Sure Healthcare Limited

Derwent House Residential Home

Inspection report

Riverside Care Complex, Hull Road
Kexby
York
North Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Derwent House Residential Home is a residential care home providing personal and nursing care to 52 people aged 65 and over at the time of the inspection. The service can support up to 65 people across two separate areas. Derwent House supports people with nursing and residential care needs and Riverview Lodge supports people living with dementia.

People's experience of using this service and what we found
People were not kept safe from harm. Risk assessments were not up to date, specific or followed by staff to ensure individuals were safe.

Processes and records were not maintained to ensure people always received their medicines safely as prescribed. There was gaps in the application of topical creams and a lack of communication meant one person's medicines were delayed in being administered after being received from the pharmacy.

Some people told us they had to wait for staff support. Staff were not sufficiently supported to fulfil their role. This had impacted on people's dignity.

Care was not always person-centred. Some staff had good knowledge about people's needs but this was not captured and reflected in care planning. People's diverse needs were not always considered.

Staff did not receive appropriate training or assessment of their competency to ensure they had the appropriate skills to meet peoples' individual needs. Lessons had not been learnt from accidents and incidents to reduce the likelihood of reoccurrence.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People, their relatives and health care professionals had mixed views about the care provided. Person-centred care was not reflected within people's care plans and associated records.

The provider failed to have adequate oversight of the service during periods when there was no registered manager. This had impacted on the quality of care being provided.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Rating at last inspection

The last rating for this service was Good (published 23 March 2018).

Why we inspected
The inspection was prompted in part due to concerns received about medication issues, fire safety, staff training, staff knowledge, lack of staffing, poor moving and handling procedures and a lack of up to date care planning. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by two notifications of specific incidents. Following which, one person using the service died and another sustained a serious injury. These incidents are subject to a criminal investigation. As a result, this inspection did not examine the circumstances of these incidents.

The information CQC received about the incidents indicated concerns about the management of falls and falls from moving and handling equipment. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the full report.

The provider had taken action to mitigate the immediate risks to people.

Enforcement
We have identified breaches in relation to keeping people safe, not working within the principles of the MCA, staff not trained and supported, people not treated with dignity and respect, a lack of systems to investigate and take action following complaints, a lack of oversight, monitoring and learning.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Derwent House Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and one Expert by Experience on the first day of inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by three inspectors.

Service and service type
Derwent House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was no registered manager. There was a new manager during the inspection, however, they are no longer employed with the service. A previous manager has now returned as the manager of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with 15 members of staff including the provider, manager, deputy manager, care manager, senior care workers, care workers and agency staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records in full and multiple care records in part and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We wrote to the provider to request assurance that the concerns identified would be addressed. Reassurances were given by the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- The provider failed to ensure the proper and safe use of medicines.
- People did not always receive their medicines as prescribed. Topical medicines such as creams and ointments were not applied as prescribed and care staff did not keep proper records when they were applied. Body maps were not always in place to guide care staff where to apply these treatments.
- Protocols were not always in place to ensure staff knew when 'as required' medication should be administered. Those that were in place lacked the required information to ensure safe administration. It was unclear from the records whether people's medication needs were being met.
- Staff lacked guidance around people's medications and side effects as care plans for people's high-risk medication were not in place.
- The service could not be assured that people's medication was effective as medicines were not being monitored for this.
- Staff did not always record the amount of a medicine given when the dose was variable, for example one or two tablets to be taken. Quantity of medicines stocked was not recorded upon receipt or the balances checked regularly, which meant that the provider could not be sure that medicines had been given as signed by staff.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of recurring accidents and incidents because systems in place to monitor them were not being used effectively. Recording of accidents and incidents lacked detail. Lessons learnt were not always considered.
- Risk assessments were not reviewed or updated following incidents, which exposed people to increased risks.
- Risk assessments and care plans lacked detail to ensure that risks could be mitigated against and some risk assessments were out of date.
- Inconsistent information in care planning regarding specialist diets placed people at increased risk of choking.
- Risks in relation to weight loss where not being monitored. Action was not taken when significant weight loss had been identified.
- Risks to people's skin integrity were not effectively managed as equipment in place to reduce this risk was not being monitored.

Preventing and controlling infection

- People were not always protected from the associated risks of infection. We identified some dirty pressure

cushions and mattresses.

The lack of appropriate monitoring and assessment of risk, care and support and medicines management meant people were not receiving safe care and treatment. This was a breach of Regulation 12, (safe care and treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Generally, the service was clean and well maintained.Some bedroom carpets were heavily stained and odorous, however, the provider stated they had plans in place to replace these.
● Cleaning schedules were in place to help maintain a clean environment.

Staffing and recruitment
● Relatives told us there was not always enough staff to keep people safe. They told us, "There is not enough staff, they are short staffed and it means they take longer to come when we need them."
● Staff told us that staffing numbers fluctuated and sometimes this meant they felt they couldn't meet people's needs.
● After the inspection, the provider told us, they have reviewed the staffing numbers in line with their dependency tool and find they sufficient staffing to meet people's needs.
● Recruitment procedures were robust.

Systems and processes to safeguard people from the risk of abuse
● Poor investigations into an incident failed to identify when the service had not safeguarded someone from the risk of abuse. As a result of this, a referral to the local authority safeguarding team had not been made.
● The previous manager had made referrals to the safeguarding team where necessary and a log of safeguarding concerns was in place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service was not working within the principles of the MCA. Best interest decisions were not in place for restrictions such as sensor mats and covert medication. Where capacity assessments had taken place, these were not decision specific.
- One person's DoLS had expired without the appropriate application being made to reapply.

Failure to work within the principles of the MCA is a breach of Regulation 11, (consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Not all staff were sufficiently supported or inducted in their roles. No staff had received an appraisal. Half of the care staff team had not received a supervision this year. One staff member told us, "It's been a couple of years since I last had a supervision." The manager told us they intended to have a supervision with all staff soon and they had implemented a system to help monitor this.
- Staff were not suitability trained or competency checked to meet the needs of people. Competency checks in moving and handling were not in place for all staff and they were not trained in specific health needs. One staff member told us, "I had 15 minutes moving and handling training when I first arrived and that's it." A relative told us, "I think the staff are lacking in dementia training."
- The provider told us they had recently recruited a new training manager who would ensure that all staff

accessed appropriate training to meet the needs of people.

Failure to have suitably trained and supported staff is a breach of Regulation 18, (staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- Systems in place to monitor people's fluid intake were ineffective. Charts provided inaccurate amounts, were not totalled and records did not prompt when action should be taken.
- Documents in place to reflect people's dietary requirements were not up to date or accurate.
- Healthcare advice was not always sought when needed. Professional advice in relation to nutritional needs. The inspection team prompted the service to seek healthcare advice for a number of people on both days of the inspection.
- We saw records of communication with agencies including social workers, district nurses and chiropodists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care plans failed to adequately instruct staff on how to deliver effective care to meet people's diverse needs.
- People's assessments were not always detailed or reflected people's individual needs.

Adapting service, design, decoration to meet people's needs

- The design of the building met people's needs. The environment was pleasant.
- Some dementia friendly signage was used within the environment to help orientate people.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff failed to show compassion and respect for people's diverse needs at end of life. Support was not provided to ensure a dignified death.
- Information about people's diverse needs was not always clear. Staff were unaware if one person required a hearing aid as they had not read their care plan. However, on checking the care plan, this contained contradictory information about their diverse needs.
- Some people told us that staff were task focused, one person said, "The staff are in a bit of a hurry sometimes."
- During lunch we observed people were not offered protective clothing when required. A staff member told us, "I don't know where the aprons are so these people haven't got one." No attempt was made to locate aprons throughout meal time.

Supporting people to express their views and be involved in making decisions about their care
- Some staff lacked knowledge of people's day to day individual needs and what was important to them. Staff told us they had not considered why some people behaved in a certain way and had not considered asking or looking into this.
- Staff told us they had not read care plans and were not involved in the care planning process. Staff were not providing personalised care as described within the care plan. A relative told us, "The care plans were non-existent as they weren't up to date. I don't know if they are any better now."

Respecting and promoting people's privacy, dignity and independence
- Not all staff demonstrated respect for people. Staff did not always promote people's dignity. For example, people were delivered personal care whilst sat on the commode and supported to sit on dirty pressure cushions. One relative told us, "I wish staff would not administer [Name] medicines when they are sat on the commode."

People's rights to be treated with dignity and respect were not consistently met. This was a breach of Regulation 10, (dignity and respect), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us some staff were caring and treated them with respect. Relatives opinions were mixed; one relative told us, "It depends who you get, there are a lot of agency staff here and I don't think they are as caring as the regular staff." Another relative told us, "Some staff here are amazing, they take the time to

support me as well as [Name]."

● During the inspection we made some observations of good communication between staff and people. Some staff were observed to be attentive to people's needs and caring in their approach.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
- There was no clear system in place for identifying, receiving, recording, handling and responding to complaints. When complaints had been made it was difficult to establish what action had been taken to address them.
- Lessons learnt had not been considered following complaints.

A lack of systems in place to investigate and take action following complaints was a breach of Regulation 16, (receiving and acting on complaints), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some relatives told us any concerns could be shared with the provider and they would be dealt with.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Care planning failed to reflected people's person-centred needs. For example, people had out of date risk assessments in place.
- Reviews were not meaningful and failed to capture people's change in needs. For example, one person's care plan for mobility had been reviewed but this review failed to reflect that person had had a recent fall.

End of life care and support
- The care plans that we looked at provided some information about people's choices at end of life.
- One person's care at their end of life did not meet best practice and failed to deliver an expected standard of care.

Failure to provide personalised care was a breach of Regulation 9, (person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
- Information available did not always meet the communication needs of people with a disability or sensory loss. The provider informed us that documents could be made available in large font upon request. The provider did not inform us of any other formats available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's wider needs were met through the provision of activities. Activities were regular and involved group and individual based activities. There was a budget for planned activities and this included external visitors and entertainment.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to ensure that the service was being managed effectively to meet the regulatory requirements.
- There was no registered manager in post. There had not been a registered manager for over 12 months prior to the inspection, despite new managers starting the process with CQC. A new manager was recently in post during the inspection but they have since left the service. After the inspection the provider informed us a previous manager had returned to be the manager of the service.
- Internal audits and systems in place had failed to identify or address the concerns we have identified during the inspection. For example, to assure peoples' safety and that staff were trained and supported in their role.
- Information which should have been stored securely and confidentially was easily accessible to staff.

Failure to operate systems or processes to ensure compliance was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Shortly before the inspection, the provider had requested a medication audit be completed by an external consultant. The provider gave us reassurance that actions identified in this audit and through our inspection, would be addressed as a priority.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- Investigations into incidents, accidents and service delivery were not effective which meant learning, reflective practice and service improvement not been achieved.
- Records were out of date. They failed to reflect the current needs of people within the service.
- Where areas of improvement had been identified little or no action was taken to address this. For example, in response to care plan and medication audits.
- The service was not always open and honest. People's relatives were not always provided feedback following concerns about people's health.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider failed to seek feedback to improve standards at the service.

● There was no records of people or relatives being engaged or involved in the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was a lack of person-centred culture being promoted within the service.

● The unstable management had impacted on the home. A relative told us, "There has been problems with not having consistent managers and staff have left, morale has been very low."

Lack of monitoring and learning from incidents and maintaining contemporaneous records meant this was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● One visiting professional told us they felt the service was responsive to people's needs and they would seek guidance from others when required.