# 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: 23 January 2014

Date of Publication: February 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

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|---|---|
| **Consent to care and treatment** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Staffing** | ✓ 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<br>Diagnostic and screening procedures<br>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 to check whether Donness Nursing Home had taken action to meet the following essential standards:

- Consent to care and treatment
- Care and welfare of people who use services
- Staffing

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 23 January 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 and talked with staff.

### What people told us and what we found

We visited Donness Nursing Home to check whether people's consent to care and treatment was confirmed so that their rights were being upheld by the home. We found that consent was always sought and that staff understood how to support people who did not have capacity to make decisions about their own welfare. Staff told us "…I always ask if they would like to get out of bed.", "…..Every day I ask people what they wish to do, even those I know don't have capacity, I still ask.", "….everything we do is always in the person's best interest, always."

We looked at whether people received the care and treatment required to maintain their health and safety. Most people were unable to tell us their experience of living at Donness Nursing Home but we saw staff providing appropriate care in an unhurried way. We saw that people's personal care needs were being met and that people looked comfortable and had equipment in place for their safety, such as pressure relieving mattress. We found that staff were knowledgeable about people, people's care was planned according to their individual needs and delivered in a safe way.

We looked at whether there were enough staff to meet people's needs and whether those staff were skilled and competent in their work. We found that care workers had a clear understanding of people's needs, had been trained to meet those needs and there were sufficient staff for the number and needs of people receiving the service.

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

**Consent to care and treatment** ✓ Met this standard

**Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

### Reasons for our judgement

Our inspection of 19th September 2013 found that the provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who use the service. The provider wrote to us and told us that they would be revising the way they record and gain consent from people who use the service. All individual care plans would be updated to reflect this and would also include clear decision's concerning people's end of life care. The provider also told us that, additional training would be given to staff, which included the Mental Capacity Act 2005. This Act protects people who are unable to make decisions about their welfare. This would increase staff knowledge and understanding of obtaining consent.

When we visited on 23rd January 2014 we spoke with the registered manager, the office supervisor and five members of staff about their understanding of consent to care and treatment and how they applied this in practice.
The staff we spoke with all confirmed they were up to date with their training in the Mental Capacity Act 2005, and showed that they had a clear understanding of the importance of obtaining people's consent before they received care and treatment. The staff explained they would ask people's consent before they gave care and would explain to people what choices they had. Comments included, "…I always ask if they would like to get out of bed.", "…..Every day I ask people what they wish to do, even those I know don't have capacity, I still ask.", "….everything we do is always in the person's best interest, always." Also, "….I think it's important we give people choice, like for breakfast each day, it's important to have a variety and not the same thing every day." This meant people were involved in decisions about their care and treatment and their views were respected by the care staff working with them.

We questioned staff about people who were not able to consent to care and treatment. Staff told us that they obtained detailed information about the person from their history and by talking with relatives and friends. For example, one person who had been residing at the home for a number of years, no longer had the capacity to make a decision about what she would like for breakfast, the staff used detailed information in the care plan alongside their knowledge of what the person historically chose for breakfast to make an informed decision of what they would like on a day to day basis. One staff member said "I give people choice, if they can't decide then I make a judgement based on either what is recorded that they like or dislike in their care plan or my personal knowledge of the person's likes." This showed staff used information to help make judgements about what was in a person's best interests and to ensure that any care and treatment provided, was given in a way that the person would have wanted.

We looked at six care records; all of them contained documents that had been put in place to obtain valid consent from people who used the service. We found that some wording within the documents was unclear and did not show how consent was being sought. The registered manager confirmed that she had already acknowledged this issue and she agreed that the current forms were not suitable. We saw newly designed forms which clearly explained the whole process of how decisions regarding consent for those persons where mental capacity had been deemed to have been lacking, had been made. The registered manager confirmed that all care records where a decision regarding a person's capacity has been made will be updated with the newly designed mental capacity form. Whilst we observed the forms being completed we were not able to test that this improvement would be sustained.

Senior members of staff were able to describe the process of making decisions in people's best interest where they did not have capacity to do this for themselves. They clearly understood the importance of following the correct procedure. However, the provider might find it useful to note that there was no written documentation in place to show that the right practical steps had been taken and no written record detailing how a best interest decision had been reached. This meant that there was no record of the process followed in making a best interest decision and so no evidence that the best interest principles set out in section 1(5) of the Mental Capacity Act 2005 were being followed correctly.

We found that some care records contained treatment escalation plans (TEP) that had been reviewed recently and updated to state whether a person (or people who knew them best) had decided whether they should or should not be resuscitated under certain conditions. However, several care records had TEP forms that were incomplete. The registered manager confirmed that arrangements have been made through the local GP to meet with the provider, legal representatives and family members where applicable, to review all TEP forms. This would be completed and full consent gained and recorded correctly by the end of February 2014. This demonstrates that suitable arrangements are in place to obtain consent from all people who use the service in relation to the treatment they are provided.

**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

We had received information of concern from an anonymous source and so we looked at aspects of this standard.

On arrival we found that people were being assisted to rise and have breakfast. Most people were unable to tell us their experience of living at Donness Nursing Home but one person's family said "It's alright here" and we saw care workers taking their time to assist people. The registered manager introduced us to one person who smiled when they saw her and appeared relaxed and comfortable.

We visited each room in the home. The provider might find it useful to note that several of the rooms had an unpleasant odour although they looked clean. Some people had remained in bed and the care workers were able to tell us why that was the case. For example, one person was "happier and more comfortable" in bed. Another person "was up yesterday and so wants to be in bed today". People receiving care in bed appeared to be comfortable. Each person had received personal care for their comfort, had access to a call bell and a drink within their reach.

We saw that people received a high standard of personal care. Care workers told us "Each person has a very good wash and we are very focused on any 'body marks', which might show people have pressure problems". We saw that people had pressure relieving equipment in place to reduce the possibility of pressure damage and found that care workers were knowledgeable about the subject.

We looked at two people's care files. We found that there was clear information about people's individual needs and how those needs were to be met. Care workers were also able to tell us about each person, what they liked, disliked; what care they needed and how that care was delivered. We saw that one person had a care plan in place for a temporary condition. This meant that nursing and care staff could provide consistent treatment for that condition because the method of treatment was clearly defined.

We had been told that care workers were not instructed how to use equipment. The five care workers we spoke with were adamant that they had received training in moving and

handling people safely and the use of hoists and other equipment.  They said that they had also received training in subjects such as catheter care, epilepsy, infection control and "yesterday was fire safety -for three hours".  They told us that new care workers never worked alone until they knew how to provide care in a safe way.

We asked the registered manager how they knew staff were safe and competent to provide for people's care and welfare. They told us that all new staff worked with an experienced care worker for a minimum of two weeks and then their competence was assessed.

**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 enough qualified, skilled and experienced staff to meet people's needs.

## Reasons for our judgement

We had received information of concern from an anonymous source and so we looked at aspects of this standard.

On our arrival we found that the home was quiet, appeared calm and there were many staff in the building. This included catering and domestic staff. A senior care worker had the role of administrator and so was able to take calls and make arrangements, such as GP visits. This meant that staff providing care were able to concentrate on that care.

We spoke to five care workers. They told us "we work like a team" and described how their work was arranged using a colour coded system. This said that this helped them to be sure that their tasks were completed and that no person lacked the care they needed. The care workers felt that there were enough staff to meet people's needs.

On the day of our visit there were 27 people using the service. We spoke to the registered manager, who is a qualified and registered nurse, about staffing arrangements. They told us that there was a nurse on duty 24 hours of every day. They showed us records which showed that, when a nurse was not available to cover a night shift, they had provided that nursing cover themselves. They said that each morning there were five care workers and one nurse to care for people and an additional worker, called a hospitality carer, whose role it was to provide breakfasts and hot drinks. In the afternoons there were three or four care workers, a nurse and the hospitality carer. At night there was one nurse and two care workers. Care workers told us that they sometimes did additional shifts but confirmed they were not expected to work unduly long hours, saying "It's our own choice".

During our visit we saw that people were receiving the care they required by care workers who were able to take their time with a task. For example, care workers sat with people assisting them to eat their lunch until they had finished what they wanted.

## 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.

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| ✓ **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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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:

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| 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

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