Mayhaven Healthcare Limited

Down House

Inspection report

277 Tavistock Road, Plymouth Devon PL6 8AA
Tel: 01752 789393
Website: www.mayhaven.com

Date of inspection visit: 9 & 11 December 2015
Date of publication: 22/02/2016

Ratings

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

Overall summary

The inspection took place on the 9 and 11 December 2015 and was unannounced. At our last inspection in November 2014 we found the provider did not have adequate systems in place to monitor the quality of the service. Also, care records lacked essential details about people's needs and information was inconsistent. We had asked the provider to address this and reviewed these concerns during this inspection. We found concerns remained in respect of people's records and the quality assurance processes within the service.

Down House is registered to provide residential and nursing care to up to 49 younger and older adults. People may be living with dementia, have a learning disability or autistic spectrum disorder or be physically disabled. They may also be living with a sensory impairment. Thirty people were living at the service during the inspection.

The service had a registered manager registered with us to run the service however, they had left on the 9 August 2015 and were no longer working at the service. They had yet to cancel their registration. 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

Summary of findings

requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The service had a manager in place to manage the service locally.

Prior to the inspection we received information of concern about the service. These included concerns about the way people's care was planned; care not being given as people chose; lack of care planning in respect of people's specific needs and staff not accurately recording people's day to day care. Risk assessments were not always accurate or reflective of current needs. The time people were waiting to have their call bells answered was leaving some people, who could not wait, at a risk of falling. People known to be at risk of falling were not having their needs assessed. Staff were not always ensuring people went to their medical appointments or ensuring people's basic health checks were completed. We found a number of concerns which we have passed to safeguarding, environmental health and the fire service, as applicable.

People's medicines were not always managed and administered safely. People were not being observed taking their medicines and staff were signing the person's medicine administration records (MARs) without staff knowing people had safely taken their medicine. For example, medicines were left on people's tables beside them in their rooms for them to take later and the staff did not check they had done so. Staff were not reporting medicines errors to the manager or provider which meant they were not investigated. There were gaps in people's MARs so it could not be guaranteed people had been given their medicine as prescribed. There was also a lack of stock taking and reconciliation of people's medicines to ensure this was accurate. Staff were not clearly recording people had their prescribed creams applied as directed. Storage of medicines was not always safe and action was not taken when the fridge was not working properly. This meant people's refrigerated medicines may have been ineffective. The fridge and medicines were replaced during the inspection.

The service did not have clear systems in place to respond in the event that a person required resuscitation. Equipment provided as part of this was not maintained in a sterile state.

There were not enough staff to meet people's needs at all times. People told us their care needs were not always met in a timely fashion. People told us they were left waiting to go to the toilet. Staff also expressed concerns about times when there were not enough staff and they had not been able to meet people's needs. The provider did not have a robust system in place to ensure staffing was sufficient to meet people's needs.

People's care records were not personalised and did not always show whether people were involved in writing them. People did not always receive their personal care as they wanted it delivered. The records of people's care were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person. People's end of life needs were not planned with them and the care planning was inconsistent. People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People were not involved in planning how to mitigate the risks they faced while living at the service. People did not have risk assessments for individual health needs in place. There was no risk assessment in place to reduce environmental risks to people's safety. The service had undergone some building work over time and the fire routes to a place of safety were uneven under foot and would have placed people at risk of tripping or falling. Also, one fire exit was accessed by a key that was placed in a hinge above the door. The provider told us some doors marked as fire exits were no longer being used as such. The concerns about people being able to exit the building safely in the event of a fire has been referred to the fire service.

The service did not have robust infection control measures in place to ensure people were kept safe from infection. Staff were not following current guidance in respect of the managing of reusable items such as commodes and bed pans. There was no audit of infection control. We have referred these concerns to environmental health.

People were not being assessed in line with the Mental Capacity Act 2015 (MCA) and conditions on authorisations to deprive a person of their liberty were not being met. Staff had not been trained in the MCA and the associated Deprivation of Liberty Safeguards (DoLS). There were no assessments of people's capacity taking place and no

Summary of findings

systems to ensure the service was not depriving people of their liberty without the necessary authorisations in place. Staff ensured they asked people's consent before providing personal care.

Staff spoke about people in a way that was not respectful at all times. People who required support from staff with their meals were regular referred to as "feeds" however staff talked with people in a kind and caring manner. People felt staff treated them with respect and always ensured their dignity was respected. People and visitors spoke highly of the staff.

People were not provided with opportunities to remain physically and cognitively active. People spent most of their time in their rooms with little opportunity to mix socially. People said they depended on family to provide social interactions and time away from the service.

Good leadership and governance was not always evident. The provider did not have robust quality assurance processes in place that had identified the issues raised during the inspection. There was confusion among staff at all levels as to different staff roles in the service. Staff were unclear of their own responsibilities and accountability.

Staff were recruited safely. Staff were trained to meet people's needs. Systems were in place to check staff were updated in their training as required. Staff understood how to identify abuse and keep people safe from harm.

People's health needs were met. People could access their GP and other health professionals as required. GPs who fed back to us were happy with how the service provided for people's health needs. People's need for good nutrition and hydration were met and monitored as required. The kitchen staff always visited people and asked what they wanted to eat each day. Creative ways were used to try and encourage people struggling with a poor appetite. People's special dietary needs were catered for and people had their food prepared in line with their care plan.

There was a complaints policy in place. People's concerns were dealt with when they arose. People felt comfortable speaking to the manager if they had any concerns. People, staff and visitors felt they could speak to the manager and they were approachable.

There were systems in place to maintain the passenger lift, lifting equipment and utilities in the service.

We found a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. People's medicines were not always managed and administered safely.

There were not enough staff to meet people's needs at all times.

People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk. People were not involved in planning how to mitigate the risks they faced while living at the service. People did not have risk assessments for individual health needs in place.

There was no risk assessment in place to mitigate environmental risks to people's safety. Concerns about fire routes being uneven under foot and lack of clarity about fire exits have been referred to the fire service.

There were no systems in place to appropriately manage people's condition in the event people collapsed suddenly. Resuscitation equipment was not maintained.

The service did not have robust infection control measures in place to ensure people were kept safe from infection. There was no infection control audit to ensure staff were following current guidance. We have referred these concerns to environmental health.

Staff were recruited safely. Staff understood how to identify abuse and keep people safe from harm.

People felt safe living at the service and would speak to staff if they had any concerns.

Is the service effective?

Requires improvement

The service was not always effective.

People were not being assessed in line the Mental Capacity Act 2005 and conditions on authorisations to deprive a person of their liberty were not being met.

Staff ensured they asked people's consent before providing personal care.

Staff were trained to meet people's needs. Systems were in place to check staff were updated in their training as required.

People's health needs were met.

People's needs for good nutrition and hydration were met.

Summary of findings

The service provided equipment to meet people's individual assessments.

Is the service caring?

Requires improvement

The service was not always caring. Staff spoke about people in a way that was not respectful at all times but talked with people in a kind and caring manner.

People's end of life needs were not planned with them and the care planning was inconsistent.

People spent most of their time in their rooms with little opportunity to mix socially. People said they depended on family to provide social interactions.

People felt staff treated them with respect and always ensured their dignity was upheld.

People and visitors spoke highly of the staff. Visitors were welcomed.

Is the service responsive?

Requires improvement

The service was not always responsive. People's care records were not personalised and did not always evidence whether people were involved in planning their own needs.

The records of people's care were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person.

People did not always receive their personal care as they wanted it delivered.

People were not provided with opportunities to remain physically and cognitively active. People relied on family to provide interactions.

There was a complaints policy in place. People's concerns were dealt with to people's satisfaction when they arose.

Is the service well-led?

Requires improvement

The service was not always well-led. The provider did not have robust quality assurance processes in place that had identified the issues raised during the inspection.

There was confusion among staff at all levels as to different staff roles in the service. Staff were unclear of their own responsibilities and accountability.

People, staff and visitors felt they could speak to the manager and they were approachable.

There were systems in place to maintain the passenger lift a, lifting equipment and utilities in the service.

Down House

Detailed findings

Background to this inspection

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

The inspection took place on the 9 and 11 December 2015 and unannounced.

The inspection team included two inspectors, two pharmacist inspectors, a specialist nurse for older persons 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.

Prior to the inspection we reviewed the information held by us from previous inspection reports, notifications and Provider Information Return (PIR). Notifications are reports on specific events registered people are required to send us by law. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we also sought feedback from professionals involved with the service. This included health and social care professionals.

During the inspection we spoke with10 people and six family members to seek their view on the service and their care. We looked at the care of five people in detail to check they were receiving their care as planned. We spoke with them where this was possible. We observed how staff looked after people in the lounge room.

We spoke with 11 staff and reviewed six staff personnel files. The manager, administrator and provider were all spoken with throughout the inspection. We also reviewed the training records for all staff and how the service was keeping this up to date. We reviewed the records the provider kept on monitoring the quality of the service, audits and maintenance records.

Requires improvement

Is the service safe?

Our findings

People's medicines were not always stored and administered safely. It was not possible to be sure people received their medicines as prescribed. There were medicines administration record (MAR) charts in use with some hand-written changes that were not rechecked to ensure they were accurate, including the strength of medicines prescribed. There were gaps on MARs where staff had not signed to show that medicines had been given.

Where they were responsible for administering medicines, staff were not ensuring people took them. We observed staff were leaving the room without observing people had taken their tablets. Staff also had signed the MAR to state the medicine had been given without knowing they had actually been taken. Two people said staff waited and watched until the medicines had actually been taken. Everyone else said staff left the medicine with them and usually returned later to check it had been taken.

A relative told us, "When my husband refuses to take his tablets the staff leave them out for me to do; he won't touch them". We reviewed this and found the medicine was signed as given with no time to state when this had been taken. This meant the necessary gaps between doses could not be assured. There was also no recording in the person's care plan or system in place to ensure staff checked with the relative that medicines had been given safely.

One person told us they self-medicated and said, "The matron said it is alright for me to have my tablets as I know when I need to take them". There was no risk assessment or care plan in place to ensure this was safe.

Homely remedies (medicines which can be administered without being prescribed) were used in accordance with a signed and dated homely remedies list, however we found one medicine had been administered from an unlabelled bottle of tablets. The manager told us these contained paracetamol. It was not clear from people's records, when homely remedies had been given so it was not possible to ensure they had not taken any other medicine that may limit the effectiveness of the tablets or place them at risk of overdose if they were taking a medicine containing the same ingredient. For example, people taking paracetamol as part of their prescribed medicines were at risk if they took this in a homely remedy such as a cold remedy containing paracetamol.

People who required prescribed creams to be applied by staff were not having this consistently recorded. Staff were also not consistently using any means to ensure they were applying people's prescribed creams as directed. People's care plans only stated staff were to use creams but did not state what cream, where it should be applied and when. The recording of applying the creams was inconsistent with days unaccounted for. Some people's creams were ticked on the MAR sheet with no signature. Others were not recorded by this method. One person was having two creams applied which were prescribed to other people in the service. Prescribed creams were not dated when opened to ensure they were disposed of in line with the manufacturer's guidelines.

People's medicines were not always stored safely and securely. On more than one occasion we observed staff administering the medicines left the medicine trolley open and unattended. At one point the trolley was open in an unlocked cupboard for over 15 minutes. We advised the manager of this who spoke to the staff about administering medicines safely and ensuring they did not leave the medicine trolley unlocked and unattended. The fridge for storing medicines had recorded over several days temperatures between minus five and plus 20 degrees centigrade. On inspection the fridge temperature was plus 20 degrees. This meant the medicines stored in the fridge could not be guaranteed as safe. For example, stock of people's insulin, a prescribed cream and eye drops. Insulin not in use should be stored in the fridge between two and eight degrees centigrade. Insulin should not freeze as this will prevent it from working properly. All stored medicines were destroyed and a new prescription ordered to replace them. The fridge was replaced.

Staff were not accurately accounting for the stock of medicines received. They were not routinely being recorded and checked. This made auditing of medicines difficult. It was not possible to check whether the correct number of doses had been given against the stock available. There was no evidence of recording of errors and near misses. The medicines policy, which was not specific to the service, was produced in 2012. One person said, "One day they dropped all my tablets on the floor, then

Is the service safe?

picked them up, gave them to me and I took them". This had not been reported by the staff member administering the medicines to the manager or provider and therefore was not investigated.

Not ensuring people's medicines were properly managed and safely administered was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were satisfied they received the correct medicine at the right time.

We found all the first aid kit contents were out of date. All contents were dated to expire in 2007. The manager ensured new stock was ordered immediately to update the contents.

We were told by the manager that the service did not have means to resuscitate people in the event of someone requiring defibrillation, oxygen or suction. The manager and provider said the policy was to "Call 999 and commence cardio pulmonary resuscitation (CPR)". Other staff however told us, "We do not resuscitate". Staff told us they dialled 999 and waited for an ambulance to arrive. They added they were near to the local acute hospital and therefore expected an ambulance to arrive quickly. We were initially told by the manager there was no oxygen stored at the service. We found there were three portable bottles all in date held in the medical room. There was also a suction machine however this had not been maintained in a sterile state. No weekly checks were made or recorded that the equipment was safe to use.

Not ensuring equipment was safe to use was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were several times when they believed there were not enough staff to meet their care needs safely. When we asked people about staffing levels they told us call bells were answered between five minutes and 20 minutes. One person said, "No there are not enough staff, some girls have to do a double shift sometimes. Occasionally when answering the call bell they will explain that they are busy and will return, which they do". Other people said, there was no difference in the call bell response time of up to 15 minutes day or night time; "The girls are very busy at all times"; "There are just about enough staff" and, "A bit short of staff recently".

Relatives gave a mixed view of whether they thought there were sufficient staff. Some felt the staffing was fine; others did not. One relative said in the days prior to the inspection their relative had been left ringing the call bell for 50 minutes. They had wanted to go to the toilet. The person explained how difficult this had been for them as they were reliant on staff to support them due to their mobility being restricted. Both the relative and person confirmed staff did not come and see them during the time the bell was ringing.

Staff said the service could do with more nurses. We were told two nurses had recently left the service and during the night the service was using nurses via an agency. On the first day one nurse was on duty and this was the manager. This meant they had many demands on them at any one time. We were told a second nurse was ill and had not been replaced. The manager advised that another nurse was due to come on duty at 2pm. On the second day of the inspection there were two nurses on duty. This was to meet the nursing needs of 21 people but to give the medicines to 30. One nursing staff member told us that there were times when they found it difficult to meet the nursing needs of all people. This had meant they had requested a member of care staff to complete a task on their behalf. This was to bandage a person's legs. This was without the necessary training and competency assessments in place. The manager stated that they were supported by the provider to replace nurses with nurses from an agency, but this was not always possible due to the demand for nurses locally.

Not ensuring staff providing treatment have the qualifications, competency and skills is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the numbers of staff to meet people's care needs on duty varied. One member of staff told us that on one occasion in the last couple of weeks, they had been left on their own to look after up to 16 people. They said as a consequence they had not had time to complete everyone's personal care before the end of their shift. They had resolved that if this occurred in the future, they would first ensure that everyone's continence pads were changed and only then support people to get washed if they had time. Another staff member described their sense of frustration when they were short-staffed and different people needed attention at the same time, but they could not help everyone at once.

Requires improvement

Is the service safe?

None of the records in respect of people's care noted how many staff were required to meet their full needs. That is, how dependent they were on staff. The manager told us the provider completed the duty rota and decided on the staffing levels. We spoke with the provider about the issues people were raising about staffing. They told us they had agreed the staffing levels about 10 years ago and used their knowledge to set the staffing levels. They confirmed they did not assess people's needs to determine the numbers of staff required to assist and support them in the way they needed. When we asked about whether they reflected on the call bell log (which can be printed to show how long it has taken staff to answer any call bell) they told us they would review what was happening at the time. If the staff were in high demand at that time they felt it was reasonable the waiting period would be longer. They advised they did not review staffing levels to see if there was a pattern when staff were in more demand and call bells were taking longer to answer.

Not ensuring there were sufficient staff to meet people's care needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place in relation to their risk of falling, manual handling, developing pressure ulcers (Waterlow), malnutrition (Malnutrition Universal Screening Tool; 'MUST') and choking. However, these were not regularly updated or always accurately reflective of people's needs. There was no clear link between risk assessment and care planning. Some people's risk assessments were not factually correct which led the risk assessment to often reflect a lower risk than reflected in other records. For example, one person was noted as having short term memory loss following a stroke but their cognitive ability on the falls risk assessment was noted as "intact". Their falls risk assessment also stated they had no falls in the past 12 months when completed on the 12 September 2015 however, in another record dated 26 December 2014 it was noted they had three falls resulting in the out of hours GP service being contacted. Another person who had been admitted in October 2015 had no risk assessment completed for their risk of falling but was noted as having a diagnosis of Parkinson's disease and other conditions which would affect their balance. People were not involved in assessing their own risk and asked how they would like these to be mitigated.

There were no individual risk assessments in place in respect of people's specific needs. For example, there were no risk assessments in place for people who were diabetic or on warfarin. Where people's behaviour was causing a concern there was no clear system in place to assess the risk and care plan to enable staff to support the person safely. For example, one person had a behaviour chart in place "as they had been hitting out at staff". However, there was no risk assessment. Also, the recording in the monitoring form was incomplete so it could not be used to reflect if external advice and support was needed. Staff were also not given information on how to support this person in the most helpful way by trying different strategies.

There was no internal or external risk assessment of the service available to ensure the premises used by the service provider were safe to use. This was requested from the provider who was unable to provide this for us to review. The service had been undergoing building works for a number of years. Areas outside the home were seen to be cluttered by various items and trip hazards. Pathways were unsafe underfoot which may limit people's safe use of the outside area. We were concerned that the route from the fire exits to a safe distance in the event of a fire was unsafe underfoot. It may not be possible to negotiate these safely with a walking frame or wheelchair, for example. We have referred the concerns about the fire exits to the fire service.

We found a number of people had call bells out of reach and others with no call bell. The manager told us some people could not use a call bell. There was no system in place to check if the people who could not use call bells required assistance or support. The manager said staff would be going to the room to give people drinks and would assist people if required. However, there was no record of this.

People's individual falls were being reviewed however, there was no service wide falls audit to ensure people's needs were being met. Accident records were collated but there was no review of these to see if there was any service wide learning in place to reflect if changes needed to be made to keep people safer. For example, when people had fallen in their bedrooms there was no check to see if these were at certain times of the day or related to staffing levels.

Requires improvement

Is the service safe?

Not ensuring people's risks were fully assessed and mitigated is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control procedures did not always ensure people were protected from the possibility of cross infection. There was no infection control risk assessment and no infection control audit in place to ensure staff were following safe infection control practices and the service was meeting current guidance. There were no systems in place to deal with spillages of bodily fluids such as blood and urine. Staff told us the care staff cleaned up the original spillage and domestic staff then used carpet cleaners if the carpet was affected. There was no dedicated cleaning equipment to use when handling these spillages. We saw dirty commodes waiting to be washed in one of the sluice rooms. Some people used bedpans and urinal bottles. These were found in people's ensuite bathrooms or rooms. The home had mechanical sluices in place to clean people's commodes, bedpans and urine bottles however, none of these were operational at the point of the inspection. Staff told us they were broken. Staff did not then have clear guidance in place on how to manage the cleaning of the commodes, bed pans and urinal bottles now the sluices were not working. We were told by the manager staff were "washing them with hot soapy water" in a sink in one of the sluice rooms. This sink was used for the rinsing of mops and other tasks. There was no cleaning process in place for this sink to ensure there was no cross contamination to the mops or staff.

The records of staff training given to us by the provider showed not all staff had undertaken recent training in infection control and some had no record of having completed this training. Only one member of staff who worked as a domestic had up to date training. None of the staff in the laundry had this training.

Not having adequate systems of infection control in place is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have systems in place to manage the safe use of chemicals at the service. The provider had no risk assessment in place in respect of the use of chemicals. People were put at risk as the provider decanted or blended chemicals together which were then not clearly labelled. For example, a cleaning product (Flash) and bleach were placed in spray bottles labelled 'bed'. We were told this was for cleaning mattresses. This was available on the trolleys used to move cleaning equipment around. These trolleys were left unattended. The chemicals were therefore accessible to people and could have resulted in ingestion, skin burns and other injuries to people.

Not having appropriate systems in place to assess, monitor and mitigate the risk to health, safety and welfare of people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said staff always wore aprons and gloves when delivering personal care. Staff were provided with disposable gloves and aprons at various points around the service. The service was odour free and people said their rooms were kept clean. The kitchen and domestic staff had daily, weekly and monthly cleaning programmes in place. All kitchen staff had completed food hygiene training.

People confirmed they felt they were living in a safe environment and had no concern for the possessions they had brought with them. Whilst no one had a lockable drawer in their bedroom one person said they understood that valuables could be locked in the office.

Staff were recruited safely to ensure they were safe to work with vulnerable people. Staff did not start work until all necessary checks were in place. Staff completed a formal application and interview process. Prospective staff were invited into the home for a "trial day". Staff had been recently recruited from another European country. These staff had been interviewed over the internet and had the necessary checks in place to ensure their history had been reviewed. When we spoke with them they struggled to understand what we were asking. This was especially when asking questions around the tasks the nurse complete. The provider stated this had been recognised and these staff were enrolling on English speaking courses.

Staff demonstrated they understood how to identify abuse and would always report concerns to the manager or provider. Staff had regular training in safeguarding vulnerable adults. Most staff knew they could raise their concerns outside the organisation if they felt their concerns were not being addressed internally.

Requires improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had not been trained in the MCA. The manager and staff did not understand about the MCA and their responsibilities in relation to this legislation and associated Deprivation of Liberty Safeguards (DoLS).

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. People at Down House were not being routinely assessed in respect of their mental capacity when required. This is despite people being noted as having conditions, such as dementia, which may mean they are less able to make decisions about their care and treatment. There were no capacity assessments in place to ensure people's right to consent was being respected. Where people lacked capacity staff could not demonstrate they were acting in people's best interest. Records did not demonstrate who had been involved in any decision making in respect of people's care and treatment.

The service had not requested any assessments on behalf of people to ensure they were not depriving people of their liberty illegally. People who lack mental capacity can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We asked the manager if there were people who required a DoLS assessment living at Down House. That is, the person was subject to continuous supervision and control and was not free to leave. As they had not completed an MCA assessment though, they could not give an accurate number of people who may require a DoLS assessment. They told us: "At least 70 per cent of people" would require a DoLS assessment.

We were told by the manager at the start of the inspection that, "One person had a DoLS in place". Staff also told us this person was subject to an authorised DoLS. This had been applied for prior to their coming to live at Down House. When we reviewed this person's records we found the DoLS requested was unauthorised. The person had been deemed as having mental capacity and therefore able to make their own decisions. When we spoke with this person they considered their stay at Down House as a temporary measure. They wanted to return home. We raised the concerns about this person with the provider as staff had not read the paperwork and understood the implications of the unauthorised DoLS. There was no further assessment of this person's capacity or evidence of reviewing this person's care to ensure they continued to consent to remaining at the service.

Not acting in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff always requested their consent before starting personal care. We observed staff always requested people's consent before commencing interactions such as using a hoist to move people from their chair to a wheelchair. Staff waited for people to respond in their own time.

People felt the staff were trained well and could effectively meet their needs. Staff underwent the core training which was identified by the provider as essential for meeting people's needs. This included safeguarding vulnerable adults, fire safety, food safety, first aid and manual handling. Staff told us they underwent a lot of training. The nurses underwent training to ensure they could meet people's specific needs such as catheter care, diabetic care and wound care. Not all staff had undertaken training to meet specific needs such as those of people living with dementia. We were advised by the provider this was being reviewed.

The manager, who had been in post for two months, stated they did not believe any formal staff supervisions had been held since August 2015. They went on to say that as they worked "on the floor" they were able to observe staff performance and knew that everyone was doing things correctly. They explained demands on staffing had meant supervisions had not been as frequent as desired. New staff had been recruited and the aim was to reinstate supervision as staff would be able to take time off from their duties. We saw action was taken if staff behaviour was

Is the service effective?

causing a concern and systems were in place to ensure this was addressed and monitored. Staff said they felt they could approach the manager for advice and guidance if required.

People said new staff were introduced to them and always worked with more experienced staff to start with. All new members of staff underwent an induction into the service. The provider was also requesting all new staff complete the new Care Certificate regardless of their previous history of working in a care setting. The Care Certificate is a national initiative to seek all staff new to caring are trained to the same standard. The provider explained they felt the Certificate would ensure all staff had the same foundation. This would then be reviewed with each new staff member in supervision to target training in respect of their identified learning needs.

People said their health needs were met. People said their GP was called without delay. Records showed people could access a range of professionals including an optician and chiropodist. One person said, "It was much easier to see a GP here than when we lived at our own home". Most records detailed medical advice and guidance however, we found staff were not always writing up GP or other health professional advice in the correct place. Some staff wrote in the expected record for professional visits whereas others wrote the details in the daily records which meant it may not be acted on. We raised this with the manager who agreed to remind staff to write details in the correct place. Also, they started to ask the GP to write in the person's notes. They highlighted they would request other health professionals to do the same as they felt this would ensure accuracy of information. We received feedback from two GPs who were positive about the service and its ability to meet people's health needs.

Staff were confused about which people were funded as residential and who was to meet their varied needs. This was especially important where their nursing needs were to be met by the community nursing team. We discussed this with the manager and provider to ensure they understood their responsibilities to everyone they were caring for. The provider and manager told us they would ensure staff were clear about the needs of people staying on a residential basis and ensure all needs were met.

People had their need for good nutrition and hydration met. People were provided with a balanced diet. Where there were concerns about people's nutrition and hydration needs, these were monitored. One person commented, "The staff are always on about us having to drink a lot". We found however, on the first day people did not always have drinks in reach. We raised this with the manager and saw this had improved on the second day. The recording of people's fluid and nutrition was not always consistent and again we raised this with the manager who raised it with staff at the handover. They were also going to talk to the night staff (as it was their role to review this) to ensure they completed the paperwork. This would then be reviewed at shift handover the following morning to ensure people had eaten and drunk enough. Action would then be taken if any concerns were raised by raising with the person and person's GP.

The kitchen staff were knowledgeable about people's food likes, dislikes and needs. They always asked people what they would like to eat each day. Creative ways were looked at to support people to eat. For example, one person expressed they would like peanut butter so this was bought specially from a local shop. One person who was struggling to maintain a desire to eat told us, "The kitchen staff have been very good; anything I fancy they get for me". Special diets were catered for and people had their food prepared in line with their care plan or specialist assessment. People were content with the quality of the food. A relative said, "Dad loves the food". People confirmed the kitchen staff visited them daily to ascertain their choice from the two main items for the following day and alternatives were made available if they did not want the choices offered. Staff could access the kitchen to provide drinks and snacks for people as required.

The service had a range of equipment available to meet people's specific needs. For example, there were a number of mechanical lifts and stand aids to support people to move safely. People were provided with their own slings which had been assessed for them. Also, people were provided with pressure relieving equipment, such as air mattresses and seating, to prevent skin breakdown as required.

Requires improvement

Is the service caring?

Our findings

People were looked after by staff who treated them with kindness and always spoke with people with respect. However, we heard staff speaking about people that was not always respectful. For example, on both days we heard staff refer to people as "feeds" and "feeders" when planning how to best meet people's needs at lunchtime. For example, one staff member said, "You do the feeds" to another member of staff. We raised this in the feedback and the manager and provider agreed to review the use of language with staff to ensure they understood how this could be perceived.

People spent most of their time in their rooms. People told us they relied on their family members for company. However, sometimes staff would pop in and check they were alright. When asked about the atmosphere in the service most people felt they could not give an opinion as they remained in their bedrooms all the time. Others comments included, "Seems alright", "All friendly here", "Friendly, I have not met any rudeness since I came here 15 months ago" and, "Very good". Comments from two different relatives were, "The atmosphere is very nice and very happy. All the other visitors seem very content. I don't hear people moaning" and, "The atmosphere is very nice, very welcoming".

The planning for people's end of life needs was inconsistent. Staff had received training in meeting people's end of life needs. Some records had end of life plans on them but they lacked the personal details required to ensure people's needs would be met as they desired at this time. One person had a care plan in place entitled "Dying" where their end of life needs were mentioned. There were a number of statements which were not specific to the person. One statement said staff would need to ask the person's opinion. We asked the manager about this as it appeared the care plan was written without the person being spoken with. They confirmed this was likely the case. They also stated they were looking to attend the training provided by the local hospice but in the meantime would seek to improve the end of life care planning with people. A relative said they had been involved with planning their loved one's end of life plan, which they felt was handled very sensitively by the staff.

People spoke about the staff with fondness. Comments included, "The staff always have a smile on their faces", "The staff are a nice lot of people here" and, "They always treat me well". People said staff always ensured their dignity was respected. Staff ensured doors and curtains were closed at times of personal care. Staff were seen and heard to knock on bedroom doors before entering. We observed staff offering care discreetly to people in the lounge. For example, people were supported with their personal care in a manner which was careful and considerate of being overheard.

People felt they received their care at times they wanted it. Everyone was content that they woke, rose and retired (with or without assistance) at a time of their own choosing. People felt staff cared about their emotional welfare. Comments we received included, "Everyone gets the same treatment. Staff come in and have a chat and a joke and we hold hands", "All staff make me feel special", "One or two staff come in at 10.30pm and make me tea and toast which is very nice", "Some do make sure I am comfortable" and, "The staff look after me well".

A relative said, "The staff are very patient and very kind. They are lovely and I can't fault any of them". All visitors told us they were welcomed and felt staff kept them informed of any necessary changes in their family member's welfare. Another relative said, "When Mum came here first I was very upset and the staff kept me very well informed and also asked me how I felt about it all. They continue to show a concern for me as well as for both my parents; I can't fault the staff here".

Staff spoke about the people they were caring for in terms that showed they cared about them. Comments included, "I love it here, I love the people, and I love getting to know them. I wish I could spend a bit more time with them to get a relationship with them, cos this is their home", "I think this is a happy home, we don't get much complaints from the residents" and, "The care here is up to standard."

Requires improvement

Is the service responsive?

Our findings

At our last inspection in November 2014 we were concerned people's care records lacked the essential details about people's needs and information was inconsistent. This meant staff did not have the information available to provide care that was consistent and appropriate. We found concerns remained in respect of people's care records.

People's admission forms were often incomplete and lacked information staff required to ensure care delivered met the person's immediate needs when they first started living in the home. Initial checks of people's health and welfare were not always completed which meant staff did not have the details available to reflect on people's needs later in the time at the service. People's likes, dislikes and how they wanted their care delivered were also not always recorded.

Records of people's care were sometimes incomplete with gaps in recordings and monitoring of people's needs not being completed. Care plans lacked detail that was essential to staff in respect of some health conditions. For example, one person had a heart condition that was not referred to in their care plan. People did not have plans in place that addressed their specific diagnosis. For example, there were no care plans in place to address the needs of people living with dementia or Parkinson's disease to ensure staff understood how to meet these people's needs.

Not keeping completed records of people's care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans lacked the necessary detail to ensure they were personalised and reflected how people wanted their care delivered. There was no evidence in the records to show that care plans had been planned with people and checked to ensure they accurately reflected their needs. The language and statements used about people and their needs were the same across different care plans. Language used was not personalised. For example, one care plan said "Assist with washing and dressing" and, "Encourage (the person) to participate" with no specific guidance for staff that related to the person themselves. There was no detail on how the person wanted their care given. There was an "About me" document on people's files but where this was filled in it was not used to inform people's care plans or inform how their care should be delivered.

People were not provided with opportunities to remain socially, cognitively and physically active. Most people stayed in their room and those who came into the lounge had only the television to watch. A volunteer came into the service on Monday and Friday afternoons to run a bingo session for people. This was well attended on the second day of the inspection. At all other times there was nothing on offer for people to attend or do. People told us they relied on their family to provide any time out of the service. None of the records reviewed included a section on how staff could ensure people's needs were to be met in respect of this. What people would like to do to remain active were not recorded. When one person was asked by staff what their plans were for the afternoon they said, "I shall lie on my bed 'cos there's nothing going on here is there?"

Not meeting people's needs in a person centred manner is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home had one operating bath but the room was also used as storage. The manager told us one person had a bath a few days prior to the inspection but this meant all the equipment had to be taken out and put in the lounge. The manager advised people were encouraged to have a shower due to the issues with storage and having to empty the bathroom out. Staff told us people had set days for their showers, normally once a week though some people's relatives had asked if they could have two showers a week and this took place.

People had care plans in place to manage skin integrity. Any changes in people's skin were identified and action taken to try and prevent pressure ulcers. Where pressure ulcers were present these were looked after and people were referred to the tissue viability nurse for advice and guidance. The body maps used to identify areas of concern on people's skin were small and it was difficult to distinguish areas being managed. It was not possible to determine the exact location, size and type of wound. There were also gaps in the monitoring forms. We spoke with the manager about this and they stated they would review the documentation and speak to staff to ensure records were completed.

Requires improvement

Is the service responsive?

Staff whose role was to provide care told us they did not read people's care plans. They wrote in the daily records only which were held in people's rooms. Staff told us they did not contribute to the writing and updating of people's care plans. This was completed by the nursing staff. All the staff we spoke with told us that care plans were kept in the nurse's office to which they had very limited access. The room could only be accessed by a key code which was only provided to the nursing staff. Some staff told us they were encouraged to read the care plans but did not have time. Others told us that they did not need to read the care plans as they were told all they needed to know at staff handovers. This meant staff did not have access to essential details about people's needs and care could therefore be inappropriate or not as desired.

Local religious leaders provided a monthly service which people could attend if they wanted to. There was a notice advertising a future Christmas service in the home.

People were not aware of any formal complaints procedure but all said they would speak with the administrator or manager if they wanted to raise an issue. The service had systems in place to respond to people's formal complaints. We were told by the provider there had been no complaints to review. We asked about people's concerns that may not have resulted in a formal complaint and were advised these were dealt with as they arose. There was no recording of these and no review process to see if lessons could be learnt and applied across the service. The provider stated they would look at a way to achieve this following the inspection.

Requires improvement

Is the service well-led?

Our findings

Down House is run by Mayhaven Healthcare Limited. This is this company's only service however, the directors also run three residential services for older people in the Plymouth area. There was a nominated individual (NI) in place who is a person appointed by the provider to be responsible for supervising the management of the service. The NI was one of the directors and was available throughout the inspection to answer questions at the provider level. The service was managed by the provider, an administrator and manager. The registered manager had left in August 2015. The NI explained there were plans in place to ensure a manager was in place as soon as possible who would apply to be registered with us.

At the last inspection we found the provider did not have adequate systems to ensure the quality of the service. At this inspection we continued to have concerns about the lack of quality monitoring of the service as systems and processes were not always in place to ensure good governance. For example, there were no audits of records to ensure people's needs were accurately identified and recorded when they first moved into the home; ongoing records of people's care were not complete and lacked essential information about people's individual needs including risk assessments. Infection control practices were not monitored to ensure they were safe.

Where audits were used these did not identify concerns. For example, an audit in respect of medicines had been introduced, but had not identified concerns in respect of the administration of medicines found on inspection. Information about people's accidents and falls was not being effectively being used to identify themes, to help keep the person safe, and prevent it from happening again.

Staff meeting people's care needs were confused about the extent of their role. For example, the staff with a caring role told us that in the event of a fire, staff would evacuate to a point outside the building and would leave people who lived in the home unattended in the building while they awaited the arrival of the fire service. The provider had a different view. The provider told us they had been advised by the fire service not to evacuate the building at all. The fire service would then manage any evacuation. This meant that in the event of a fire confusion among staff could place people at risk. We have advised the fire service of both the staff and provider's view.

Systems to ensure the service was a safe place to reside were not being completed consistently. There were no internal or external risk assessments available to view on this inspection. Robust systems or checks were not in place to ensure all aspects of the service were safe for people to access. For example, the service was undergoing building works and outside the building there were areas with uneven floors, no grab rails and trip hazards and inside areas restricted people's movements.

Systems to assess, monitor and mitigate risks did not ensure service users were protected from risks relating to health and safety. For example, the provider did not have systems in place to manage the safe use of chemicals at the service.

The manager had been unable to effectively assess, monitor and improve the quality of the service provided, because they had been working as a nurse. They advised us of changes they wanted to make however, were unable to complete these due to demands on their time. They advised they had not administrative time.

Not having robust systems in place to ensure the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke to the provider about how they ensured good leadership and governance, they advised there were no formal systems in place which could evidence this. They told us they were in the service daily and dealt with issues when they arose. The manager, who was the most senior person with a nursing qualification, often deferred to the administrator and provider when we were seeking answers in relation to people's nursing needs.

Most people identified the manager as being in charge. Some relatives and people identified the provider. People, relatives and staff both felt they could speak to the manager who they described as approachable and willing to seek solutions to any issues raised. One staff member said, "The new matron is lovely too, she's kind, she's not worked here long; five or six months maybe."

We found there were systems in place to request people and professionals' views of the service by means of an annual questionnaire. Residents' meetings were usually held every three months. These were run by family members associated with Down House. There had been a break due to unforeseen circumstances, but the provider

Requires improvement

Is the service well-led?

was hoping the meetings would be started again as soon as possible. Although none of the people spoken with could recall attending any meetings one relative said, "I attended the last meeting of residents and relatives in the summer of 2015 and found the information about the building works and the dates of events very useful".

The provider had systems in place to ensure some equipment and the utilities were maintained. There was no recording of water temperatures to prevent scalding. The provider agreed to look at putting systems in place to record this. CQC had received the essential notifications required to be sent by law. Notifications are specific events registered persons are required to tell us about.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1) and (3)(a)(b)** **Care and treatment was not always appropriate, did not always meet people's needs or reflect their preferences. The registered person had not collaboratively, with the person, completed an assessment of needs and preferences or designed care or treatment with a view to achieving people's preferences and ensuring their needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)** **Sufficient numbers of staff were not always employed to meet people's care needs.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1)(2)(3)** **Care and treatment was not always provided with consent as the registered person was not acting in accordance with the MCA 2005 for people who were unable to consent because they lacked mental capacity to make particular decisions for themselves.**

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by the 4 March 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1) and (2)(a)(b)(c)(d)(e)(g)(h)** **Care and treatment was not provided in a safe way for people including assessing the risks to the health and safety of people; doing all that was reasonably possible to mitigate risks; ensuring all staff providing treatment were suitably qualified; ensuring the premises were safe; ensuring equipment was safe to use; the proper and safe administration of medicines; assessing the risk of and controlling the spread of infections.**

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by the 4 March 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) and (2)(a)(b)(c)**

This section is primarily information for the provider

Enforcement actions

Systems and process were not established to assess, monitor and improve the quality and safety of the service (including the quality of the experience of people receiving the service) and assess, monitor and mitigate the risk to the health, safety and welfare of service users. Records of people's care were not always accurate, complete and contemporaneous.

The enforcement action we took:

We issued a warning notice.

We have told the provider they are required to become compliant with the Regulation by the 4 March 2016.