people had consented to receive care this early. It was documented that one of these people could be resistive to personal care. No evidence was available to show that the reasons for this resistance had been investigated or practices amended in an attempt to alleviate the persons distress or anxiety during personal care. Staff had not considered that the waking of some people and the provision of more than essential care at a very early time in the morning could amount to abusive, improper treatment and did not respect the person's right to have a good night's sleep.

The above was discussed with the manager who agreed that care provided at this time, without consent was not acceptable practice. The manager told us they, 'flick through' the daily records but had not picked up on this practice. The manager contacted night staff during the inspection to discuss this practice and fed back to the inspectors that night staff had been told to get people up from 5am by previous management staff. The manager also said that they had been informed by night staff that they did not wake people and it would be mood dependent as to whether people were got up early. However, on reviewing daily records there was no indication that people had woken up naturally, been given a choice or that attempts had been made to resettle them to sleep. The manager agreed to look into these practices and confirmed that they would also complete more robust audits on daily care records.

The failure to protect people from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Each person had a care file which contained individual information about their physical and psychological needs and provided staff with guidance on how people should be supported and what they could do for themselves. However, we found that information for some people about their preferences, likes and dislikes and life history was minimal. This was discussed with the manager who agreed that this was an area for development. Although this information was minimal within care records, during the inspection it was clear that staff knew people well and were aware of people's interest and relationships. For example, we heard staff talking to people about things they enjoyed and family members.

Staff responded appropriately when people's needs changed. One person said, "Staff will come quickly when I need them." A visiting professional told us that during one of their regular visits they heard a person request to see a doctor and said, "The doctor arrived within 30 minutes." During the inspection we heard a staff member on the telephone to the doctor discussing a sudden deterioration in one person's health. Staff handover meetings were completed between each staff shift and provided staff with the opportunity to discuss changes in people's needs and share ideas on how to best meet people's changing needs.

A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, tools were used to identify the need for nutritional support, to assess people's pain levels, risks of developing pressure injuries and to monitor their bowel movements. The use of these tools helped ensure that any changes in people's needs could be responded to and acted on in a timely manner.

With the exception of getting people up early, as highlighted above, staff understood the importance of respecting people's choice. People confirmed they were offered choices about meals, where they spent time and what they did. Choices were offered in line with people's care plans and preferred communication style. Throughout the inspection we saw that people's choices were respect. One person had chosen to remain in their arm chair for their main meal and a staff member ensured their comfort to allow them to eat safely. Another person wished to remain in their room and told us that staff would check on them regularly to see if they needed anything. People who were able to clearly communicate their needs, views and wishes told us that their wishes around when they wanted to get up/go to bed or if they wanted a bath or shower were respected. One person commented, "I always make the decisions. I'm not under order or told when I have to do things."

People had access to a range of activities and people told us they enjoyed the activities on offer. A person told us, "I like the activities; I enjoy some more than others but I can choose if I join in or not." Another person said, "We have enough to do." A third person told us, "I do get bored sometimes so have asked the staff for little jobs to do; I now help fold the tea-towels and things." Activities were arranged by the staff and there was an activities programme in place which was displayed in the front entrance of the home to keep people informed of activities on offer. Activities included games, armchair exercises, reminiscence, crafts and quizzes. The provider also used activities staff from external providers which included, arts and craft, music and reminiscence sessions linked to different themes. Activities were discussed during the monthly resident's meetings to give people the opportunity to comment on past activities and share ideas about things that they could do in the future. Downside House had developed some links with the local community. For example, some people attended the local Alzheimer café and were involved with Age UK.

The complaints policy was displayed in the entrance of home and the manager told us they worked closely with people to enable concerns to be addressed promptly and effectively. One complaint had been received since the last inspection. The manager was able to explain the actions they took in response to the complaint and provided us written documentation that demonstrated that the complaint was delt with effectively. Actions included; meeting with the person who had made the complaint; keeping them updated both verbally and in writing; conducting a full investigation and implementing remedial action.

At the time of the inspection there was a limited need for the use of technology to support people. Special pressure relieving mattresses had been installed to support people at risk of pressure injuries and pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. There was a call bell system in place to allow people to request help when required. People were also supported to access the internet if they wished.

At the time of the inspection no one living at Downside House was receiving end of life care. However, the manager and staff were able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Staff had received training in end of life care and demonstrated that they understood this. Care plans contained limited information about people's individual end of life wishes; however, the manager told us that this was an area currently under development and that they liaised closely with people and family members to ensure that people's wishes were respected. For example, recently one person had chosen to return to the home following a stay in the local hospice and they were fully supported to do this.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at Downside House and felt it was well run. One person said, "I think it is well run, the manager is good." Another person told us, "The manager talks to us regularly and we always see them around the home." A visiting professional said, "It's a nice place; I would and have recommended the home." A family member said, "The new manager seems proactive and approachable."

The provider did not have effective systems and processes in place to ensure that people were safe and their needs met. From reviewing records, discussion with the manager and review of the minutes from the residents meetings regular themes for improvements had emerged and an action plan had been developed. However, reasonable time frames for these actions had not always been set, actions had not been completed promptly and some of the action taken had not been sustained or properly thought through. For example, the manager was aware that staff supervisions were not always happening and put a process in place to help ensure these were completed; the process implemented was not effective. A quality audit completed by the Clinical Commissioning Group had highlighted that PRN plans were not always robust or in place. The management team had put measures in place to rectify this but had not followed best practice guidance and these were poorly completed and lacked detail. The manager had highlighted within their monthly manager's report that people's PEEPs were not up to date and these had still not been updated 11 days later. Additionally, some systems that had been put in place to help ensure people's wellbeing were not embedded in practice and appeared to be short lived. For example, a hoist sling audit had been implemented where all hoist slings were to be thoroughly checked they were safe to use on a month basis. On viewing this audit, the slings had only been checked once, in May 2018.

Resident meetings were held approximately every month to discuss all aspects of care, update people on any changes in the home and to get people's views on the service provided. From reviewing the residents' meeting minutes for the months of July, August and September 2018 we found that some positive changes had been made as suggested by the people living at the home. For example, themed foods and specific activities. However, we also found that people's views were not always considered and suggestions made were not always acted on. For example, in July 2018 people living at the home commented that they 'would like to see the garden back up and running' and would like to 'be able to have a summer party and a BBQ in the garden.' However, we found that although the garden had ramp access the main garden was lawn without any path access to the greenhouse, vegetable area or flower beds and limited seating was available to people. This meant that it could only be accessed safely by people without mobility impairments. The registered manager confirmed that no garden party or BBQ had taken place in the summer as requested by people.

There was a programme of audits and quality checks in place which were currently being completed by the management team. Regular audits had been completed of the environment, medicines, health and safety and infection control. However, there was no clear auditing process in place to review people's daily records of care, supervision and to ensure the staff were following the principles of the Mental Capacity Act. Therefore, the concerns we found in these areas had not been identified. Additionally, the medicines audit had failed to identify the concerns noted with the management of topical creams. These issues were

discussed with manager who acknowledged the shortfalls in these areas and agreed to review and update the current documentation and processes.

The failure to effectively assess, monitor and improve the quality and safety of services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager is a person who has registered with the CQC 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. At the time of the inspection there was not a registered manager in place. The previous registered manager had left the service in June 2018. At this inspection there was a manager in place who had taken over the overall running of the service, with support from the directors of the provider's company. The manager told us they had commenced the registration process with the Care Quality Commission (CQC).

Although there was no registered manager in place, there was still a clear management structure in place. This structure consisted of the four directors of the provider's company, the manager, two deputy managers and senior staff members. Each had clear roles and responsibilities which were understood by all staff. People and their family members told us felt able to approach the management team and staff at any time. One person said, "The manager will often and talk us; they are very approachable." A family member told us, "I can speak to the manager at any time and am always kept up to date on what has been going on."

Observations and feedback from people showed the home had a positive and open culture. Visitors were welcomed at any time. Staff told us that they enjoyed working at Downside House and spoke positively about the culture and management of the service. They confirmed they felt able to raise issues and make suggestions about the way the service was provided and these were taken seriously and discussed. Staff's comments included; "They [manager] are very supportive", "They [manager] would absolutely take action on any concerns I raised" and "The manager is interested in us [staff] and always asks how we are." The manager operated an open-door policy and we saw staff and people regularly visited their office for a chat. They, and the deputy managers, were visible around the home, interacting with people and staff throughout the day.

The directors of the provider's company were engaged in running the service and their vision and values centred on providing care to people in a personalised way. One of the directors of the provider's company visited the home weekly to oversee the running of the service and the manager sent them a monthly report, which highlighted any issues that there had been or that needed to be addressed. The manager told us that they wanted to, "improve people's quality of life."

The service worked in partnership with the local authority, healthcare professionals and social services to help ensure that people received effective and safe care. A social care professional told us, "I don't have any concerns about the home or management; they keep me updated."

Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed prominently in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provide failed to ensure that capacity assessments and best interest decisions were made in accordance with the Mental Capacity Act 2005.

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 The provider had failed to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of the service.