J Sai Country Home Limited

Durban House

Inspection report

33 Woodley Lane
Woodley lane
Romsey
Hampshire
SO51 7JL

Tel: 01794512332
Website: www.romseynursingcarehome.co.uk

Date of inspection visit:
27 November 2018
28 November 2018

Date of publication:
15 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 November 2018 and was unannounced.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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At this inspection we found the service remained Good.

Durban House 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 provides accommodation, nursing and personal care and support to a maximum of 42 older people, including those who may have a physical disability or be living with dementia. There were 40 people living in the home at the time of our inspection.

There was a friendly atmosphere in the home and staff supported people in a kind and caring way that took account of their individual needs and preferences. People were supported to express their views and be involved in making decisions about their care and support.

There were systems and processes in place to protect people from harm, including how medicines were managed. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to the management team.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised. There was an induction, training and development programme, which supported staff to gain relevant knowledge and skills.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received regular and on-going health checks. They were supported to eat and drink enough to meet their needs and to make informed choices about what they ate.

The service was responsive to people's needs and staff listened to what they said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People could be confident that any concerns or complaints they raised would be dealt with.

The registered manager was promoting an open, empowering and inclusive culture within the service. Quality assurance systems were in place, however there were sometimes gaps in the way these processes were taking place, particularly in relation to record keeping. We have recommended the provider and registered manager formalise the process for auditing and monitoring gaps in recording, while their new systems are being embedded in practice.

Further information is in the detailed findings below

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service requires improvement. We have recommended the provider and registered manager formalise the process for auditing and monitoring gaps in recording, while their new quality assurance systems are being embedded in practice.	**Requires Improvement**

Durban House

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 was a comprehensive inspection that took place on 27 and 28 November 2018 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered manager 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 checked other information that we held about the service and the service provider, including previous inspection reports and notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

Although we were not able to hold a full conversation with many of the people living in the home, some were able to make comments and we were able to observe staff interacting with people. We spoke with six people and two relatives, one of the service directors, the registered manager, the deputy manager and another trained nurse, two care co-ordinators, three senior care assistants, an activities co-ordinator and the senior housekeeper. We looked at a range of records including care plans for ten people, medicines records, staff rotas, training records, and risk assessments. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided.

Following the inspection visit we received feedback from a community health and social care professional about the service provided at Durban House.

The home was last inspected on 11 October 2016 when the service was rated good overall and no breach of the regulations was identified.

Good

Is the service safe?

Our findings

People told us they were safely cared for and we observed open and friendly interactions between staff and people who lived at the service. A relative told us, "I never have to worry knowing he is here".

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse to the management team and agencies so that people in their care were protected and their rights upheld. Policies were in place in relation to safeguarding and whistleblowing procedures and these were accessible to all staff. Whistleblowing is a policy protecting staff if they need to report concerns to other agencies in the event of the service not taking appropriate action. Staff received safeguarding awareness training and on-going refresher courses.

Assessment of risk to people's health and wellbeing were regularly reviewed to ensure guidance to staff remained up to date. Where a particular risk had been identified regarding the health of an individual, for example for those who had poor skin integrity, equipment such as air mattresses and other pressure relieving equipment had been supplied. Staff had been instructed to assist the person to turn in bed regularly. However, charts to record staff actions had not always been completed consistently. This is discussed further in the Well Led section of this report.

Risk to the environment was regularly assessed and action was taken to help to ensure people remained safe. We checked fire safety procedures within the building and found these to be up to date. There were PEEPS (Personal Emergency Evacuation Plans) in place which were accessible to emergency teams and which had been regularly updated to reflect current occupancy. PEEPS are bespoke 'escape plans' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

There were safe systems for the administration, ordering, and disposal of medicines. Records were maintained of all medicines received into the service, disposed of and returned to the supplying pharmacist. Medicines were managed safely by suitably qualified staff. Prescribed liquids and tablets were kept secure in a dedicated room which was only accessed by nominated staff with responsibilities for managing medication. Those staff had undertaken regular medication training and regularly had their competency checked.

Medicines including controlled drugs were safely stored. Controlled drugs are regulated under the Misuse of Drugs Act and require additional safeguards to be in place. The temperature of the medication room and fridge were monitored and recorded daily. This helped to ensure they were within the range required so that medicines remained effective. Items of medication which on opening had an expiry date were labelled with the date they were first opened and were within their use by date.

Staff were safely recruited and all pre employment checks had been completed to help to ensure only staff who were suitable for their role were employed.

We received feedback from people who told us although they were very satisfied with the care and support provided they were concerned there were not always sufficient care staff employed to meet the needs of all people living at Durban House. They had noticed this particularly regarding the staffing of the small lounge where they said there were times people who were not always able to call for assistance should they need it were left unsupervised. They said this was particularly the case at weekends. Senior staff told us people in this lounge were less vulnerable or dependent and staff were coming and going throughout the day. In the other lounge, where the most vulnerable or dependent people were during the day, a member of staff was present at all times

During the inspection we found there were sufficient staff deployed to meet people's needs.

The service had a low staff turnover which meant people received continuity of care. There were nine care staff and two registered nurses deployed in the mornings, and seven care staff and two registered nurses on duty in the afternoon. There was an additional member of care staff on duty during the day to provide one-to-one support to meet a person's assessed needs. Night duties were covered by three care staff and one registered nurse. Care and nursing staff were supported by housekeeping and catering staff and by an activity coordinator.

The home environment was clean and staff were aware of infection control procedures. Staff received training in infection prevention and control (IPC) and used protective clothing when carrying out cleaning and personal care tasks. Cleaning schedules were well organised and maintained by a housekeeping team. The housekeeper in charge of the team confirmed they were provided with all the equipment and resources they needed to do the job. Audits of IPC procedures were carried out and recorded including remedial actions taken.

Good

Is the service effective?

Our findings

People said that they received effective care. One person said, "Since being here I feel so much better". Another person's relative told us, "They have got to know him now. He is more settled. He has put on weight and is looking well".

A community care professional told us, "I have always found staff that I have liaised with at Durban House to be skilled in all aspects of delivering effective care. (They) are currently working with a resident ….. who has very complex needs. She is well supported by staff and consideration is taken into account regarding her capacity and consent".

A pre-admission needs assessment took place that included any cultural and spiritual expression, diet, communication, physical and mental health needs a person may have, as well as any special equipment and relevant staff training that may be required. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. Each day a verbal handover between staff on shift was backed up with a written record containing an updated summary of each person's current support needs. A communications book and task allocation lists overseen by team leaders also helped to ensure all care tasks were covered.

The staff training programme showed that staff were provided with relevant knowledge and skills to support them in meeting people's needs. A system was in place to track the training that each member of staff attended. There was also a record of booked and on-going further training. The managers in the home had received training to support staff learning and development in-house, including subjects such as dementia awareness, the Mental Capacity Act 2015, and safeguarding.

Kitchen staff also completed dementia awareness training, which supported a consistent approach to care within the service. Some staff had studied for additional qualifications such as an NVQ (National Vocational Qualification) or Diploma in Health and Social Care. New staff completed the Care Certificate. The Care Certificate is a nationally recognised set of induction standards for health and social care staff.

Staff confirmed they received useful training and regular updates, as well as supervision and appraisal of their work. We saw records showing that supervising staff also carried out observations of staff working practices, for example in relation to moving and repositioning people, supporting people to eat and drink, personal care and dignity.

People's nutritional needs were assessed and there was detail in care plans to help staff to ensure these needs were being met. People's dietary likes and dislikes were noted to help to ensure they were given meals which appealed to them. People confirmed they were provided with sufficient amounts of food which was to their liking, for example a representative comment was "It's very good, a good variety". One person who had type 2 diabetes said staff assisted them to test their blood sugar levels every morning and provided them with the information they needed about how to manage their dietary intake that day. This showed staff supported people but also ensured they maintained their independence.

We observed people were offered regular hot and cold drinks. Staff prompted and encouraged people to drink regularly. Staff closely monitored the food and fluid intake of people who were particularly at risk of not having sufficient amounts to eat or drink. The records of one person who needed this level of intervention did not specify the daily goal for fluid intake and we discussed with staff how this could be made clearer.

People were supported to receive ongoing healthcare support. Staff had liaised when they needed to with specialist healthcare professionals to maintain people's health. For example, staff had involved a speech and language therapist to assess and provide guidance for people who were at risk of choking. Staff had followed this guidance and had provided people concerned with the advised pureed diet. Some people were not able to tell staff verbally if they were in pain. When this was the case staff used The Abbey Pain scale, which is a tool designed to assist in the assessment of pain in people who are unable to clearly articulate their needs. For example, for people living with dementia.

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.

Records showed that support was provided to people who lacked capacity to be involved in decisions about their care, in accordance with the legal requirements of the MCA. Where appropriate, best interest decisions were recorded and acted upon in ways that did not restrict people more than necessary, for example where a person needed to have their medicine administered covertly. Staff had received training in the MCA and showed an understanding of the principles in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond.

People can only be deprived of their liberty so that they can 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 are 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 were being met. Relevant applications for DoLS had been submitted by the home and had either been approved or were awaiting assessment. The home was complying with the conditions applied to the authorised DoLS.

The environment had been adapted to suit the needs and preferences of people living at the home. There were two lounges, the larger of which had been divided into two areas. This enabled people to have a choice of a quieter area with some background music and a television area. Toilets were signposted and there were boards in communal areas with information about the date and weather which assisted people with memory problems. These were updated to ensure they relayed accurate information.

Good

Is the service caring?

Our findings

A community care professional told us, "In my experience I have always found the home/staff very caring and considerate in all aspects of the work they provide to residents and professionals alike".

Staff ensured people living at Durban House were treated with kindness respect and compassion. This helped people new to the home to settle in. One person said for "I'm getting used to things slowly. It all seems very nice but it takes some getting used to". People spoke highly of staff and said they were caring and kind. Comments included "They're very obliging. If there is anything I want they try and get it for me". "No complaints at all. The staff are very pleasant". Everyone is nice and considerate". "They are second to none". "I get on with all the staff"; and "The staff are excellent". A regular visitor said the care provided was "Excellent" and confirmed their relative was "Always treated with respect and dignity".

We observed staff speaking to people who were sitting down bent down so they ensured they were on their level. We also observed people during mealtimes helping each other at tables. Staff were observed offering support to people, for example if they wanted their meal cut up.

We observed a late morning in one of the communal areas. One member of staff played the piano and people living at the service and staff were singing along to well known tunes. One person said, "It's amazing how a little bit of music can have such a powerful effect".

Staff clearly knew people well and called people by their preferred names. Staff knew and respected people's preferences regarding how they wished to live their lives. We saw staff encouraging people to spend time in communal areas but respecting their wishes when they preferred to spend time alone in their rooms.

Staff respected people's privacy and dignity. There were clear instructions about how to support people who needed help to move within their individual care plans and staff followed this guidance. When they were supporting people to transfer from an armchair to a wheelchair they used screens to afford people some privacy. Whilst they were assisting people they communicated effectively with them, and took into account any difficulties people may experience in communicating. For example, they told a person in short sentences what they proposed to do and why they proposed to do it. This helped to ensure the person understood what was going to happen and it helped staff to ensure the person was consenting to the support.

Staff were mindful of maintaining people's dignity by ensuring they supported them to dress and accessorise to their taste and preference. On one of the days of our visits staff told us they regularly dressed a person's hair before they went out to a local club as the hairdresser, who attended on that day, did not arrive in time to do it.

Visitors were also treated with respect. One regular visitor said of staff, "They are accommodating". When they visited at mealtimes, they said staff asked them if they had eaten. They said, "I'm always made

welcome and looked after". Another person described how involved they felt in the care of their relative. They said "I spend a lot of time here and it's important for me to have that. I feel it's a whole holistic approach. It's not just looking after [their relative], they really look out for me".

Relatives said communication between themselves and staff was good, one person saying for example "I have no doubt at all they would phone me at any time". Relatives were also invited to attend reviews of care. This helped them to be confident the service was providing consistently good care. One relative said, "I don't worry at all about (person) when I go. I know (person) is well looked after".

People's wishes and choices were known and acted upon by staff. For example, we asked people whether their dietary preferences were respected. One person told us, "If it's fish they get me something else". Another person said, "They will always do me a jacket potato with cheese and salad"; and, "We went through a period of having chicken a lot. I don't like chicken so I had a word with (staff) and things changed". Another person said, "I went to a residents meeting and they asked for suggestions about the food. I asked for more fish and before you knew it there were more fish dishes".

Good

Is the service responsive?

Our findings

People's needs were assessed and a written care plan was drawn up to identify what those needs were and to give staff guidance about how those needs could be addressed. There was a low staff turnover, which helped staff to have had a good understanding of people's care and support needs.

While staff demonstrated knowledge of people's needs, some of this detail did not always appear in people's care plans. For example, some behavioural support plans did not provide specific guidance about how to assist the individuals, such as trigger factors and de-escalation techniques. We discussed that these could be enhanced further by personalising them to the individual.

Another person's behaviour support plan showed the service had referred to the community mental health team for advice. The person was subsequently discharged from the community team's oversight as the person was more settled and their behaviours were being appropriately managed by the staff team.

People's social needs were recorded in sufficient detail to help to ensure staff had a good knowledge of people's hobbies and interests. Staff had acted upon this information and one person told us once staff had found out their relative liked playing the piano they had put a keyboard in their room to help them to settle in.

The service employed an activity coordinator. They organised activities that were tailored to the needs and abilities of people living at the home, as well as organizing group activities that brought people together. Staff were inclusive and activities were adapted so people who wanted to could join in. For example, staff described how they had led a game of quoits and had guided a person with poor vision by using their voice so they knew where to throw. Events were tailored to meet people's experiences. A relative said "At the residents meeting the manager asked for suggestions (for activities). I asked for an Austrian day. They went to town. [Staff) researched it, ordered outfits. It was a wonderful day. We're not sure (person) understood, but from the family's point of view it really lifted us. The chef did schnitzel and strudel. There was a singer in that day who sang 'Edelweiss and Wooden Heart', it was marvellous". They said, "They do go the extra mile here. There are constantly things going on for the residents and they involve the family".

From time to time the service also brought in outside entertainers and singers. A hairdresser visited every week for those who wanted their hair done. One person told us, "It's one thing that is a must - getting my hair done".

People were encouraged to maintain links in the community, which meant people continued to attend local clubs and groups they were part of before moving into the home.

Staff respected people's preferences regarding their daily routine. Some people chose to spend their time in their bedrooms and whilst staff ensured people were aware of what was happening in communal areas their respected people's choices. Staff discussed with people when they preferred to get up and go to bed and observed these preferences as far as possible. One person told us they got up "Usually when it suits the staff

but it suits me as well". People's bathing choices were known and so they could choose between having a bath or a shower. Staff also knew how often people liked to bathe and people we spoke with said they were bathed or showered as often as they wanted.

The service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Each person had their communication needs assessed and documented as part of their care plans and was supported accordingly. This included the use of picture cards to assist in communication and written information being available in large print.

People's concerns were listened to and staff responded where appropriate to improve the quality of care and support provided. One relative said, "I find anything I raise is dealt with immediately". They described how they had raised a concern about their relative's bedroom as they felt without an alteration it could compromise their wellbeing. They said their concern was addressed straight away and the environment had been adapted to make it safer.

There was a procedure in place which explained how complaints would be answered and what people could do if they remained dissatisfied. This was also available in other languages and formats, such as braille, if people needed this. A record had been kept of complaints or concerns received and responses from the provider detailing actions taken. There were nine recorded complaints between October 2017 and November 2018. Actions taken in response included internal investigations, staff disciplinary procedures, and the registered manager or provider meeting with concerned parties. The registered manager carried out a monthly audit of any complaints received and actions taken and a summary report of this was recorded.

When people reached the end of their life, staff worked with the GP and community nursing team to meet their needs. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. The service was working towards accreditation for the Gold Standards Framework (GSF) in end of life care. The GSF is a programme to improve end-of-life care in nursing homes by offering staff training and a framework to help identify, assess and deliver care. The registered manager told us all staff in the home had been involved in the training.

Requires Improvement

Is the service well-led?

Our findings

There was an established registered manager in post. 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.

The registered manager spent time in the home talking with people who lived there and with their relatives. People who were able to tell us said of the registered manager, "Very approachable" and "I see them quite a bit".

There was also a deputy manager and if neither manager was present, there was a trained nurse on duty at all times. Supervision arrangements for nursing staff included managers recording observations of nurses managing shifts.

The registered manager and a senior member of staff told us one of the company directors visited the home each week and was "Very supportive", including with regard to any training, equipment and other resources they requested. Records of these visits were held on file.

Quality assurance systems were in place, however there were sometimes gaps in the way these processes were taking place, particularly in relation to record keeping that included medicines, food and fluid and turning charts.

For example, a senior member of the care team explained that food and fluid and turning charts were signed off as completed and checked by the senior staff at the end of each shift. However, we noted there were inconsistencies in recording, actions being taken and fluid charts not being totalled, which meant the process for checking that the stipulated care was being carried out in a timely manner was not robust or reliable. It was also not clear how the nurses were then made aware of any concerns. A senior member of the care team said that care staff would raise concerns if, for example, fluid balances were low. However, staff were signing records as being completed and actioned and there was no evidence to support this or that the nurses were being made aware.

We recommend the provider and registered manager formalise the process for auditing and monitoring gaps in recording, while the new systems are being embedded in practice.

The registered manager had been implementing an action plan to further improve the service, which included changed systems of accountability within the home. They had delegated some areas of responsibility to senior staff and had included catering and domestic staff in meetings regarding the running of the home. As a result communication had improved. Staff spoke positively about the changes and felt involved in the process.

Staff performance issues were addressed in line with company policy. There were clear lines of

accountability within the service with each shift having a designated member of staff in charge.

The service worked in partnership with community health and social care professionals to help ensure people received the care they needed. This included the tissue viability nurse, dietician and GP who all visited the home and provided support and advice. A community care professional told us, "I have always found the home to deliver high quality care".

Staff meetings took place and staff said they felt the registered manager and senior staff listened to them and were open to suggestions for developing and improving the service. Minutes of the meetings were taken so any staff who did not attend were kept informed.

Annual satisfaction surveys were carried out that included questionnaires sent to people who used the service and their relatives, staff and external professionals. We saw that the results of a recent survey for people's relatives were overall positive, with the 12 people who responded saying they were satisfied overall with the care provided.

There was a note from the registered manager to senior staff asking them to action highlighted areas from the responses. There was no further record to show what, if any, actions were taken. For example, concerns had been raised about staff presence in one of the lounges on more than one occasion but it was not clear what ongoing action or reviews were taking place.

Following a recent survey of the views of people using the service, an action plan had been drawn up that included looking for ways to access transport for more trips outside of the home.

Staff responsiveness to call bells was monitored to ensure when people pressed their call bell staff answered in a timely way.

The registered manager kept up to date with developments in the social care industry through being a member of a local care association.

The registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of registration. The rating from the previous inspection report was displayed in the home and on the provider's website.