Sure Healthcare Limited

Derwent House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on the 8 September 2015. The inspection was unannounced. At the last inspection carried out in January 2014, the home was meeting all of the regulations.

Derwent House Residential Home provides personal care and support for up to 65 older people, some of whom may be assessed as needing nursing care or have dementia care needs. The home has two units Riverview Lodge, which is a newly registered unit for people living with dementia and Derwent House, which is a unit for older people who may also require nursing care. The service is set in a rural position, east of the City of York. There is ample car parking on site. On the day of our inspection there were 38 people living at the home.

Summary of findings

The service has 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 and there were systems and processes in place to help safeguard people living at the home.

We saw that risks to people were recorded within individual risk assessments. Maintenance and health and safety checks were carried out on the premises to ensure that they were safe.

Recruitment checks were carried out before staff started work to check that they had been assessed as safe to work with vulnerable adults.

There had been issues with staff recruitment which the registered provider was trying to address as an on-going recruitment drive was in place and we saw evidence that the registered provider was trying to recruit new staff. However the registered provider needed to monitor this closely as some people felt that staffing issues were impacting on care delivery.

We were told that medicines were being left in people's rooms which is poor practice and meant that people may not be receiving there medicines as prescribed. Although we did not observe this practice we were told this both before and during our visit. We have recommended that the registered provider assesses their medication systems so that they can be assured people are receiving their medicines safely and as prescribed.

The service was clean and smelt pleasant during our visit. Pest control had recently carried out some work and we saw that domestic staff were available.

New staff received an induction when they commenced employment although one staff member told us that this had not taken place.

There was evidence that staff received training to support them in their roles although some further service specific training for example in dementia care may be of benefit.

Supervision was not taking place as frequently as it should have been which the registered manager had identified and was trying to address.

People were supported to make their own decisions and when they were unable to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

People received a varied choice of meals and their likes and dislikes were taken into account. Where concerns were identified regarding people's nutritional needs, access to relevant professionals was sought.

People had access to health care services which included visits from the GP and district nursing service.

People told us they were well cared for and liked living at Derwent House. People told us they were treated with dignity and respect by staff.

People had detailed care records in place to record how they should be cared for and the support they may require. These records were reviewed regularly.

The home had systems in place to audit the service provided. People's views were sought and meetings were held to seek people's views. However staffing numbers were impacting on the quality of records and some of the support systems in place which had led to poor staff morale. We have recommended the registered provider continues to monitor this.

We have made three recommendations during our inspection which will be assessed further in our next inspection of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service requires improvement to be safe

Requires improvement

People told us they felt safe and there were systems and processes which helped to protect people.

The registered provider told us that they were struggling to recruit staff and this was re-iterated throughout our visit. On occasions this had impacted on care delivery. We have recommended that the registered provider continues to monitor the staffing levels so that they can be confident that people's needs are met.

Some aspects of medicines management were well managed, however we were told that secondary dispensing was taking place which meant that people may not have received their medicines as prescribed and also meant that records may not have been accurately maintained. We have recommended the provider reviews their medication practices.

Is the service effective?
The service was effective

Good

Staff had induction, training and support to enable them to meet people's needs although further service specific training may be of benefit. Plans were in place to address the gaps in supervision.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and previous applications to authorise DoLS had been made to the local authority.

People were supported to eat and drink enough to maintain their health and wellbeing.

People told us and we saw records to confirm that people had access to a range of health professionals.

Is the service caring?
The service was caring

Good

People told us that they received care which met their needs and we observed kind and caring interactions throughout our visit.

People told us that they were treated with dignity and respect and we saw examples of this throughout our visit. One person raised concern in this area.

Is the service responsive?
The service was responsive

Good

Summary of findings

People's needs were recorded within their care plan and these were reviewed as their needs changed. We noted that some areas of people's care records were not up to date.

An activity coordinator was employed by the service and they provided a range of social opportunities to people. Visitors told us they were made welcome and could visit at any time.

Is the service well-led?

The service requires improvement to be well led

The service had a registered manager. Current staffing problems were impacting on morale and meant that some of the documentation, records and systems to support staff were not up to date.

Requires improvement

Derwent House Residential Home

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.

The inspection took place on the 8 September 2015 in response to concerns we had received. The inspection was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to our inspection we looked at information we hold about the service which included safeguarding and whistleblowing information and other information, for example, notifications. Notifications are information the provider sends us to inform us of significant events.

We did not ask the provider to complete a Provider Information Return (PIR) as the inspection was bought forward. A PIR is a document which the provider completes detailing some key information about the service.

During our inspection we spent time speaking with eight people who used the service, eight staff, three relatives and a visiting health professional.

As some of the people living at the service had a dementia type illness we also carried out a Short Observational Framework for Inspection (SOFI). SOFI is a tool used to record the experiences of people who may not be able to communicate their needs to us directly. It looks at the interactions and experiences people may have.

We carried out a tour of the service, spending time in both units. We looked at records including four staff recruitment and training records, four care plans, four people's medication records and a selection of records used to monitor the quality of the service. We also looked at four weeks' staff rotas.

We sought and received feedback from the local authority safeguarding and commissioning team at City of York Council who were looking into some concerns regarding the service.

Requires improvement

Is the service safe?

Our findings

People consistently told us they felt safe. This was re-iterated by relatives we spoke with. Comments included "I feel safe ... yes" and "My relative is safe here."

Staff told us there were safeguarding policies and procedures in place to support them. They were knowledgeable about the types of abuse they might see and were able to tell us what action they would take if they had any concerns. Comments included "Anything untoward I would tell" and "I have completed a safeguarding pack, I would whistle blow (tell someone)." We looked at the staff training records and saw that all staff had completed safeguarding vulnerable adults training.

We saw that the service had appropriately referred safeguarding concerns to the Local Authority safeguarding team. This showed us that the service was protecting people from abuse and avoidable harm.

We looked at how risks to people were managed. The home had individual risk assessments in place for risks such as falls, pressure care and nutritional intake. We saw that these were reviewed and updated regularly so that any changes could be recorded. We spoke with staff who told us that risks were recorded in care plans. They gave examples of some of the risks they had identified; for example, people with diabetes or people who expressed distressed behaviour. They were able to tell us how they would try to minimise these risks.

We looked at accident and incident records and saw that there were eleven records in August. These were broken down each month so that the registered manager could see what occurred and put measures in place to reduce the likelihood of them happening again, where possible.

We also looked at maintenance records and safety checks which were carried out to reduce the risks in the environment. This included weekly checks on the fire alarm, emergency lights, nurse call, door sensors, lifts and water temperatures. We saw maintenance records for gas safety, electrical safety, legionella, clinical waste, fire and portable appliance testing. These checks helped to ensure that the building was maintained safely. However, we were made aware of one member of staff who had not been shown what emergency fire evacuation procedures were which could pose a risk to people. We asked the registered manager to address this issue straight away which they agreed to do.

We looked at the recruitment files for four staff employed at the service. We saw that application forms were completed, interviews held and that two employment references and Disclosure and Barring Service (DBS) first checks had been obtained before people started to work there. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

Prior to our visit concerns had been raised about staffing levels and the high use of agency staff. People told us that this was impacting on care delivery. During our visit staff told us that staffing numbers were not always sufficient and they told us that this was impacting on the care being provided.

People provided mixed comments about staffing levels. Comments included; "You can be kept waiting for so long. On two occasions over an hour. There are too many agency staff." "Staff are wonderful, I have got to know most of them. We are short staffed at the moment but those we have are very good" and "The staff are great, nothing is too much trouble." Another person told us "The buzzers ring for long periods" and we observed this for ourselves during our visit.

We saw entries in the daily diary such as "Too busy to bath X", "No weights, baths or files done today, too busy", "Weights not done, no time" and "Sorry unable to do files."

We recommend that the registered provider continues to monitor and review the staffing levels so that they can be confident that people's needs can be met and ensure that adequate numbers of staff are on duty.

The service had opened a new unit and some of the existing staff had transferred across to the new unit. There were vacancies for four carers and a domestic. The registered provider had advertised the positions but had had a very poor response. They were trying to advertise in different areas to encourage new staff to come and work and had offered a number of incentive schemes to try to attract prospective employees. They had identified that

Requires improvement

Is the service safe?

staffing levels had been poor and had been covering shifts with agency staff. They told us that they were doing everything possible to fill the vacancies and said that recruitment was on-going.

We looked at medication policies, procedures and systems and found that medication was ordered and stored correctly across both units of the service. People were encouraged to self-medicate where they were able and there were risk assessments in place to support this. One person said "The nurses give me my medicines on time." Another said "They (the staff) bring my medicines when I need them."

We looked at a random selection of controlled drugs and found that these were being stored and managed appropriately. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs legislation. The nurse on duty had a clear understanding of how these would be stored, managed, administered and recorded within a CD book.

We looked at systems to administer medication. We were told by two staff that on occasions, on Derwent House unit, medication was left in pots in people's individual bedrooms. They told us that this meant people did not always have their medication administered as prescribed as the medication might not be found by the person until later in the day. The Royal Pharmaceutical Society Guidance states "Medicines must be given from the container they were supplied in. Doses must not be put out in advance of administration, for example in medicine pots –this is secondary dispensing and can lead to mix-ups and errors." This practice may also mean that Medication Administration Records (MAR) were not being signed accurately or that people were receiving their medication as prescribed by their GP. Although we did not observe this practice during our visit, this concern was also raised anonymously prior to our visit.

We looked at MAR's across both units and found that the amount of medication booked in or carried forward was not always recorded which meant that auditing quantities of medication was difficult. We shared this with the staff on duty.

We recommend that the registered provider reviews their medication processes so that they follow The Royal Pharmaceutical Society Guidance and National Institute for Health and Care Excellence (NICE) guidance.

Prior to our visit we were told that the service had experienced an infestation of body parasites. We were also told that the service sometimes smelt unpleasant. During our visit the home smelt clean and fresh. Communal areas were clean and pest control had been contacted and had supported the home in managing the infestation. We observed some unpleasant odours in the wet room on the new unit and a couple of the bedrooms which we shared with the registered manger during our visit. They agreed to address this. However the remainder of the home was clean and fresh throughout our visit. We asked people if their rooms were kept clean and all but one person we spoke with responded positively. They said their rooms were cleaned regularly and they had no issues. One person said "My bin only gets emptied every four days. I think there should be a daily clean." The home employed domestic staff and we observed staff wearing personal protective equipment (PPE) throughout our visit. All staff received training in infection control. This helped to keep their knowledge up to date.

Good

Is the service effective?

Our findings

We looked at the induction training and supervision records of staff on duty. Staff received an induction when they commenced employment. All but one of the staff we spoke with confirmed that they had received an induction and we saw records of this.

We looked at the staff training plan and training records for staff on duty on the day of our visit. Training was provided in a range of topics which included health and safety, infection control, nutrition, food safety, fire safety, manual handling, equality and diversity, safeguarding vulnerable adults, mental capacity and non-abusive physical and psychological intervention (NAPPI) training.

We looked at staff supervision records and found that staff were not receiving regular supervision. Staff told us that they should have supervision every three months but we saw that three of the four files looked at had gaps of up to six months between supervisions. We saw that the lack of staff supervision had been discussed in a staff meeting and acknowledged as an area which would be improved once staffing levels had been increased. All staff received an annual appraisal and these were up to date.

There was insufficient evidence that the registered manager was accessing specific guidance and training linked to best practice in the leadership and delivery of care. Staff had not received training in dementia and there was insufficient evidence that legislation and guidance had been considered to demonstrate that the service could provide a 'dementia friendly' environment.

Staff we spoke with understood the importance of the Mental Capacity Act 2005 (MCA). Staff told us how they might support people to make decisions by offering simple choices or by showing a choice of options. Comments from staff included "This (MCA) is in place to support people who are unable to make appropriate decisions themselves" and "If I am doing menus, I will talk through choices, offer choices in all aspects of daily care for example baths or showers, what clothes to wear….everything."

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the MCA and are designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The registered manager had previously sought authorisation for DoLS, although there were none in place when we carried out our visit.

We asked staff if they had to support people who expressed distressed behaviour. Staff gave examples of when they did this. They told us that physical restraint was never used; instead they tried to divert people so they could be supported to calm down. Additional training to support care staff was discussed with the registered manager during our visit.

Some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place so that they could express their future wishes. These were held in people's care files and were appropriately completed.

People spoke positively of the food provided; comments included "The food is very good, you get a choice." "The food is very good and you get to meet different people at the dining table."

We observed the dining experience on both units of the service. Staff wore personal protective equipment (PPE) to serve food and there was a choice of drinks available. Tables were nicely laid and a chef served the meals from a hot trolley. People spoke positively of the food provided and it looked and smelt appetising. It would be good practice if the registered manager considered alternate menu formats for people living with dementia. Pictorial menus can mean that people's choices and preferences can be more easily made and taken into account.

We saw from care files that people's nutritional needs were assessed and those deemed at risk of malnutrition or dehydration were monitored closely. Appropriate advice was sought where people had been assessed as being at risk. Staff were able to tell us about different diets and gave an example of supporting people with diabetes.

People told us that they could see a health professional when they needed to. They told us about visits from their GP. We spoke with a district nurse who was visiting on the day of our inspection. They spoke positively of the care provide to people and said the service was pro-active in seeking advice where this was needed. One person said "I see my GP when I want to." Information regarding people's health conditions was recorded in their care plan.

Good

Is the service effective?

We carried out a tour of the service and found it had large pleasant gardens to the rear of the property, which people used during the warmer weather. There was also a vegetable patch which people could access. There was communal space in which people could spend time with others and also smaller areas where people could sit with their relatives and friends.

Good

Is the service caring?

Our findings

People told us they were well cared for. Comments included “It’s very good here, the staff are wonderful”, “Staff are pleasant caring and very tender.” Another person said “I get well looked after.” Relatives and visitors said “I think the care is generally ok, sometimes clothes are an issue. My relative always looks and smells clean” and “My relative is always clean and people’s privacy and dignity is respected, for example, people are always taken to the toilet discreetly.” Another person said “The care is very good. The two staff on this unit do a good job and once more staff are employed things will be even better.”

We carried out some observations and saw that interactions between those working and living at the service were positive. Staff bent down to people’s level when talking to them so that hand and eye contact could be made and they explained what they were doing before carrying out care tasks.

We saw that information regarding people’s diversity was included in the assessment which was carried out when moving into the service. People talked about their spiritual needs, some told us that a priest visited the service and gave them communion; others told us that they would like to take part in this. Others told us that they visited their local churches with relatives so they could attend their regular place of worship.

We saw from care records that detailed information had been gained about people’s history, their likes and dislikes and the things which were important to them. This helped support people in feeling valued and listened to by staff.

We saw that people had signed in agreement to some parts of their care plan, for example, in the sections where they were providing consent. We saw examples where relatives had signed on their behalf.

We saw that information about accessing advocacy services was displayed in the home. This meant that people could gain support where they may not be able to make their views known.

People told us they were treated with dignity and respect. Comments included “I am treated with dignity. I can make choices such as when I want to get up” and “Staff are polite, they knock on my door before entering. I am treated with dignity.” Feedback in this area was positive although we observed one relative expressing concern that their relation was wearing clothes which were back to front. Staff immediately responded taking the person to get changed. Our observations made throughout visit demonstrated that people were spoken to politely, we observed staff explaining what they were doing before carrying out care tasks and we observed staff knocking on doors before entering people’s rooms. However, one person said that they had been left on the toilet for a long time on one occasion and also said they did not like it when staff whispered between themselves when assisting them with personal care tasks. We shared this with the registered manager at the end of our visit.

We saw that people’s personal care records were stored in an office so that information remained confidential and accessible only by those who needed to access them.

Visitors were able to visit the home at any time and we saw visitors popping in and out throughout the day. There were no real restrictions on visiting although they were encouraged not to interrupt mealtimes in the main dining room.

People’s end of life wishes were sought and these were recorded within their individual care plan. The registered manager told us that the service provided end of life care to people as requested and they told us that people’s wishes were discussed with relatives. Although the service had care plans in place they were not being utilised as well as they could be. For example; there were no individual care plans for end of life care and the care plans in place may have been irrelevant. The registered manager agreed to look at this further.

Good

Is the service responsive?

Our findings

We looked at four care plans. We saw that care files contained pre-admission information, my life story (detailed information about people's lives), mental capacity assessments and risk assessments for example, for manual handling, pressure sores and nutrition. They also included individual care plans so that, for example, one person's file had information regarding communication, death and dying, elimination, mobility, nutrition, personal care and socialisation. Care plans recorded the way in which people wanted to be cared for and the level of support required. However, despite risks being identified and care plans being written, we saw some examples where areas identified in risk assessments were not then included within care plans. For example, we saw that a pressure sore risk assessment had been completed in June 2015. The individual had been assessed as high risk, but there was no care plan in place for pressure care. A further example was someone identified at risk of malnutrition. The care plan did not included information which had been identified in the nutritional risk assessment. We discussed this with the registered manager who confirmed that staffing levels had impacted on some of the reviews and updates of care records and that she was trying to address this.

We saw that care plans were being reviewed regularly and staff told us that each year a formal review was carried out. We spoke with one person who was on a short stay at the service. They said "So far it is lovely. The staff spent time talking to me and my daughter yesterday about my care needs."

We observed some people participating in social activities during our visit. People said "Sometimes there is a sing song here" and "I played snakes and ladders, it is a bit of fun." The service had a designated activities co-ordinator who had a planned activity programme each week. There were plans to employ an additional co-ordinator to provide activities on the new unit. People told us that their relatives and friends were able to visit them at any time and this was confirmed by visitors who we spoke with during our visit. We asked people if they went out on outings. They told us that the minibus had broken down during the last trip and had not been fixed. We spoke with the registered provider regarding this and they agreed to remedy this.

People told us they could choose how to spend their time. They could choose to remain in their rooms if they wanted or they could join others in communal lounges.

The service had a complaints procedure which was displayed in a communal area. This included information about how to contact the local authority. People told us they could raise complaints and their comments included "No concerns to talk about" and "I have no complaints at all."

There were formal and informal systems available for raising any issues and the registered manager confirmed that no formal complaints had been made. They told us because issues were dealt with immediately this meant that formal complaints were rarely made. Relatives and visitors who we spoke with said that they felt confident speaking to the registered manager or staff and we observed them doing this during our visit.

Requires improvement

Is the service well-led?

Our findings

Derwent House had a registered manager. People spoke positively of the registered manager and said that she was approachable. Comments included "The manager and all of the staff are very approachable" and "The manager is lovely."

We spoke with a visiting health professional who said "The home is very pro-active in ringing us and good at contacting us if they need equipment. Standards of care have improved and there is a better working relationship between us and the home than there used to be."

We spoke with staff about the management support they received. They said that staffing levels had affected morale. Comments included "Morale is up and down. I have had no supervision for a while. I don't always feel the manager is approachable" and "The manager is approachable. I get supervision sometimes but I can't remember when I had the last one." The staff we spoke with all said that staffing levels were impacting on morale although they appreciated that recruitment was taking place. They also told us that the registered manager was covering nursing shifts to help fill any gaps. We spoke with the registered provider following our visit and shared some of the feedback from staff. They acknowledged that staffing levels had impacted on morale but confirmed they were doing everything possible to recruit and said that new staff were due to commence employment shortly.

We asked the registered manager what dementia care models had been considered when setting up the new unit. They confirmed that as yet no set model was being followed but that further work would be carried out so that best practice guidance and legislation in dementia care was considered.

Although there were systems in place to support staff these were not always kept up to date and this should be considered particularly where new staff were employed. We also identified records which were not up to date during our visit which we were told was a direct result of the staffing issues. This alongside the concerns identified with medication practices meant that management systems may not be as robust as they should be.

We recommend that the registered provider continues to monitor quality management systems at the service so that people can be reassured that improvements are being made.

We saw that relative and resident meetings were held on a monthly basis and we looked at the minutes from these. We saw that any action points were followed up in the next meeting. For example a comment had been made about the curtains coming down and about portion sizes at mealtimes. We saw that both these points had been actioned and signed off by the registered manager.

Staff meetings also took place; we looked at the minutes for the August, May and February 2015 meetings which had taken place. Minutes were held of these meetings so that any staff unable to attend could find out what had been discussed.

A number of quality audits were carried out and we saw audits for slings, accidents, infection control, housekeeping, pressure ulcers, care plans, finances, health and safety and medication.

The registered provider also carried out a quality audit in August 2015 which looked at all aspects of service provision and provided a rating overall. They had rated the home as 'good' using their internal system. We saw that where any areas for improvement were required action plans were put in place and these were followed up in the registered provider visits.

We were shown a copy of the 2014 quality audit report which was compiled following the results of the quality questionnaires which had been sent out in 2014. The report detailed the responses received, and any actions which the home had taken to remedy shortfalls. The registered manager told us that the 2015 surveys were in the process of being sent out.

We saw that notifications were submitted to the Care Quality Commission as required. These are forms which enable the registered manager to tell us about certain events, changes or incidents.