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: 14 February 2013

Date of Publication: April 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖	Action needed
Management of medicines	✖	Enforcement action taken
Assessing and monitoring the quality of service provision	✖	Action needed
Records	✖	Action needed

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

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 14 February 2013, 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 staff, reviewed information we asked the provider to send to us and took advice from our pharmacist.

What people told us and what we found

We met with three people who lived in the home and observed eight others in the lounge and dining room. We met with five staff on duty and the registered manager, and were supported by a staff member to look round the home.

One person told us, "You couldn't have people wait on you better." Staff told us that people joined in keep fit sessions and a musical entertainer visited regularly.

However, we found that care planning and risk assessment had not been carried out consistently. Guidance for staff was not updated and accurate. Staff did not always record accurately what they had done and in some instances there was no evidence that they had done what the care plan said was needed. We saw staff moving a person from their wheelchair to an easy chair in a way that might cause the person harm.

Recording of medications was unreliable. It was not always clear that people had been given medication according to the instructions from the prescriber. We found instances of unsafe practice when staff had given medication without carrying out a check that was necessary beforehand.

We found that there were insufficient checks in place to ensure that the home was run in a safe way. This included a lack of medication reviews, to ensure that people were being given the correct medicines to promote their well being and lack of evaluation of accidents and incidents to see whether there was anything more that could be done to prevent people falling.

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

What we have told the provider to do

We have asked the provider to send us a report by 02 April 2013, setting out the action

they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Donness Nursing Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People at Donness Nursing Home are at risk of unsafe and inappropriate treatment because care is not planned or delivered in a safe way.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at care records of five people, spoke with them or observed them and spoke with staff about their care. We found examples of significant gaps in recording which could have resulted in harm to people. For example, the care plan of one person who had particular difficulties with feeding said that staff should monitor their bowel movements and report any instance where there was no action for three days. The chart showed longer gaps of up to eight days, with no record of reporting or action taken. This meant that they may have suffered unnecessary discomfort or illness.

We saw two people in bed during the day with bed rails in place. We looked at the care plan for one of them. It said, "Xx requires safety rails in bed with frequent observation to ensure safety." We asked whether there were records showing when night staff had checked and the registered manager was not able to give us this information. Staff told us that the person was sleeping well and "No longer tries" to get out of bed. This suggested that there had previously been a safety issue with no system in place to ensure that staff checked them at suitable intervals.

We saw staff lifting a person in a way that might cause them harm. Suitable equipment was in place but they were not using it. We looked at the guidance for staff in the person's care records. It was confusing. It said that the person was "reliant on staff" and "cannot weight bear" but also said "do not use mobility aids." We were told that staff had received training in moving and handling the week before this inspection. However, the trainer had not undertaken training to prepare them for this task in line with professional guidance and the requirements of the Institution of Occupational Safety and Health.

We saw that one person was using an airwave mattress to protect their skin from pressure damage. We did not see any guidance for staff on how it should be adjusted to suit the person. We asked the registered manager who showed us a weight chart provided by the

suppliers to guide staff on the correct setting for the mattress. We could see that the setting had not been adjusted in line with the weight of the person. This meant that the person was put at unnecessary risk of pressure damage. However, staff told us that they had seen the person's skin each day and made sure they were comfortable.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People living at Donness Nursing Home are not protected against the risks associated with the unsafe use of medicines because medications are not administered in accordance with professional guidance.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at policy and the records relating to medicine management and talked to staff about how they carried this out. We saw that the medicines were safely stored and the controlled drugs stored correctly and safely in line with relevant legislation.

We had previously had concerns about the competence of trained staff at Donness with respect to effective administration of analgesics. We received further concerning information with respect to harm that had been caused to a person no longer living at the home whose medication had been delivered at the wrong dose via a syringe driver. The overall review of this matter had not yet been concluded.

We were told that the qualified staff who administered medication in the home had received training in medication but the manager was unable to locate documentation to support this.

We looked at the Medication Administration Records (MAR). We found that the prescriber's instructions had not always been followed. For example, an instruction had been given to introduce breaks in the administration of diazepam to one person in order to reduce their dependency. This had not been followed, with no reason given.

We saw that medication that had been prescribed to be given 'as and when required'(PRN) had been given throughout the day and by night with no explanation for its use and no information about who had made the decision that it was needed. There was no guidance for staff in the home's policy with respect to administering PRN medication. We did not see information in care plans that would advise staff of the steps that should be taken to alleviate the person's condition before the PRN medication was offered. This meant that people had been given more medication than the prescriber had intended which could cause them harm.

There was no record of creams, ointments or eye drops having been given. We did not see guidance for staff on where the creams or ointments were to be applied. This meant that the registered manager could not be sure that these had been applied correctly to promote people's health and welfare.

One person was administered a daily medication for which trained staff were instructed to check their pulse before administration as it should not be given if the rate were below a certain level. We saw that only one day out of 19 was their pulse rate recorded. This meant that the person may have been given the medication when it was unnecessary or harmful for them.

We saw two instances where the prescriber had increased the dosage required. This had lead to one person being left without their medication as staff had failed to order additional supplies in time.

We found that alterations to people's medication had been advised to staff by phone. They had not waited for written confirmation before administering the altered doses, which would be in accordance with professional guidance, to ensure accuracy of administration.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

People at Donness Nursing Home are not protected against the risks of inappropriate or unsafe care because risks to their safety and welfare are not effectively identified or managed.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The registered manager told us that she had completed a recognised quality assurance assessment over previous years. She said she had changed to a new system and would provide the Commission with an audit in order to demonstrate that a robust system of checking was being introduced.

The registered manager told us that she completed an audit for tissue viability with the Tissue Viability Team from the local District Hospital in September 2012. However, the shortfalls reported in other sections occurred repeatedly due to the absence of a system of checking. For example, the failures to use record charts in a useful way had not been noticed by the registered manager.

We saw that accidents had been recorded but we did not see any analysis of what happened which could have helped people in the home avoid having further accidents. For example, staff showed us a movement monitor which had been installed in the bedroom of a person who was known to get up by night and who was at risk of falling. We saw that there were records of this person having fallen three times in the first two weeks of February 2013. Skin flaps and bruising to their chin had been recorded. There was no advice to staff on how to avoid further accidents.

We saw potential hazards in the environment. A fire door was propped open with a piece of furniture which left people at potential risk in an emergency. Soap was left in communal bathrooms which posed a risk of cross contamination. Uneven floors were unmarked trip hazards. Staff were aware of these and had not taken action to reduce the risk.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People living at Donness Nursing Home are not protected against unsafe or inappropriate care and treatment because records kept in respect of them are not always accurate or complete.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at care records and records of accidents and incidents. We found care plans that were not dated. Monthly resumes had been written which did not evaluate the plan but referred to current health issues and showed that the person's care was being considered.

Risk assessments with respect to pressure ulcers had been made on behalf of one person who was being nursed in bed. The most recent was on 01/10/2012. It said their skin had been examined. It gave advice about sleeping in alternate lying positions. A chart had been included in the care record for staff to enter which position they were in and when they were helped to move. It was blank. The registered manager said it was not needed.

When we were checking the daily care records against accident records we found it was not easy to tell from care records what had happened. Some cross referencing showed up inconsistencies. For example, one checklist stated that a GP had been called following an accident, while another record relating to the same incident said there had not. One entry on 26 January 2013 was difficult to read but the registered manager agreed that it said "Appeared to have seizure." However, there was no seizure entered on this date on the person's chart of seizures that was kept to inform their GP of their pattern of seizures. This meant that the information available to monitor and adjust their medication was incorrect.

The registered manager sent the Commission an audit she completed in January 2013 in order to monitor the quality of recording in care records in the home. This showed that she had found shortfalls in legibility, accuracy including the time of the record and "inadequate content". She had drawn up a list of actions required by the staff. These improvements had not been put into practice to support safe care.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People at Donness Nursing Home are at risk of unsafe and inappropriate treatment because care is not planned or delivered in a safe way. This is in breach of regulation 9(1)b(ii) of the Health and Social Care Act 2008.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: People at Donness Nursing Home are not protected against the risks of inappropriate or unsafe care because risks to their safety and welfare are not effectively identified or managed. This is in breach of regulation 10(1)b of the Health and Social Care Act 2008.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records** **How the regulation was not being met:** People living at Donness Nursing Home are not protected against unsafe or inappropriate care and treatment because records kept in respect of them are not always accurate or complete. This is a breach of regulation 20(1)a of the Health and Social Care Act 2008.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 09 April 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines** **How the regulation was not being met:** People living at Donness Nursing Home are not protected against the risks associated with the unsafe use of medicines because medications are not administered in accordance with professional guidance. This is in breach of regulation 13 of the Health and Social Care Act 2008.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk