Donisthorpe Hall

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 14, 17 and 21 March 2016 and was unannounced. At the previous inspection in June 2015 we found seven breaches in regulations which related to safe care and treatment, staffing, person centred care, quality assurance, safeguarding people from abuse, consent to care and notification of significant events. We rated the service as inadequate. At this inspection we found the provider was still in breach of six of the same regulations. We found the provider had made improvements in one area and was safeguarding people from abuse.

Donisthorpe Hall provides residential, nursing and dementia care for a maximum of 189 residents. Care is provided in six specialist units. The management team told us there were 127 people using the service when we inspected. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs. At the time of the inspection, the service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us they felt safe but we found they were not protected from risks associated with unsafe or inappropriate care. People told us there were not enough staff and we observed sometimes people did not receive care in a timely way. The service used a high number of agency staff which resulted in people regularly being cared for by staff they did not know. People using the service were not protected against the risks associated with the administration, use and management of medicines.

Staff did not always receive appropriate training and support although the provider had introduced more training opportunities and was supporting all care staff to complete the 'care certificate' which is an identified set of standards that health and social care workers adhere to in their daily working life. Some senior care workers and managers were undertaking management training. Staff did not understand what they must do to comply with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and did not act within the law. The provider had effective recruitment and selection procedures in place.

People told us they received appropriate care. However, there was a lack of consistency in how people's care was assessed, planned and delivered. There was not always enough information to guide staff on people's care and support. Some people's health and well-being needed to be closely monitored but we found this was not being done properly. People's care records showed they had accessed a range of health professionals.

People lived in a pleasant and well maintained environment. They enjoyed the food and were offered a choice of meals. Drinks and snacks were offered to people throughout the day. People also enjoyed the range of social activities provided at the home and in the local and wider community.

The service was disorganised. The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not always implemented. Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a lack of consistency in how risk was managed. People were not protected against the risks associated with the unsafe management of medicines.

There was not sufficient skilled and competent staff being deployed to meet people's needs.

People were safeguarded from abuse. Safeguarding incidents were reported to the relevant agencies.

Is the service effective?

Inadequate

The service was not effective.

Staff were not always appropriately trained and supported so people may be cared for by staff who do not have the right skills and knowledge.

Key requirements of the Mental Capacity Act 2005 were not fully understood.

People enjoyed the food and were offered a choice of meals. Drinks and snacks were offered to people throughout the day.

Is the service caring?

Requires Improvement

The service was not always caring.

People were complimentary about the staff and told us they were satisfied with the care they received.

We saw people looked well dressed and cared for.

Some people's care records did not have information about their history so they might receive care from staff who do not know or understand them.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There was a lack of consistency in how well people's needs were assessed and their care and support was planned.

People enjoyed a range of social activities.

Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of consistency in how the service was managed.

The systems in place to monitor the quality of service provision were not effective. Actions to improve the service were sometimes identified but then not followed up.

The provider did not take appropriate action following the last CQC inspection. The provider failed to notify CQC about important events that had occurred in the service.

Donisthorpe Hall

Detailed findings

Background to this inspection

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

This inspection took place over three days on 14, 17 and 21 March 2016. Day one and two were unannounced and day three was announced so we could meet members of the management team to provide feedback about our inspection findings. On day one, six adult social care inspectors, an inspection manager, a pharmacist inspector and a specialist advisor in governance attended. On day two, two adult social care inspectors, an inspection manager and a specialist advisor in governance attended. On day three, an adult social care inspector and a specialist advisor in governance attended.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home, information that was shared by the local safeguarding authority, the local authority, other professionals and relatives. We contacted Healthwatch who is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of this inspection there were 127 people using the service. We spoke with 18 people who used the service, 11 relatives, 21 staff, including care workers, ancillary workers, nurses, care managers, activity workers, the registered manager, chief operating officer, operations manager, estates manager and head of human resources. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as rotas, staff recruitment and training records, policies and procedures, quality audits and medicines records. We looked at 14 people's care records.

Inadequate

Is the service safe?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to safe care and treatment because the provider did not have systems for the proper and safe management of medicines and they were not doing all that was reasonable to mitigate risk. They did not have enough competent staff to meet people's needs. At this inspection we found similar concerns. At the previous inspection in June 2015 we found the provider was not safeguarding people from abuse. At this inspection we found they had made improvements in this area.

We looked at how the provider managed medicines and found they did not do this safely.
Electronic medicines administration records (MARs) were in use. On the day of the inspection there was limited access to these. We could only view three people's MARs so we asked the home to provide further examples for us to review. The home printed 27 MARs and we reviewed 16 of them.

We looked at three (MARs) and spoke with the nurses responsible for medicines on the Maple unit. Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, however, stock balance checks had not been carried out regularly. The medicines management policy stated this should be done weekly and this was confirmed by the nurse on duty, but we saw one medicine had not been checked since 22 February 2016.

We checked medicines which required cold storage and found records were not always completed in accordance with the National Institute for Health and Care Excellence (NICE) guidance, 'Managing medicines in care homes guideline (March 2014)'. We saw only four temperature records had been completed out of a possible 14 in March 2016. During our visit the fridge thermometer showed the temperature exceeded the safe range and on two other occasions the temperature had been recorded as over the normal range and no action had been recorded. We asked the unit manager who was unaware there had been a problem with the fridge. This meant we could not be sure that medicines requiring refrigeration were safe to use.

Records indicated temperatures in the treatment room used to store medicines on the downstairs unit were consistently higher than the recommended maximum during January and February 2016.

Nurses recorded administrations on laptops during the medicines round using a barcode scanning system. We were concerned about how long the morning medicines round took on the Maple unit. Three people who were prescribed medicines at 9:00am did not receive them until at 11:41am, 12:06pm and 12:42pm, respectively.

Medicines were not always given as they had been prescribed. One person was prescribed a medicine used for thyroid problems which had been signed 'N' (offered, not required) on five days in February 2016. We checked medication notes and the electronic care notes but there was no entry to explain why the medicine

had not been given. Missing this medicine regularly could have caused the person to become unwell. The dose of this medicine was increased following a visit by the doctor, however, it took five days for the increased dose to be administered. On one day the person had been given both the lower and the increased dose because the old dose had not been deleted from the MAR. This meant they had been given almost double the dose prescribed. The same person had been prescribed a medicine to lower cholesterol which had been signed 'N' on six occasions in February 2016. Again, we checked medication notes and the electronic care notes but there was no entry to explain why the medicine had not been given. In addition, the person was prescribed a medicine for epilepsy which had been signed 'N' on three occasions in February 2016. There was no entry in the medication or care notes to explain why this had not been given. Missing medicines for epilepsy could increase the risk of the person having a seizure.

One person was self-administering their medicines; we checked their records and asked staff and found an assessment had not been completed to assess their capability to look after their own medicines. Staff did not check or keep records of whether medicines had been taken as prescribed. The person told us they never took one of their medicines which was unopened in their room, and staff had not attempted to inform the doctor the person was not taking it.

A third person was prescribed a strong pain relief patch which should have been applied once-weekly. We found this had been signed as 'N' on two occasions, however, the controlled drugs register confirmed the patch had been applied correctly. This meant the MAR did not accurately reflect the medicines which had been given. The patch was due to be applied on 12 March 2016, and again the MAR had been signed 'N'. On this occasion the controlled drugs register showed the patch had not been applied. We counted the number of remaining patches which confirmed it had not been changed. This meant the person may have experienced significant pain. We asked to see records relating to pain scores, but we were told this had not been recorded. This meant staff were not routinely checking whether the person was experiencing any pain which could have resulted in significant distress.

Similar concerns found on the day of the inspection were evident with the 16 MARs we reviewed. Seven people did not receive their medicine as prescribed by their doctor as the home had run out of stock; one of which was a heart medicine and another person's medicine for diabetes. Paracetamol was given too early for four people as the minimum time interval between doses was less than four hours. One person who was taking a blood pressure medicine that should have been given once a day in the morning was given a dose at midnight on one day and then another dose on the following morning medicines round which would have been over the recommended daily dose.

We concluded the registered person was not managing medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at how the provider was assessing and managing risk, and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe; however, other systems were not effective so people were not protected.

People had assessments and care plans that should identify areas of risk and action to help keep them safe; we found these were not always effective. For example, one person was assessed as 'severely underweight' but when we looked at their records we saw appropriate action was not taken. Another person was given salad at lunch; their care assessment showed they were at risk of choking and should have been offered a 'soft fork mashable' diet. One person had fallen several times, and had sustained injuries but changes were not made to their assessment and care plan, which would have helped identify how to prevent repeat falls. We saw some examples where risk was managed effectively. Assessments, in one unit, contained key areas

of risk, such as bathing/showering, falls and pressure care, and had been reviewed regularly and updated where appropriate.

We looked at two people's care records which showed they sometimes got angry with others and displayed behaviours that challenged. They did not have assessments relating to their behaviour so the level of risk was not assessed and care plans did not contain information to guide staff.

All staff we spoke with said they would record and report accidents and incidents but when we looked at records we found this was not always happening. For example, there were ten incidents in one person's daily notes which included attacking staff but no incident forms had been completed. Another person had several falls but accidents forms had not always been completed. We concluded the registered person was not assessing the risks to the health and safety of service users and did not do all that was reasonable to mitigate risk. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had reintroduced an emergency evacuation system which was known as a 'traffic light system' (red, amber and green) to indicate the level of support people needed in the event of an emergency evacuation. This involved using colour indicators on people's bedroom doors. Staff we spoke with understood the indicators and could tell us what they would do in the event of a fire. In some units there was a listing which showed the name of people living on the unit along with their moving and handling needs which had been rated as red, amber, or green; whereas in other units, lists were not up to date and staff did not know where these were kept. The management team who was responsible for estates agreed to make sure the emergency evacuation lists were updated and readily available to ensure people's safety.

We visited all units and looked around some bedrooms, bath and shower rooms and various communal living spaces. People lived in a pleasant and well maintained environment. At the time of the inspection we saw the home being decorated and one of the decorators confirmed this was an on-going programme, which ensured the home's standard of décor was maintained. Service records and certificates showed the building and equipment were checked to make sure they were safe. A schedule was in place to make sure checks were kept up to date; this was rigorously adhered to and it was evident this aspect of the service was very well managed.

Some staff we spoke with had a good understanding of how to manage risk. For example, they described the hazards people may face when bathing or showering. They described risks due to poor mobility and what they did to prevent this; for example, making sure people had the right equipment and aids in place.

We found the provider did not have enough competent staff to meet people's needs. People told us they did not always feel there were sufficient staff to meet their care and support needs. These were some of the things they said, "I don't think there is enough staff as they seem to be run off their feet", "I have raised issues about the lack of staff at residents' meetings over the past couple of years", "Sometimes we have to wait a long time for staff, we are told there is a shortage", "Care is ok, just waiting on call bells. Think they are short staffed", "It's not easy waiting for someone to support you to the toilet. You feel like saying something you should not", "They are always changing staff. You never know who is coming to attend to you. They tell me they are from the agency, but I don't know them"; "There is a high turnover of staff. I don't think they are paying them enough to keep them", "The staffing is ridiculous. Sometimes you have to wait ages to be served your meal. The place is badly run. The buzzer could ring for half an hour. The staff are dissatisfied .This is a good place if you have dementia you don't know what's going on", "No there isn't enough staff, sometimes you are calling for staff and they take a long time", "No one helps me I always ring down for people to come and make my bed". Some people told us there were enough staff.

We found visiting relatives also had concerns about staffing levels. One relative told us, "We are always worried about staffing levels. Staffing problems are always raised at relatives and resident meetings." Another relative said, "A few weeks ago, [name of person] was told, sorry you had to wait but I was dealing with other people. My [name of person] was waiting a good 20 minutes before anyone came and they were getting distressed." Another relative said, "On weekends there are less staff than through the week. [Name of person] came to visit my mum and there was no staff in the dining room. Other people were in there sat at the table with their food and no one to support them."

During the inspection we observed some people received prompt responses when they requested assistance but we also saw occasions where people did not receive appropriate support because there were not enough skilled and experienced staff. In one unit two people should have received one to one staffing support but there were not enough staff on duty. The member of staff in charge told us, "The staff are over stretched. We have to prioritise. People have a sensor so staff are checking but they have to leave the room where they are supposed to be. The baseline is there is not enough staff." On another occasion, one person was in pain, so staff had to ask another member of staff to leave their training session so they could administer medication. On another occasion staff told us they were short of staff. They said ten out of the 17 people on the unit required assistance from two staff. One member of staff said they should have four care workers and one nurse on duty but at the time they only had three care workers and one nurse. On another occasion, one person had requested assistance because they wanted to go to the toilet. They had to wait, did not getting to the toilet in time, which resulted in them being incontinent. We looked at staffing rotas but it was very difficult establishing staffing levels. The rota system was confusing and different pieces of information gave a different picture. A member of the management team who was overseeing staffing arrangements told us this had been an ongoing problem so they had very recently decided to plan staffing centrally rather than at unit level. This had only just been introduced so was in the early stages. The information available indicated some units were appropriately staffed whereas other units were not. For example, over an 18 day period, we found one unit was not fully staffed on eight occasions during the day and on two occasions during the night.

We observed call bells were ringing. We were told response times were not generally monitored. One person's response times were investigated in response to a complaint and this showed areas of concern such as failure to respond in less than 12 minutes on three occasions and failure to respond until after one hour and 13 minutes on another occasion during a six day audit.

We got a mixed response when we spoke to staff about staffing arrangements. Some staff we spoke with told us they sometimes felt under pressure. One staff member said, "I don't think we get to call bells quick enough because they are always going off and there are not enough of us to go round." Another member of staff said, "One day there was just two staff on, last Saturday. It is hit and miss, the staffing. There are 10 people who need two to one care and there are times when we don't have two staff to help." Another member of staff said, "At times we use a lot of agency so they don't always respond as quick." Another member of staff spoke about agency usage and told us, "Compared to what it was, it's heaven." Two members of staff told us when they were staffed to the planned numbers they had sufficient staff to meet people's needs as long as everyone worked as part of the team and 'pulled their weight'. One of the members of staff said the nursing staff did not do this; they often refused to be part of the team and would not help with getting people up, washed or bathed.

Members of the management team told us the staffing levels were not safe and raised concerns about the high usage of agency staff. The registered manager said they were concerned that the agency were not able to provide the home with sufficiently skilled/experienced qualified nurses with the awareness and knowledge around dementia care. She said, "At times, the registered nurses only seem to have a PIN and a

pulse." We looked at records which showed in the month of February 2016 the ratio of qualified nurses was over 50%. Eight nurses were required to work during the day; some shifts were covered by permanent staff but others were covered with mainly agency staff; on one occasion seven out of eight staff were agency workers. The registered manager and provider had already taken action to address some of the difficulties by closing one of the units and were looking at other options to improve the overall staffing arrangements. We concluded there were not sufficient numbers of suitable staff deployed throughout the home. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We found the provider had introduced better systems to help make sure people were safeguarded from abuse. Staff we spoke with understood safeguarding procedures and were clear they had to report any concerns to a member of the management team. They told us they had received safeguarding training. The provider had recently updated their safeguarding policy and had issued staff with leaflets and advice cards. We asked several members of staff about people's finances. They told us the systems in place safeguarded people because money was not held on any of the units, and people could purchase personal care items and food and drink from the café but did not have to pay for these at the time.

People we spoke with said they felt safe living at Donisthorpe Hall. These were some of the comments people made, "Yes I do feel safe, I know no one will come in and attack us or take our things", "Yes, no reason not to be", "Safe that's the only reason I am here", "Yes I like it here I feel safe in my home", One relative told us, "Yes [name of person] feels safe here."

We looked at care records and saw where safeguarding incidents had occurred appropriate action had been taken in response. The registered manager explained they had met as a management team and clarified what needed referring and reporting to the local safeguarding authority and CQC. Our records showed the provider had notified us when safeguarding incidents had occurred.

The home followed safe recruitment practices. We looked at staff and volunteer recruitment records and found relevant checks had been completed before staff had worked unsupervised at the home. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. A member of the management team who oversaw staff recruitment showed us they periodically carried out DBS checks to make sure existing staff were still suitable. Another member of the management team who oversaw recruitment of volunteers said they DBS checked all volunteers when they commenced and were introducing a system to renew these for volunteers that had worked at the home for a prolonged period.

Inadequate

Is the service effective?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to supporting staff and consenting to care. At this inspection we found similar concerns.

When the provider submitted the PIR in December 2015, they told us 171 staff delivered regulated activities at Donisthorpe Hall; this included providing personal care. They told us 147 staff had been employed for more than 12 weeks but only 77 members of staff had completed many of the key training sessions such as health and safety, safeguarding adults, dignity, respect and person centred care, food hygiene, prevention and infection control and emergency awareness. They said 144 staff had completed moving and handling. At the inspection we saw training records which indicated less than a third of staff had received some key training, however, it was difficult to establish if all training completed had been captured on the data we reviewed. The information provided to us indicated that less than a third of staff had completed fire training in the last 12 months. We spoke with a member of the management team who was responsible for facilitating fire training. They were confident all staff had received fire training within the last year and showed us records that evidenced a much higher percentage of staff had attended fire training than the figures we had been given at the start of the inspection; this included signed attendance records. The human resources manager said they could only input data on the central training system that was provided by care leads from each unit. We received some information about staff training but then additional information suggested this was incorrect.

We looked at the induction pack which was given to newly appointed staff and saw this was comprehensive and included essential information such as clear advice on whistleblowing and safeguarding. We saw the provider was supporting all care staff to complete the 'care certificate' which is an identified set of standards that health and social care workers adhere to in their daily working life. Staff who were appointed and had already achieved the care certificate were assessed to ensure they met the required standard. Several staff told us they had benefitted from doing the care certificate training. The provider was supporting some senior care workers and managers to undertake management training.

Supervision and appraisal records indicated staff were not receiving regular supervision and most staff had not been appraised in the last 12 months. Supervision is where staff attend regular, structured meetings with a supervisor to discuss their performance and are supported to do their job well.

We received a mixed response when we asked staff about staff support and it was evident staff were unclear who was responsible for carrying out supervisions and how often. Some staff said they had received regular supervision sessions; others said they had not. One member of staff who was in charge of a unit told us supervisions were held every three months. Another member of staff in charge of another unit and had worked at the home for six months stated supervision records were kept with the care management team and human resources did everyone's supervision. They said they had received one supervision session since starting with the home. A member of staff who had worked at the home for four months said, "I sat with the unit manager to see how things were going but this was not recorded. The first formal supervision was at the end of three months. I am expecting another at six months." A member of staff who had worked at the home

for four months said, "I have had moving and handling training. I had a mentor when I started and completed a week of shadowing. My probation was for three months but was extended to six months. This is done for everyone." Another member of staff said, "I have a chat once a week but not sure if this is recorded. I don't have supervision throughout the year. I have had an annual appraisal with human resources."

We were told the provider did not have a supervision policy or any guidance around the frequency of supervision. The head of human resources said a policy was being drafted. We saw a recruitment policy that stated staff should receive supervision after one month, two month and three month. We saw from the supervision records this was not being provided to new members of staff.

Two members of the care management team told us they had identified staff were not receiving regular supervision and had introduced a matrix to help ensure all staff received supervision every two months. We saw a copy of this which was due to commence at the beginning of April 2016. We concluded that staff were not receiving appropriate support, training, supervision and appraisal as was necessary to enable them perform their job safely and appropriately. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. (The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).) It was evident from discussions with staff and management, and reviewing documentation there was a lack of understanding of the legislation.

In the PIR the provider told us 31 people were subject to authorisation under DoLS. We looked at a spreadsheet which indicated only four people were subject to authorisation under DoLS. We asked the registered manager to confirm the actual number but they were unable to tell us this. We got a mixed response when we asked staff about people who were subject to authorisation under DoLS and it was evident they did not know. One senior care worker told us applications had been submitted to the local authority but were not yet authorised; we saw copies of these in people's care files. The senior care worker told us they had contacted the local authority to check on the status. However, there was no written evidence of these discussions. In another unit, the nurse in charge told us they were unsure if anyone was subject to authorisation under DoLS but said they had applied for one for 'everyone' which showed a lack of understanding regarding people's capacity. We saw a spreadsheet in the same unit that indicated two DoLS applications had been submitted in December 2015 and January 2016.

We looked at people's care records and found that sometimes mental capacity assessments were not completed even though a DoLS authorisation had been submitted. In one unit a senior care worker told us, "I would say everybody here does not have full mental capacity." However, when we looked at three care files on the same unit we found two people did not have appropriate mental capacity assessments; one person did not have an assessment and the other had an assessment but it referred to 'he' rather than she.

Staff we spoke with did not generally understand what they must do to comply with the MCA. One member of staff said, "I don't know, I am still learning. Most cannot communicate their needs and most are bed bound." Another member of staff in charge of one unit told us mental capacity assessments were kept in finance. One member of staff gave an overview of the MCA and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. For example, making sure

people were supported and given time to make decisions such as what to wear, what to do and what to eat and how they did this. They spoke about always making sure everything they did with people was in their best interests. A member of the management team who oversaw care planning and assessments told us they were involved in the MCA or DoLS processes because the registered manager oversaw this aspect.The training records we reviewed showed 49% of staff had completed DoLS training, and in the PIR the provider said 77 staff had completed MCA and DoLS training. We concluded that staff were not acting in accordance with the MCA. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need to consent.

We saw drinks and snacks were offered to people throughout the day. People we spoke with said they mostly enjoyed the meals and always had plenty to eat and drink. Daily menus were displayed showing up to six choices per course. Pictures of meals were added in some areas to assist people in making choices. People told us they had a choice. Comments included, "They try to please you, there are always choices and if they don't suit, they will offer you other things", "Breakfast is the best meal of the day, the rest is a lot to be desired", "Food is very good, Plenty of it. We get cups of tea and biscuits and fruit is always out", "There is plenty of food and you can choose what you want", "The food is good but I don't think it's prepared right, there's no seasoning so it tastes bland. The menu choices are written down each morning." Staff told us the food was good and there was plenty of choice.

We observed at least one meal time in all units and saw in the main, people had a good experience and received good support. Tables had cloths and were set with serviettes and condiments. In some units we saw people were given plastic cups for their drinks. Members of staff, referred to as 'hosts' helped organise meal times in the units. We observed breakfast experiences and saw people were offered a range of hot and cold food, which included finger foods. One person received support to eat their porridge but then enjoyed eating some sandwiches independently.

In one unit, people received good support at lunchtime, and ate in an unhurried and relaxed atmosphere. During the meal staff chatted with people and were considerate and patient when helping people choose what they wanted to eat. We saw staff offering alternatives to people who did not want the menu choices. Five people were assisted to eat their meal by members of staff who remained focused on the person they were supporting. They chatted with them and explained their action at every stage. In another unit, five people were in the dining room, two people were in a small lounge and everyone else ate in their room. A host was serving people in the dining room, and care staff were serving and supporting people in the small lounge and in their rooms. Cold drinks were offered and people were asked what they would like to eat.

We observed lunch in one unit which was chaotic. People did not always receive good support, and one person waited 40 minutes before they received assistance. In another unit, we saw staff assisted people to the dining room and were respectful and kind as they did this. However, at the beginning of the meal, only one member of staff was in the dining room with ten people; two staff were supporting a person with personal care. Some people were waiting for staff to cut up their food and people did not receive a drink until 15 minutes after they had started eating. One person asked for a drink which then triggered the member of staff to ask others.

We spoke with the chef who discussed the catering arrangements. They told us everything they made was fresh on the day. They said they used certain suppliers and were never restricted when purchasing provisions. They told us they were aware of people's nutritional needs and had up to date documentation about people's individual dietary requirements. We saw this was updated regularly, however, we found it did not include one person who required a 'soft diet'.

People told us they received effective support with their healthcare needs and saw health professionals such as opticians and GPs. One person told us, "The Doctor comes straight away if we are ill and they get you to hospital if you need to go." Another person said, "When I have to go to the hospital they always send a member of staff with me." A visiting relative said, "I am quite content with [name of person] being here as I know she is well looked after, with GPs and dentist."

Staff we spoke with told us people's health needs were met. One member of staff said, "It's important to report things so that things can be nipped in the bud, much better to get early treatment such as antibiotics." They also said there were systems in place to make sure people were accompanied to hospital appointments; both planned and emergencies. They said, "We never send someone off alone." They also said people who used the service could attend health care professionals such as dentists in the community and they frequently did. Another member of staff said, "Doctors come in when we need them. We also communicate by phone."

We saw from people's care records they had accessed a range of health professionals and included GPs, opticians, dieticians, speech and language therapy, dentists and district nurses. However, we saw there were also examples where people's health had deteriorated and other health professionals were not consulted promptly. For example, when someone lost weight. When we identified any concerns during the inspection we raised these with an appropriate member of staff who agreed to ensure these were followed up.

Requires Improvement

Is the service caring?

Our findings

We received mainly positive feedback from people who used the service and relatives about the care they received. People we spoke with were complimentary about the staff. Comments included, "I have had respect and kindness shown to me", "The staff are lovely, just very busy so don't have time to chat", "Staff are fabulous. There are lots of staff changes though I am unsure who people are". One person told us their experience was inconsistent. They said, "Staff generally speak to me with respect but it varies on the member of staff." A relative told us, "All staff are very obliging even the agency staff." When we asked people if staff understood how to meet their needs, one person said, "Staff understand my personal care needs and always ask how I feel." A relative told us, "Yes my mum is never upset or has mucky clothes on. Some days they may only have a couple of staff on though, think it may be down to staff holidays."

During the inspection we saw on occasions, in different units, staff were kind and caring in their approach with people. Staff were patient and gave people time. Staff talked to people who used the service in a friendly and respectful manner. We saw examples when people were distressed staff provided reassurance and comfort. People were comfortable and relaxed around staff. During meal times we saw people received individual support from staff. In one unit, we saw breakfast was very well organised and staff provided different levels of support to meet people's individual needs. For example, one person received dedicated staff time and were given assistance to eat. Another person was encouraged to eat but then given support when they started to struggle. Another person received prompts and lots of encouragement to eat independently. In the main, we observed good care practices, although in one unit we noted staff did not always interact well with people and focussed on the task rather than the person. In another unit, we saw a member of staff who had assisted a person to eat then use the handle of the same spoon to stir another person's drink. One person was having soup but the spoon being used was too big. A member of staff took a teaspoon from the sugar bowl and was wiping this with a serviette ready for them to use. A member of the inspection team intervened and asked the member of staff to use a clean spoon. During the morning, some people were being weighed in the small lounge; this was not done in private to ensure people's dignity.

The home has a longstanding association with the Jewish community in Leeds. There was a synagogue on site and all meals prepared met Jewish dietary requirements, known as Kosher. The service also offered care to people of other faiths and beliefs.

We looked at care records to find out how staff understood people's history, likes, preferences and needs. Some people had care plans that provided good information. We saw people had 'resident details' and a 'pen picture-life', which provided details about their background. They also had one page profiles which were available for staff to familiarise themselves with the needs of people. They covered 'what is important to me', 'what I don't like', 'how best to support me with my care needs', 'how best to support me at meal times' and 'people who are important to me'. However, we also saw that people's 'life history section' was sometimes blank and one person's 'one page profile' which provided an overview of their care needs, was out of date and had taken three months to change. We found there was a high usage of agency staff, therefore, having up to date information is very important when staff are not familiar with the person they are supporting.

People who used the service told us they made choices regarding the support they received. One person told us, "I get up and go to bed whenever I want to, you can sleep all day if you wish." Another person said, "It is my choice when I get up for instance, they are days when I fancy a good breakfast so I get up early or if I have to go somewhere." Another person told us, "I can do what I like, when I like and how I like it." Staff we spoke with said people were given choice. One member of staff said, "It's important to ask people how they like things, what they want to do and to ensure choices are respected."

People said staff supported and encouraged them to do things for themselves. They also described ways in which they felt the staff treated them as individuals and knew their preferences. For example, one person said, "They always knock on my door and ask if they can come in. " Another person said "Staff know me well and I feel listened to." Staff we spoke with said they provided good care and were respectful of people's privacy and dignity. They said it was important to ensure people had privacy, for example, when bathing or going to the toilet and to encourage as much independence as possible.

We saw people looked well dressed and cared for. For example, we saw people were wearing jewellery and some people had their nails painted and hair was nicely styled. People told us they chose their own clothes.

People and their relatives told us they were free to make visits at any time, and we saw visitors were made welcome when they came into Donisthorpe Hall.

We noted information was displayed in the home to help people understand their care. This included information about the home and what people should do if they were unhappy about their care. The previous inspection report was displayed in the entrance; an information sheet titled 'what we have done since CQC inspection' was available.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to person centred care. Some people's care plans did not identify how care should be delivered and had not been updated when their needs had changed. At this inspection we found similar concerns.

People provided generally positive feedback about the care they received but told us they did not feel involved in identifying how their needs should be met. One person said, "I have had no input into my care plan no one ever asks me about it." Another person said, "When I came a few years ago I was asked about things and they wrote it down since then I have not seen anything they have written." Another person said, "I don't know what that is." Another person said, "I am unsure of a care plan." One visiting relative told us, "I am not involved in [name of person] care plan." Another visiting relative told us, "I was initially asked for input but that's about it."

The service used mainly electronic care records although some checklists and charts were paper based. We looked at care plans and saw there was very little evidence to show how people had been involved in developing their care plan, In one unit we reviewed two care plans and neither had any evidence to show how people had been involved.

Some staff we spoke with said the care plans gave them enough information and guidance on how to provide the support people wanted and needed. Staff said they were encouraged to report changes in needs and these were acted upon promptly. One member of staff said, "We deliver person centred care and have the time to do so most of the time. I will not rush anyone; it's not about rushing people."

We saw evidence of pre-assessments which were completed before people moved into the home. Care plans covered communication, medical history, eating and drinking, interests and hobbies, mental health, night care, personal hygiene, personal relationships and religious and cultural needs. However, we saw there was a lack of consistency in how care plans were completed. Some were informative and described what staff must do to meet the person's needs; others did not contain enough information. Care plan audits were not being carried out effectively so omissions were not being picked up. Reviews were generally taking place, and sometimes on a monthly basis, although there was often little evidence of change, to show a meaningful review had taken place.

One person had a section in the care plan for 'bowel and continence' which contained good details of their needs. An advanced care plan stated they had a 'Do Not Attempt Cardiopulmonary Resuscitation' in place which should be reviewed every three months; we saw this was being reviewed correctly. Another person's care plan stated they must wear their call bell pendant to ensure they could request assistance. We observed the person wearing the pendant.

One person's eating and drinking section in the care plan stated to 'document dietary intake for three days. If no improvement follow local policy.' Daily notes and food intake were not recorded for three days. Another person's interest and hobbies section stated 'Likes to listen to music and engages with staff'. [Name person]

to have opportunity to engage in activity' However when we looked at records they showed the person was only engaging in activity once per month.

It was difficult to establish if people's personal care needs were being met although people looked clean. In one unit, we saw entries on the electronic care record system which showed people were having a bath or shower, although the entries were occasional. One person's care record showed they had only been bathed five times in over three months. Another person's care record showed they had been bathed only five times in two months. We spoke with a staff member who told us agency staff did not always record where they provided this care, although they did say agency staff were given their own login and password to add entries. In another unit, one person's care plan stated they had between one- two showers per week. We saw they had regular showers in February 2016 but no showers had been recorded in March 2016. In another unit, one person's record showed they had a bath or shower on only six occasions between 1 January and 14 March 2016. Another person's record showed they only had three between this period. We asked staff about arrangements for bathing and showering. One member of staff said, "You get a gist of what is going on. We always record if people have a bath or shower." The nurse in charge said the records were accurate and staff were giving people a daily wash. Another member of staff said, "The electronic system has good information. We record baths and showers under routine notes and not as a specific activity."

We were informed by staff that they completed checklists to make sure people's needs were being met. For example, a fluid chart for everybody, and a 15 minute checklist for people who were in their rooms which included checking if they were ok, wanted a drink and had not fallen on the floor. We looked at some of these checklists and found they were incomplete and did not provide assurance that people's needs were being met. For example, one person's recommended fluid intake was calculated at 2059mls but their fluid chart over a five day period indicated they had only received the recommended intake on one day. Another person's recommended fluid intake was calculated at 1923mls but their fluid chart indicated they had only received between 960mls and 1425mls. We looked at the 15 minute observation records and again found these were incomplete. One person's fluid chart indicated they had insufficient fluid over a 24 hour period. Staff had noted the person's urine was dark and strong smelling but there was no evidence they had taken any action. We shared these concerns with a member of the management team who assured us they would take prompt action. We concluded the care and treatment of people using the service was not appropriate, and at times, did not meet their needs. The provider was not carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of people using the service. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We saw there was a scheduled and varied programme of social activities, which people told us they enjoyed. Some told us the range of activities had improved. One person said, "There are quite a lot of activities that I like to be involved in. I like quiz, bingo and music." Another person said, "I like to read a lot and make good use of the library." Another person said, "Whatever is taking place I join in, there's always something going on. Best of all is the exercise class." We saw information in the reception area and on the units about planned activities. People told us they were able to maintain links with the wider community. One person said, "I go out into the community, we go shopping in town sometimes. You can take part in as many or few activities as you want." Two people felt activities could improve. One person said," There is not enough activities, I enjoy going out, but it's mostly people who need support go out in the community." Another person said," I want to get out in the garden but there's no one to help me as I used to walk out myself before."

During the inspection, we saw social activities included an outing to Roundhay Park, keep moving, choir, film and in the evening bingo. Other activities on offer included 'book club', quiz, film afternoon, sing a long,

computers and listening to audio books and table tennis. One person who was going to Roundhay Park said "I like getting out when the weather is nice."

The service had activity workers who planned and co-ordinated activities. Volunteers helped facilitate activities. A member of the management team oversaw the activity and volunteer programme. Activity planner sheets were displayed in the units and evaluation sheets were completed after each activity. We looked at some of the activity records and saw people participated in a wide range of activities.

Staff we spoke with said they thought people had enough to do. They described the types of activity on offer to people. They also said that if they could be spared from the unit they would sometimes accompany people who used the service on activities. One member of staff described how they had supported someone to attend bingo. They said the person had been too anxious to go alone so it had been arranged for the staff to go with them. They said this person was now going to the concerts in the home without staff support.

The provider had displayed information about how to complain in the home, giving people the contact details they needed. Complaint and suggestions leaflets were available in the entrance hall. Some people said they would raise concerns but others expressed hesitation. One person who used the service said, "If I have had to complain they have done something about it." Another person said, "I don't want to get into trouble, I made a complaint about things including shortage of staff and was made to feel I was mad." Another person said, "I don't like to start trouble but I would get them told." A relative told us "I don't have any complaints, I can't recommend it highly enough and am thrilled [name of person] got a bed here. The home got [name of person] a large adapted remote so she could turn the television over herself without having to ask people to do it for her." Some concerns were raised because people did not know who was in charge or who they could talk to if they wanted to discuss any concerns. One person said, "If I wanted to complain I would but I don't know who to go to." Others said they would speak to whoever was in charge.

One visiting relative talked about a recent experience where they had raised a concern. They had contacted a member of the management team about a potential risk relating to the premises and told us prompt action was taken in response to the concern. A member of staff discussed another recent incident where a relative had raised a concern about delayed medication, which had led to a change in care practice They said they believed it was reported to safeguarding. There was no record of the concern/complaint/safeguarding or what action had been taken or how the investigation had been completed.

When we asked about formal complaint records we were told by a member of the management team that most units did not deal with these; one unit had a formal complaint record file but this was empty and the member of staff in charge said they had not received any written complaints. We looked at complaints held centrally and found these were coordinated by a member of the administration team. Complaints received were logged and acknowledged, and then sent to the registered manager to review and commence investigation. On completion of the investigation, a response to the complainant was made. This process was usually completed within two weeks.

We saw people had provided positive feedback and complimented the home. One unit had received nine compliments; several complimented staff and thanked them for their 'kindness and caring attitude'.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager. They were registered as a 'registered manager' by the Care Quality Commission in December 2015 so were not in post at the inspection in June 2015. At the previous inspection we found breaches in regulation relating to good governance because the quality assurance systems were not effective. At this inspection we found similar concerns.

The registered manager was supported by a management team, which included the chief operating officer, an operations manager, estates manager, head of human resources and two care managers. The registered manager said they were actively recruiting additional care managers. Each unit had a designated lead which dependant on the type of unit was either a registered nurse or senior care worker.

We got a mixed response when we asked staff about management and leadership. Some felt the service was well managed whereas others did not. Several members of staff said the registered manager visited the units daily. A member of the catering team said, "We work really hard; it's a good place to work. Management are great." Another member of staff said, "[Name of care manager] comes to make sure things are being done right." Another member of staff said, "It's definitely got better, they are trying to get everybody on board with the paperwork. I think it is working." Another member of staff said, "It's really poor. It's just hopeless. Changes are made without communicating them to staff until they are in place." Another member of staff said, "I think every unit should have a permanent manager; I find it awkward because there is no one for guidance or advice. We definitely need unit managers to manage the units." A member of staff who had worked at the home for four months did not know who the registered manager was. A visiting relative told us there was a lack of communication from the home, and gave an example where important information about their relative was not shared with them.

During the inspection we found it was difficult to locate information and establish what systems were in place for gathering, recording and evaluating information about the quality and safety of the service. We received different information from members of staff and managers. We were shown different records which provided conflicting information. There was a lack of organisation and systems were not operated effectively. For example, in one unit, we struggled to establish staffing levels. We began by looking at rotas held on the unit. These did not show what was actually worked. The nurse in charge told us there was a rota book kept by the care management team but when we reviewed this it showed similar to the unit rota. A member of the care management team suggested using handover records to look at numbers and skill mix of staff who had worked. We reviewed the handover records and were then told by another member of the care management team that these would not be accurate as "staff don't complete these properly, can't get them to do." They said the 'Daily requirements' sheets were an accurate record of what was worked on each unit. However, these records did not use staff surnames so it was confusing when permanent staff or agency staff had the same first name.

We looked at audits and found there was a lack of consistency in how and when these were carried out. The registered manager told us a medicine IT system (EMAR) had recently been introduced which could facilitate medicine audits. However, at the time of the inspection the registered manager said there was no audit

evidence available. A member of the care management team said they had previously done some medicine audits but these had not been written up. A clinical audit was due in January 2016 but had not been undertaken. There were no dignity audits.

The registered manager said monthly care plan audits should be completed and they had tried to make this a priority of the nursing staff. However, we found these were not being completed. In one unit, we saw on the office wall there was an overview of when care plan reviews and audits were due. However, there was no documentary evidence provided that actual audits were carried out. In two other units we were told there were no care plan audits. A member of the care management team told us the registered manager was responsible for carrying out the audits. We saw from minutes that, at a meeting in February 2016, nursing staff had been informed that failure to complete care plan audits was a disciplinary offence. However no disciplinary action was undertaken even though care plan audits were not being carried out.

The registered manager said mattress audits were undertaken monthly, together with a hand hygiene audit. We saw a number of mattress audits which were kept in the relevant units. However, they were not available in all units.

A 'care audit' was carried out by two members of the management team in October 2015. Several issues were highlighted such as, catering assistants were not serving meals (nursing staff were), there was a slow response to call bells, nurses were distracted during medicine rounds and there was a lack of protected meal times. We saw action was taken to address some of the issues; catering assistants were serving meals and nurses wore 'red 'do not disturb' tabards when they were administering medicines. However, we found meal times remained unprotected and there was no system for checking call bell response times.

The service did not carry out a formal 'end of Life' audit programme. However, we saw there were some reflections after people had died; this is good practice and helps a service learn and improve their end of life care delivery.

We asked staff about accident and incident reporting but were told different systems were in place. Some said they sent incident forms to the care management team and others said they sent forms to a member of the administration team. Once logged centrally, they were sent to a third party company for review and reporting. This was a recent development and information was only available for incidents over the past four months. The report indicated the type of incident but there was no evidence of how patterns or trends were identified within the service. There was no breakdown of incidents that had occurred within each unit. A member of the management team said this was an area that was being developed.

We saw that following some accidents/incidents, a 'root cause analysis' (RCA) was carried out and actions were identified to reduce the risk of repeat events. However, when we looked at three of these in more detail, we found these were not comprehensive. For example, a RCA was undertaken after one person left the home despite their care plan identifying them at risk and to monitor closely. The RCA focussed on the CCTV recordings which showed incorrect times and required the clocks to be synchronised. When we checked the CCTV system there was a discrepancy of 15 minutes. Another person sustained a serious injury and it was evident there was a delay in seeking medical assistance. Following the RCA, no staff member was disciplined, nor was there evidence of staff being informed formally of the need for prompt action. Another person had several falls but appropriate action was not taken to reduce the risk of repeat events. A number of accident records stated 'manager's investigation recorded' and 'increase staff awareness' and 'staff to continue to be vigilant'. However, when we looked at the person's care plan this did not make any reference to staff awareness or vigilance. The care plan stated 'mobility with assistance'- falls risk assessment to be reviewed monthly or post fall. We saw the falls risk assessment had not been reviewed after a fall. The

person last fell four days before the inspection. We brought these concerns to the attention of a member of the management team who assured us they would ensure appropriate action was taken.

The provider undertook quality assurance surveys and sent them to three separate stakeholders: people who used the service, relative/friends and staff. The response rates were low with only 16 from 145 sent to people who used the service returned (11%), 24 from relatives/friends (18%) and 30 from 220 staff (13%).The feedback from people who used the service and relatives was generally satisfactory. However, the one from staff was contradictory; the preference indicator (Likert scale) showed staff were satisfied but the free text comments did not reflect this. There was no specific action plan to address the survey results although the registered manager said there were plans to introduce a staff forum/council in the future.

Most people we spoke with were aware resident meetings were held. One person told us, "I am not interested in going to these meetings." Another person said, "Yes I go to the meetings regular we discuss if we have any issues or want anything changing." Another person told us, "I am unsure of any resident meetings." We saw there was a 'resident's welfare group' which was chaired by a trustee.

The registered manager said staff/team meetings were held but had not been minuted and attendance was not recorded. The last staff meeting minute the registered manager could locate was dated June 2015. We asked in individual units but most said they did not hold meeting minutes; one unit showed us minutes from a meeting held in January 2016. Another unit had a staff meeting file which showed the last meeting took place in June 2015, however, the minutes contained no evidence of 'feedback around concerns' or 'lessons learned' where staff could use the opportunity for learning. One member of staff told us a recent meeting was held and they had been able to put points across and had felt listened to. They said this had mainly been about workload issues and some team members not 'pulling their weight'. Minutes for this meeting were not available. At the inspection we identified there was a lack of gathering, recording and evaluating information about the quality and safety of the service and concluded the provider's systems and processes were not operated effectively. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

At previous inspections we have reported that the provider has not always notified us about important events. It is an offence not to notify CQC when a relevant incident, event or change has occurred. At the last inspection we found the provider had notified CQC about some significant events such as deaths and serious injuries, however, they had not sent any notification of abuse or allegations of abuse. We said we were dealing with this breach separately and would report on this when the work was complete. After the inspection in June 2015, we monitored notifications of abuse or allegations of abuse and found the provider was sending these through when incidents arose. At this inspection, we checked a number of safeguarding cases and found we were notified about these. We concluded the provider had sent notifications of abuse or allegations of abuse. However, we found they had not sent any notification to CQC about authorisations to deprive a person of their liberty, which is a notifiable event. It was evident at this inspection they were again failing to report notifiable events. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents.