Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Donness Nursing Home

42 Atlantic Way, Westward Ho, Bideford, EX39 1JD

Tel: 01237474459

Date of Inspection: 12 August 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mr & Mrs P Newton
Registered Manager	Mrs Yvonne Newton
Overview of the service	Donness Nursing Home provides personal and nursing care for up to 34 older people who may have a dementia, learning disabilities, physical disabilities and sensory impairments.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 August 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with commissioners of services.

We spoke with health care professionals with knowledge of the home.

What people told us and what we found

Our inspection team was made up of an inspector who spent one day at Donness Nursing Home. We considered our inspection findings to answer questions we always ask:

Is the service safe?
Is the service caring?
Is the service effective?
Is the service responsive?
Is the service well led?

This is a summary of what we found.

On the day of our inspection there were 27 people living at Donness Nursing Home. The summary is based on conversations with three people using the service, five staff supporting them, two people's families, two health care professionals, the registered manager (known as matron), observation and records.

If you want to see the evidence supporting our summary please read the full report.

Is the service safe?

The service was safe because staff had a good understanding of people's needs and ensured those needs were met. This included close monitoring of diet, blood sugar levels, falls and psychological needs. Advice was sought appropriately and within a reasonable timescale. Necessary equipment was provided. People who had been admitted with pressure sores or whose diet was a concern were making considerable improvement.

Care plans included considerations of the Mental Capacity Act (2005) and staff demonstrated an understanding of the Mental Capacity Act (2005). People were protected

through the Deprivation of Liberty Safeguards (DoLS) which were properly managed so as to protect people from being deprived of their liberty unlawfully. The registered manager had taken advice about an application under DoLS the day before our visit.

The service was safe because checks were completed prior to new staff starting work at the home. This ensured those staff members were suitable to work in a care home environment. There were sufficient staff to meet people's needs in a safe way but this was marginal some nights whilst an additional night care worker was being employed.

The service would be safer if all accidents were better recorded and investigated in a timely manner.

Is the service caring?

The service was caring because people's individual needs were understood and met. For example, one person had decided they wanted to stay in bed permanently. They were made comfortable and protected from risks from inactivity. They appeared happy and settled when we visited them.

Staff were attentive to people's needs and dignity. We saw care workers act quickly when one person started removing their clothes. Other care workers were discreetly monitoring a person's diet. That person's family told us "They care. They go beyond the basic needs. It's about mum as a person".

We heard and saw staff interact with people in an unhurried and respectful way. One person told us "Most staff are caring".

The service was caring because people's well-being was seen as the priority. People appeared to be comfortable and relaxed at the home.

Is the service effective?

The service was effective because people's health and welfare were promoted. People received an assessment of their needs prior to admission. Risks were assessed and risk management planned. The person's care plan was then completed and updated as the person settled into the home. The care plans were reviewed monthly following discussion with the person and/or their family representatives and health professionals. One person's family told us "I feel the staff are geared to his needs".

Health professionals had no concerns about the standards of care provided.

People received a nutritious diet which they told us they were happy with. Comments included "Food is pretty good" and "Not too bad. Quite good".

Is the home responsive?

The registered manager (matron) was clearly well known to people and their families who felt they were able to take any issues to them, the office manager and the staff. The home also sought staff and people's views through an annual survey of opinion.

The home had responded to changes in people's needs and circumstances. We saw how people's needs were reviewed and their plan of care amended where necessary. We saw how people's health had improved since admission to the home.

Is the home well-led?

The home was well-led because the service was monitored. For example, we saw how a missing record had been highlighted as an issue. People's views were sought and audits undertaken. There were efficient arrangements for communication between the registered manager (matron), office manager, nursing, care and support staff at the home. However, we saw matron did not always act quickly enough and one staff said "or show us that she has acted".

We saw the registered manager was "very approachable" and people using the service, their families, health professionals and some staff wanted to tell us this. However, some staff members did not take issues they had to the manager.

The home was well-led because it ran effectively and there were contingency plans in place for any foreseeable emergency.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Many of the people using the service were unable to communicate their opinion of the home but we spoke to two people's families. One told us "If I have any concern I find the home is already aware of the situation. They deal with it. When mum goes out she is always happy to come back. They care. They go beyond the basic needs. It's about mum as a person". Another family told us "I feel the staff are geared to his needs". A visiting health professional gave us examples of good care at the home and said they had no concerns.

We looked closely at the care of one person recently admitted to Donness. Their needs had been assessed by the registered manager prior to admission whilst they were in hospital. The person's family said they had also provided information before and after the person's admission. The person told us they did not want to get out of bed. This was clear in the person's care plan and the registered manager was fully aware of the person's preferences and needs. We saw the person looked comfortable, had drinks available to them, hearing aid in place and was watching a television program with interest. Their care plan described their needs in full and risks, such as pressure damage, had been assessed and were being managed.

One person was exhibiting distress and anxiety. The home was aware of the person's distress and had taken steps to help them. A community psychiatric nurse had been contacted and visited the day prior to our visit. The home had also taken advice about the lawfull deprivation of that person's liberty for their protection.

Care plans included considerations of the Mental Capacity Act (2005) and staff demonstrated an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and how they applied to their practice. We found the service to be meeting the requirements of the Mental Capacity Act (2005). People's human rights

were therefore properly recognised, respected and promoted.

We saw people received an acceptably good standard of personal care and their individuality was promoted. Care workers had a good understanding of people's needs and individual preferences. We saw people's health care needs were being met. For example, people who had been admitted with pressure damage were now improving. A district nurse with knowledge of the home told us "The standard of care seems to be good. We have no concerns".

We saw care plans included people's health, emotional and social needs and were regularly reviewed. Where risks were identified steps were taken to mitigate the risks, for example, one person had a three day food assessment in place because there were concerns around the amount of food they ate.

We asked about activities at the home and were told there were regular musical events and "about 11 o'clock carers do some activities with people and these will be written in the person's daily notes". We saw this was the case. We saw Communion was held for one person during our visit which showed people were able to follow their faith.

We observed care workers providing people with unhurried attention and ensuring they were comfortable. When one person removed their shirt care workers quickly ensured their dignity was maintained. This showed they were attentive to their needs.

There were arrangements in place to deal with foreseeable emergencies. We spoke with the registered manager about foreseeable emergencies. We found these had been well thought through. Examples included all staff having enhanced police (DBS) checks toward evidence of their suitability to work closely with vulnerable people should illness have greatly reduced staffing levels. There was also an agreement with another care home that people could be transferred there should Donness be unsafe for any reason.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink. On our arrival at 9am we saw trays with cooked breakfasts being taken to people's rooms. We saw people had a variety of breakfast options available to them.

We looked at the menus for the home, which we were told worked on a four week basis. There was no lunch option but the cook told us preferences were met. For example, that day one person was having a fish meal instead of the planned meat option which they did not like.

The cook said there were currently no vegetarian diets required. We saw six out of seven days the lunch meal was meat with vegetables. On Fridays there was fish. We saw the supper time menu was very varied and included tuna, scrambled egg, cheese and onion, bubble and squeak, vegetable rolls and poached eggs. The registered manager told us people were satisfied with the lunch time meals because they ate them and those who were able told her they were satisfied with the food.

We asked people who were able to communicate with us their opinion of the menu options and meals provided. Their comments included "Food is pretty good" and "Not too bad. Quite good". One person's family told us "Breakfast looked gorgeous".

People were supported to be able to eat and drink sufficient amounts to meet their needs. At 3pm we saw people had tea and cake provided and at 5pm we saw people eating supper. One person, whose weight and diet was of concern, had eaten their egg sandwiches. A health professional told us "The home is very much in control of X eating and trying to get their weight up. They provide discrete management". We observed how care workers were unobtrusively checking the person had eaten enough.

One person had the condition of diabetes and their weight and blood sugar levels needed careful monitoring. We saw from records how much these were improved since their arrival at Donness. A health professional said that person's diabetes was now much better controlled.

We saw people were regularly provided with drinks and water was available in people's rooms. Records included assessments of people's nutritional needs and food preferences. We saw food supplements were prescribed and special diets, such as pureed foods, were

provided where an assessment of risk identified the need.

We were told the last meal was at supper between 5 and 6pm but drinks and a snack were also provided early evening and food and drinks were always available. A nurse told us that when they checked people during the night they were offered a drink if they were awake.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at five staff files to see if there were effective recruitment procedures in place to protect people from unsuitable staff.

We found a full employment history was in place for each person with an explanation for any gaps in employment.

We saw photocopies of training certificates to show staff had the necessary skills and qualifications to care for people.

There was evidence to show proof of identity had been obtained for new employees. For example each staff file contained photocopied personal documents which included passports, utility bills and national insurance details.

There was evidence to show the registered manager had sought evidence of previous conduct during employment. These included references from previous employers.

Where care workers had previously worked with vulnerable people the reason for leaving employment had been sought.

We saw evidence to show the home had sought evidence of any previous criminal activity and whether the person was barred from working with vulnerable adults, called DBS checks. Those checks had been completed prior to the staff's employment.

We found in the five staff files there was not satisfactory information about any physical or mental condition relevant to the person's employment. The registered manager told us they had taken advice from a nursing home organisation about this and were able to show us one application, already underway, where this check had been reinstated so the required information would be available for all new people employed.

We found that one person employed was under the age of 18, the age generally considered appropriate for providing intimate personal care. However, we saw that person was undertaking an apprenticeship in health and social care and so their employment was for that reason.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were generally enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were generally enough qualified, skilled and experienced staff to meet people's needs.

We were told staff shifts were between 7.30 am and 2pm; 12 midday and 8.30pm and 8.30pm and 7.30am. This meant additional staff over the lunchtime period were able to help people needing assistance.

There were 27 people using the service the time of our visit. We spoke to people and their families about staffing at the home. One person told us "It depends how busy they are (when you use the call bell)". Another person told us "The routine (of receiving morning care) depends on how busy they are". They added that pain relief was always available when they needed it. One person's family said "staff are around" when they visited at the weekends.

We found people were assisted with rising and morning care within a reasonable timescale and the care we observed was unhurried. Call bells were answered fairly quickly and we saw no needs went unmet. One person, who had falls before admission, had none since they were admitted to Donness and we saw from accident records that the number of accidents was within expected parameters for a nursing home. We spoke to the registered manager about this and they said a lot of motion monitors were used to help alert staff to people's movements; this helped to reduce accidents.

During the morning when we spent time on the lower ground floor there were no staff in evidence for much of the time. However, the two people residing on that floor were fully able to call for assistance. Staff told us the way the work was organised helped them to be efficient with their time. For example, each care worker was responsible for people with a range of needs, some needing full assistance and some much less assistance, and this worked well.

None of the staff members we spoke with felt there were enough staff. One said how tired they became during a full day at the home and we were told how this was increased when staff were asked to cover staffing shortages.

We were concerned to see from the rota that on some nights there was only one care worker with one nurse to care for the 27 people, some needing two staff to attend to them. We spoke with a night staff who told us "We need another staff. Some nights are very, very quiet and some are very, very busy. It is awkward if a patient is walking around and then bells ring. (The manager) is hiring more staff". The registered manager confirmed that another staff member had been interviewed and will be in post immediately the recruitment checks are completed. The registered manager also lives next to the home and said they were always available if called for assistance. One nurse confirmed this.

Nursing and care staff were supported by a 'hospitality' staff whose role was to assist people with their meal. The home also employed a cook and domestic staff. The registered manager (matron) was additional to a nurse on each day shift and the care was coordinated by a senior care worker with the title of office manager. We saw the office manager organising staff, arranging for health professionals to visit and ensuring medicines were ordered and available. This showed the arrangements at the home made efficient use of the skills of staff available.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

The registered manager told us there was an annual feedback survey used to gain people's views and this was due to be sent soon. There was also a survey for staff. Staff also received a 3-4 monthly supervision of their work.

We saw the registered manager (known as matron) was very accessible to people and staff. Visitors greeted matron when they arrived and those we spoke with felt they were kept informed and had good communication with staff. For example, one person, whose relative needed close dietary monitoring, said "I feel I can always go to staff". That person's dietary health was improving.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. Matron was in daily contact with events at the home and worked closely with the office manager, a senior care worker who coordinated the care arrangements, such as health care appointments and medicines ordering. In addition, each shift had a nurse who provided the nursing care. Expert advice had been sought where necessary to promote people's health and well-being. This had included a visit from a community psychiatric nurse and discussion with a Deprivation of Liberty assessor the day before our visit.

We saw how people's health and safety were monitored through assessment of risks as part of care planning. Health professionals felt the home had a good understanding of how to promote people's health and safety and this is what we found.

There was evidence that learning from incidents / investigations did not take place in a timely way although appropriate changes had been implemented prior to a full investigation. We saw there had been an accident where a person fell from their wheelchair when on an outing from the home. This was their own wheelchair and there were three staff present. Matron had immediately taken steps to ensure this did not happen again by discussing with the family how to improve safety. The provider may wish to note there had been no formal investigation of the event, which could mean lessons,

which could be learned from the accident, might not have been learned at all or in a timely manner .

We saw accidents and incidents were monitored and we saw nothing within the home which could pose a risk to people. We saw standards at the home were monitored. For example, where one daily record had been missed this had been identified and a note included for the staff involved.

We asked staff if they thought the home was well-led. One staff member said matron was "very approachable, but perhaps does not always act quickly enough or let staff know that she does". Two other staff members said "It is well-led." However, they added that "moans" were not always taken to the matron to deal with first hand. We found systems were in place to ensure staff could voice their concerns; however the provider may wish to note some staff felt the need to voice their concerns elsewhere.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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