Care Quality Commission

Inspection Report

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

Donisthorpe Hall Company Limited by Guarantee

Donisthorpe Hall, Shadwell Lane, Leeds, LS17 6AW

Tel: 01132684248

Date of Inspections: 27 August 2013
21 August 2013

Date of Publication: September 2013

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
Safeguarding people who use services from abuse	✓ Met this standard
Notification of other incidents	✓ Met this standard

Details about this location

Registered Provider	Donisthorpe Hall Management Committee
Registered Manager	Mrs. Maria Holdsworth
Overview of the service	Donisthorpe Hall provides residential, nursing and dementia care for a maximum of 189 residents. Care is provided in seven specialist units. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs.
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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Care and welfare of people who use services	6
Safeguarding people who use services from abuse	10
Notification of other incidents	12
About CQC Inspections	13
How we define our judgements	14
Glossary of terms we use in this report	16
Contact us	18

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 21 August 2013 and 27 August 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

When we inspected Donisthorpe Hall in May 2013 we found people were not adequately protected from the risk of abuse because the provider had not followed local guidance or national regulations on the reporting of abuse. We carried out this inspection to check what changes the provider had made to ensure people were protected from the risk of abuse.

Three of the units at the home are specifically to support people with dementia. People with dementia are not always able to express their feelings or wishes clearly and can be at greater risk of abuse. As part of our inspection visit we also wanted to check how people with dementia were protected and supported to live well.

We spoke with the Registered Manager, Dementia Care Manager, Training Manager, two Unit Managers, nine care assistants, people living at the home and relatives. We observed how people were supported during the day and at lunch time on Units 1, 3, 4, 5 and Silver Lodge.

Staff told us they were confident they were able to meet people's needs safely. They said they had received training in dementia awareness, how to identify triggers for people's behaviour and how to respond. They were able to give examples of approaches applicable in relation to different scenarios.

Staff told us they enjoyed their jobs. One said, "I like working here, I think residents get good care. It's like a family home." A relative told us "The staff are very supportive and approachable, they take time to listen to what you have to say."

We observed how people were supported. We found staff were in the main respectful and attentive to people's needs. We saw several examples of good practice and thought being given to people's individual needs. However, we also observed instances where opportunities to enrich people's experiences were missed and staff responded to people in a perfunctory manner.

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. Staff told us they found care plans accessible and easy to use. They took account of people's needs, cultural and religious values or beliefs and included personal histories. One relative we spoke with told us they had been asked to write a full life history about her father. Other relatives confirmed they had been consulted by staff about people's care needs and had been involved in reviews.

Each person living at the home had a named keyworker who was responsible for co-ordinating their care and support needs. Paper copies of care plans were kept on each unit; monthly reviews were recorded electronically and were accessible by authorised staff. Changes to care plans were authorised by the Unit Managers or when appropriate by other senior staff.

Staff told us they were confident they were able to meet people's needs safely. They said they had received training in dementia awareness, how to identify triggers for people's behaviour and how to respond. They were able to give examples of approaches applicable in relation to different scenarios. They said the Dementia Care Manager was supportive and advised on methods and approaches to consider when assisting people who were distressed or agitated. Staff told us they enjoyed their jobs. They said, "I love working here, I get on well with everyone. I love putting a smile on people's faces, making them happy, cheering them up" and "I like working here, I think residents get good care. It's like a family home."

We observed how people were supported on five of the units at the home. We found the provider had considered how to use decorations and colours to help people find their way around the rooms and corridors. We found staff were in the main respectful and attentive to people's needs. We saw several examples of good practice and thought being given to people's individual needs. However, we also observed instances where opportunities to enrich people's experiences were missed and staff responded to people in a perfunctory manner.

On the dementia units (Units 3, 4 and 5) signage on doors assisted people to identify the toilets, bathrooms, dining room/lounge and bedrooms. We observed staff knocking on doors before entering and addressing people by name before entering into conversation. One relative told us "The staff are very supportive and approachable, they take time to listen to what you have to say."

Topical pictures, illustrating events which would be familiar to older people were displayed in the corridors, providing points of interest and opportunities for conversation. There was a cinema and on the first day of our inspection visit there was a concert. There were activity programmes on each of the units. Activities included; games, art and craft work, singing and outings.

Despite the range of activities advertised at the home we noted some people were sat passively in the lounges. In one lounge background music was playing and some people were singing along to familiar tunes. Tactile sensory activity mats and materials were available for people to explore different textures but people did not appear to be using them. One relative said there was a lack of activity and each time they visited the person they came to see was asleep. They said they had told staff what the person was interested in and liked to do but had not seen any of their suggestions being taken up.

On Silver Lodge Ground Floor, a small residential unit, we were told most of the people were independent. Some people only needed help to bathe, get dried or dressed but others required hoisting. We were told there were only three members of staff on the unit to look after 19 people. This meant that if two members of staff were needed to help a person who needed hoisting there was only one member of staff to support the other 18 people. The staff told us mornings and mealtimes were sometimes chaotic and although the night staff helped to get people up, some people had to wait for assistance.

In Unit 4 we found people were seated side by side in the main lounge area. There was a selection of small tables on which staff had placed snacks. A larger table provided hot and cold drink options. Many of the chairs were close together and there was no room or tables in-between to place drinks. Some people were dozing and others were engaged in singing and chatting with staff. The staff interacted with people in a respectful manner. One relative told us, "The staff are wonderful here, very friendly and helpful."

In Unit 5 we found people seated in a split lounge and dining area, some sat side by side. A television was playing but many of the people in the lounge were dozing. One staff member was talking to people whilst another served drinks. Chairs in one area were too close together and did not allow for tables in-between for people to stand their drinks on.

We observed lunch in Unit 1, Unit 3 and in the Silver Lodge First Floor Nursing Unit. People had their essential needs met but for some the lunch time experience could have been improved. The dining and lounge area in Unit 3 was large and accommodated over 30 people. The majority of people were seated at dining tables. Three people remained sat in lounge chairs and were observed eating meals from small tables which were at an inappropriate height and not close enough to enable them to eat with ease. Red plastic cups and white plates with a coloured rim were in use. The provider may wish to give consideration to the design and use of colours in relation to crockery. This would assist people with orientation and dignity at meal times.

Meals were served by carers, the Unit Manager and Dementia Care Manager. Dining tables were covered with table cloths but cutlery was presented as food was placed on the table. Some soup spoons were already in the bowls as they were given to people which

suggested a lack of understanding of the social aspects of mealtimes. People were not given the opportunity to set out their cutlery and the process appeared essentially a routine task rather than an opportunity to engage with people. People wore blue plastic aprons but we did not hear staff asking people if they wanted to wear an apron. No choice of condiments was offered.

Lunch was not calm or relaxing. We saw staff were attempting to assist people with their meals. They were respectful and supportive. However, the background music was loud. At the back of the room three residents were sat at a smaller seating area, two of whom continued to shout throughout the meal. Staff were attempting to support them using a variety of skills including de-escalation, reassurance and distraction.

The process of serving food appeared disjointed and disorganised. Some residents were observed waiting over ten minutes for the next serving. Others were sat waiting for assistance from staff. One member of staff was interrupted three times whilst trying to assist one person with their food.

After lunch we heard a call for help at the end of a corridor on Unit 3. We found four people seated in a small lounge. Two people were seated in specialised chairs. The other two people were seated in lounge chairs with small tables to the front. Sandwiches a dessert and drinks were on the tables. One resident had poured their soup onto her dessert and mixed their juice and soup together in another beaker.

One person continued to call out for help but no one appeared. We remained with them and sought to offer reassurance. They continued to call out for a further ten minutes after which a member of staff appeared. They did not address the person who had been calling out but crouched down to encourage one of the other people to eat their food. We asked whether the two people without meals had already eaten. We were told one person had and the person who had been calling out had been offered food but had thrown it on the floor. We were told they would be offered food again later on. The member of staff attending people in this area did not attempt to reassure or enquire as to why the person was shouting out. They did not show sufficient regard for people's individual needs and there was a risk that their nutritional requirements would not be met.

In Silver Lodge First Floor Nursing Unit the three care staff on duty were busy getting people ready for lunch. We observed preparations and lunch being served. Eleven people were sat at tables in the dining room. Another three people were sat in large wheelchairs in the lounge area. One of the dining tables faced the wall and the two people in wheelchairs positioned at the table had a limited view of the rest of the room.

At one table people were independent and did not need assistance. Three other people needed help to eat lunch. One person could not manage to eat at all without assistance. There were only two members of staff available. This meant the staff had to constantly move between people and were unable to provide individual support with eating. At times lunch appeared chaotic with no real structure and people who needed assistance had to wait longer than others.

People were offered few choices. Every person was provided with a blue plastic apron. We did not hear staff asking people if they wished to wear an apron and this appeared to be routine procedure. Soup was served but people were not given any choice and unless they asked they were not told what type of soup it was. People were offered a choice of main course, chicken or the 'vegetarian option' but no description of what type of chicken or what the vegetarian option was. Those that chose chicken were given their meal ready

plated with mashed potato, broccoli and gravy.

We observed some positive interactions between care staff and residents. One person had received a letter and there was a general discussion about it around that table. At other times staff interactions with people were primarily task orientated and in the form of a question, such as; "Would you like potato." Sometimes staff spoke to each other across the table about people and their food choices. One said about a person they were assisting, "She always says it's alright." Another said to a person, "You're always in a rush." People were not always treated respectfully or supported at a pace appropriate to their needs.

In comparison lunch on Unit 1 appeared calm and well organised. People arrived for lunch from 12.30 p.m. Others were assisted by staff and positioned at tables with room between for staff to support them. In all fifteen people had lunch, eight of whom appeared relatively independent. Those needing support to eat their lunch were sat together at a large table in a shaded area of the dining room. They were assisted throughout by three staff. We were told the room had been arranged in this way to make it more comfortable for people with higher support needs and who tended to lose their appetite when they were too warm.

Lunch was served from 12.40 p.m. Staff explained what was available and offered people choices. People who did not want a hot meal were offered sandwiches. Staff spoke respectfully and showed consideration for people's individual needs. They encouraged people to eat their meal, supported them when necessary but encouraged them to eat as independently as they could. Where people were helped with feeding, staff watched carefully for signs that they were ready for another portion. Staff engaged with people warmly throughout the lunch. People appeared to enjoy their lunch and the company of others. There was a sense of a large family sharing a meal.

People's care and treatment reflected relevant research and guidance. The provider had prepared a three year Dementia Strategy. The strategy included an action plan aimed at promoting good practice through involvement of people and their relatives in their care, staff development and regular audit. The Dementia Care Manager told us the home was developing person centred approaches with the support of the Bradford Dementia Group. Two senior members of staff had attended a dementia mapping course and were beginning to apply mapping methods within the home. Examples were given of the use of orientation signage, advising staff of techniques to use when working with people who were disorientated or distressed and introducing the change of clothing for staff to casual tops with bright colours to assist people in distinguishing staff from visitors.

We were not provided with examples of how the provider had taken account of the National Dementia Strategy (2009), the Prime Minister's dementia challenge (2012) or the National Institute for Care Excellence guidance on dementia (2013). The provider should consider how this guidance could be used to support dementia care within the home.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The Registered Manager told us all the unit managers had been shown our last inspection report and told about our concerns. We saw the record of a Unit Managers' meeting held on 17th June 2013. The record included a section on "Safeguarding and Whistleblowing." There was a note of the outcome of our inspection visit and the importance of raising staff awareness of safeguarding procedures and reporting arrangements. Unit managers had been asked to share the information with the care staff. We were told the importance of safeguarding awareness and training was reinforced in staff handovers and team meetings.

Senior managers were scheduled to attend additional training, arranged by Leeds Safeguarding Adults Partnership, which included a study of the causes and prevention of institutional abuse and multi-agency procedures. All of the units at the home had a named Dignity Champion who had undertaken additional training and whose role was to develop awareness and good practice among clinical and non-clinical staff.

We were shown training records which confirmed the staff had attended safeguarding training within the last three years or were scheduled to attend training before the end of 2013. We saw staff had been asked to complete evaluation forms after they had completed their training or e-learning. We asked to see examples of the responses and noted staff had found their training useful and had felt their understanding and awareness of safeguarding issues had increased.

We asked the care staff about safeguarding and protecting vulnerable adults from abuse. They described safeguarding as, "Protecting residents, yourselves from abuse" and "Protecting residents, adults, visitors, ourselves. It can be financial, physical or verbal." They were able to describe signs which might indicate a person was suffering or had suffered abuse. They gave examples such as; bruising as an indication of physical abuse or becoming withdrawn or other changes in behaviour as possible signs of emotional or psychological abuse.

One member of staff said it was important to always speak to people respectfully; speaking harshly or abruptly to people was not acceptable. Another member of staff

described how they took care with moving and handling techniques, how they supported people to stand or get out of bed, so as not to injure them or cause bruising which could indicate physical abuse or neglect.

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff told us how some people could become annoyed with other people. The staff described how they looked for signs or "triggers" that a person was becoming agitated and they needed to intervene to calm the situation before a conflict developed. For example one member of staff described how a particular person was liable to shout out when they were alone and had no one to talk to. They said spending some time socialising with the person would usually calm them down. Another member of staff (describing how people got upset) said, "It happens for a reason, they may need to go to the toilet but do not always know how to tell you, you need to be alert to the signs."

The provider responded appropriately to any allegation of abuse. All the staff we spoke with told us they would report any concerns to their unit manager or another senior member of staff. Some told us how they had used body maps (simple diagrams showing the physical outline of a body) to record the location and size of any bruising they observed. The staff were confident any concerns they raised would be dealt with appropriately but said they would call the police or social services if necessary to ensure people were protected from abuse.

Notification of other incidents ✓ Met this standard

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The provider had notfied the Care Quality Commission about incidents that affect the health, safety and welfare of people who used the service.

Reasons for our judgement

We reviewed our records and the number of Statutory Notifications submitted by the Registered Manager. The Registered Manager had acted in accordance with regulatory requirements and informed the commission when there had been an allegation of abuse of a person at the home, an injury to a person or a death at the home. We found one recent incident where a person living at the home had attended hospital for treatment and been found to have sustained an injury unrelated to the original concern. The hospital had correctly referred the injury to the local authority adult safeguarding unit for investigation. However the Registered Manager had not considered that a Statutory Notification of the injury was required. The Registered Manager should note that all injuries falling within the scope of Regulation 18 of Care Quality Commission (Registration) Regulations 2009 must be notified to the Care Quality Commission.

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.

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

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.