J Sai Country Home Limited

Durban House

Inspection report

33 Woodley Lane
Woodley lane
Romsey
Hampshire
SO51 7JL

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

Date of inspection visit:
29 June 2021
30 June 2021

Date of publication:
01 December 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Durban House provides personal and nursing care for up to 42 people who may be living with dementia. At the time of our inspection 34 people were using the service.

People's experience of using this service and what we found
The provider failed to ensure sufficient staff were appropriately deployed to meet people's needs at all times.

We could not be assured risks associated with people's needs were always assessed appropriately or managed.

We were not confident that unexplained injuries were investigated to ensure people were safeguarded.

Infection control procedures were not always followed in relation to cleanliness and clinical care.

The management of medicines requires improvement.

Governance systems were not effective in promoting a person-centred culture and failed to ensure people received high quality care.

Audits conducted by management failed to identify specific areas of concern we found during our inspection.

Care records required improvement to ensure continuity of care.

Some policies required review to ensure all relevant information was in these and they were being adhered to.

Staff did not always treat people with dignity and respect.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published on 1 January 2019)

Why we inspected
The inspection was prompted in part due to concerns received about skin care, dignity not being provided, a lack of leadership and safeguarding concerns.

We undertook this focused inspection to check people were safely cared for. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service is requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Durban House on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Durban House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out the inspection with the support of a specialist 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.

Service and service type
Durban House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced. Inspection activity started on 29 June 2021 and ended on 12 July 2021. We visited Durban House on 29 June 2021.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from various local authorities, commissioners and professionals who work with the service. We used information held on our system about the service to plan our inspection. We used all of this information to plan our inspection.

During the inspection
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 spoke with registered manager, the operations manager, a senior carer, five care workers and two nurses. We spoke with 11 relatives over the phone to obtain their feedback about the quality of care provided. We looked at various care records for 14 people and four staff members. This included records in relation to falls, skin care, medicines, catheter care, nutrition, diabetes, end of life care, infection control, safeguarding, rotas and recruitment. We also looked at records and certificates in relation to the maintenance of the building.

After the inspection
We continued to review evidence sent to us by the providers management team. This included training and induction, policies and procedures as well as internal quality assurances processes.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● The provider failed to ensure sufficient numbers of staff were appropriately deployed to keep people safe and meet their needs at all times. During the lunchtime period, many staff were available to assist people with their meals in the dining areas. However, in other areas of the home, this was not the case. At 12.25pm we heard one person in their bedroom shout for help. They said, "Help me, I am going to fall". We attempted to find staff, but no staff were available, which meant they failed to respond to the request. We entered the person's bedroom to find them positioned on the edge of their wheelchair. The person said, "Please help me I am going to fall off". We assisted the person to get their balance, so they were able to get themself into a safe position. We then visited the nurse's office to explain no staff were available to provide assistance.

● On a second occasion, we heard another person shout, "Please help me I need to go to the toilet". No staff were available to respond to the request. We entered the person's bedroom and they said, "They don't take a lot of notice of me. If I ask to go to the toilet they say wait until someone can take you and then they don't come back". We walked around the first floor to find a care worker and found no staff available. We immediately returned to the nurse's office and told them they needed to organise staff to support the person with their personal care. This was then arranged.

● Whilst the provider told us how staff were allocated during their shits, on a number of occasions throughout the inspection visit we observed that staff were not in the areas they were allocated to and that people did not always have their needs responded to because staff were not available.

● Most relatives we spoke with felt they were unable to comments of the staffing levels of if staff had enough time to spend with people. However, one relative said, "A member of staff said that there is very limited staff on at night", "When I telephone after 15.00 no one answers." The provider sent us a record of unanswered calls over a period of 14 weeks. Whilst the number of unanswered calls did not appear to be excessively high, we did observe that 50% of these were after 15:00 hours. This relative also told us, "When you ring the doorbell the office staff do not come to answer it straight away".

The failure to have deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● We were not assured that risks to people had been assessed and plans implemented to reduce these. For example, one person living with diabetes did not have a plan in place which contained sufficient information to guide staff about the risks associated with diabetes, what they should monitor for and what action they should take if the risks presented. This would have been important as only 9 of 33 care staff had received any

training in diabetes and one two of these were within the last year.

● For another person we saw they were a risk of a serious medical complication which could have potential life threatening implication for them. No plan of care identifying the signs, symptoms, monitoring or action staff should take was in place. This would have been important as no staff had received any training regarding this condition.

● We received feedback from seven relatives that their relative had experienced falls since living at Durban House and reflected some action take to reduce the risks. Comments from relatives included; Mum has had a couple of minor falls out of bed. They have put a crash mat down now by her bed.", "She had a fall out of bed. She fell onto the mat put by her bed. Since then though her mobility has decreased so much that falls now are not a problem. She now has to be hoisted into a chair or wheel-chair". Another relative told us how their relative had been referred to the falls team following a fall.

● Whilst we saw some action taken to reduce the risks for people, we were not always confident that mitigation had been fully explored. For example. We observed that some people in the home were provided with an alarm mat which was located by their bedside. These alarms are used to inform staff of a person's movement and in the case of high risk of falls aim to get staff assistance to them promptly. However, we did not observe these being used when people were seated in chairs, in communal areas. Plans of care did not guide staff to using the alarms at these times. For example, one person was assessed as being a high risk of falls and whilst their plan stated to use a sensor mat in their room, it was not used in communal areas and a falls records reflected this person had suffered a fall in a communal area which was not witnessed by staff.'

● We were not confident that appropriate monitoring of people's health was undertaken following falls especially where staff could not be confident that no head injury had occurred because these were unwitnessed. For example, for two people we found records did not reflect appropriate post falls monitoring took place and regular checks of people's clinical vital signs were undertaken.

● Prior to the inspection concerns had been raised that people were at risk due to pressure injuries. We were not confident that who were at risk of skin damage were cared for safely. Seventeen people living in the home had been identified as being at risk of skin damage and as requiring support to change their position. However, records for some people did not reflect that they were receiving the correct support to help them change position and reduce the risk of skin breakdown for people. For example, one person's record reflected they were seated in a chair for nine hours on one day, without being supported to change position during this time. A second persons care plan stated they should be supported to change position every three hours but the records of change of position sent to us did not reflect this was happening and showed extended periods of time without changing position. A third person care records provided inconsistent information about how often they should be supported to change position and the daily records sent to us demonstrated that they were not always supported to change position in line with either of these records.

The failure to ensure risks associated with people's needs were assessed and plans implemented to reduce the risk was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Relatives told us they did were not always provided with explanations regarding bruising or skin damage. One relative said, "She has some bruising on her sometimes. She had some bruising on her forehead last time which I queried. They didn't know what had happened with that".

● We were not always confident that the cause of bruising was investigated to ensure people were safeguarded. This was because records did not evidence investigations into bruises were undertaken. For example, for one person the bruise incident report sent to us did not record a cause or detail an investigation into the cause. In addition, it provided no recommendations to avoid incidents of a similar nature.

A failure to ensure systems and processes were operated effectively used to identify potential areas of concerns was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff had been trained in safeguarding and were able to identify the possible signs and symptoms of different types of abuse. Conversations with staff confirmed this.

Preventing and controlling infection
● Where specific intervention in relation to people's clinical needs were required, we were not confident these were being followed. For example, staff were unable to confirm they followed good infection prevention and control measures when providing catheter care.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Chairs in the lounge areas were stained and crumbs were found on various areas of the flooring and on seats. The provider told us a schedule was in place for the refurbishment of the lounge which included the replacement of chairs. They also confirmed that some of the chairs in the lounge had already been replaced.
● We were not always assured the provider was using PPE effectively and safely. Staff failed to consistently use PPE in accordance with best practice guidance. For example, gloves were being used at inappropriate times meaning that good hand hygiene would not be maintained.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely
● Where people were prescribed topical creams to be applied by staff, we found these were not always being provided. For example, for one person the records showed they did not have their creams applied consistently.
● Some people were living with diabetes and whilst plans were in place regarding their diabetes we found, and a nurse confirmed no instructions for the use of hypoglycaemic agents (these are used to raise blood sugar levels) were in place.
● There was clear evidence of no longer required medicines being securely stored, recorded and witnessed as being put for disposal.
● The temperature of medicines storage areas was maintained within safe limits.
● Medicines that have legal controls, 'Controlled drugs' (CD's) were appropriately stored and recorded.
● Staff received training in the how to support people with their medicine.
● Records contained in staff files showed some staff had received competency assessments to check they were appropriately skilled to administer medicine.
● Relatives told us they believed people received their medicine at the correct times and felt they were provided with PRN (as and when required medicine) when required.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● The provider failed to create a culture that was person-centred and empowering for people. We consistently observed staff failing to provide person-centred care. For example, staff did not always respond to people's repositioning needs, and at times lacked compassion and dignity when people needed assistance. At 10.55am we observed one person sitting on a chair in the lounge. Their hands were bruised and their skin was frail so there were likely to be vulnerable to skin damage. They were crouched over leaning forward on the edge of the chair with their hands hanging off the sides and they were gently banging their head against the wooden bed table that was placed in front of them. At 11.10am a member of staff looked at the person and said, "She is very tired". Due to their communication, the person was unable to respond. Six staff members walked past the person, looked at them and did not take any action to stop the possibility of the person falling or harming themselves from repeatedly banging their head on the table. At 11.19am the person started to vocalise. A member of staff placed a drink on the table and repositioned the person. We returned at 11.28am and found the person had returned to the unsafe position again and was banging their head on the table. We observed no engagement from staff again until at 11.35. We then intervened and told the nursing staff to make sure the person was safe and comfortable. They responded by placing a pillow on the table to avoid the person hurting their head. The person was also repositioned in the chair to a more comfortable position.

● We observed another person in the lounge sitting on a chair. They had slid down the chair and their head was hanging off the side without any support or any pillows to provide comfort. During a period of eight minutes of observation, no staff member supported the person to become more comfortable or had considered the risk of a fall. After eight minutes a member of staff walked past the person and said, "Look at (person's) arm, it's all twisted". The staff member supported the person to a more comfortable position. We returned 10 minutes later to find they had slid back into their previous position. The person was asleep and was at high risk of falling off their chair. We intervened again and asked a staff member to make sure the person was safe and comfortable.

● At 11.00am another person was sitting on a chair playing with their napkin and rubbing their hands together. At 11.15am we observed the same person repeatedly rubbing their hands on the table. At 11.25am we observed the person emptying their drink on the table and rubbing their hands in it and into their clothes. No meaningful activity was provided for this person.

● When we spoke with one person, they told us they didn't like tennis. When we asked them if they wanted something else on the TV, they said they yes but couldn't as the TV only had two working channels. We

raised this with a member of staff, and they said, "Oh well, you'll just have to watch the tennis". We reported this the management team and they confirmed following the inspection that the TV was repaired. However, the action of the staff member was not person centred or respectful.
● Relatives did not always provide positive feedback. One relative said, "I want him to have his dignity. He is a proud man. It's taken ages to get them to cut his hair right and they cut his eyebrows which he has never done." A second relative told us, "[the person] glasses (prescription) keep getting broken and I don't know how they get broken. They don't clean [the person] glasses either. I now buy off-the-peg ones. I don't know what has been going on over the last year." A third relative told us that 2 sets of false teeth had been lost since their relative moved into Durban House and a fourth relative told us they had needed to complain because their relatives socks kept getting lost. A fifth relative told us that the activities and entertainment used to be good and said, "but is has been vastly cut back and there are now no activities".

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

● Positive comments from relatives included, "They are kind and caring. They have a good relationship with X", "She seems very happy here. Nothing seems too much trouble for the staff. [person's name] will ask to go to the toilet and off they take her straight away." And "There are a lot of new ones lately. The ones I know are doing really well."
● The registered manager told us an additional activities worker had been employed and were due to start working in the home soon. In addition, we were informed following the inspection of training the activities worker had undertaken in May 2021 and the roll out of an activities programme as a result of this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● At the last inspection we recommended the provider formalise their process for auditing and monitoring gaps in various areas of their recording systems.
● At this inspection we identified multiple concerns that the provider had failed to recognise and improve before our inspection. Some quality assurance systems were in place to assess, monitor and improve the service. However, where they were in place, they were not consistently effective and had failed to identify some of the concerns we found during the inspection. They failed to identify or drive improvement in relation to a lack of clear guidance in care plans and risk assessments, a failure of staff to adhere to care plan guidance, a failure to adhere to falls protocols, a lack of investigation into unexplained injuries, poor staff culture and person-centred care.
● Records did not always contain sufficient information for staff to provide effective care and support to people. We were not assured the policy regarding blood glucose testing kits was adhered to because staff could not provide evidence of this. We found that the medicines policy required review to ensure all relevant information was in this, specifically the use of syringe drivers.

The failure to operate effective systems to assess, monitor and improve the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● During our feedback session at the end our visit we told the registered manager and the operations manager of our concerns. They were both receptive, were open and transparent about the quality of care provided and acknowledged the home needed to make improvements.

Continuous learning and improving care

● We could not be assured the provider had learned lessons when things went wrong. Information relating to improvement contained in our previous report had not been actioned robustly. The provider had some systems in place to support them to identify where areas needed to be improved on including an annual review and improvement plan. However as stated above the more regular governance processes did not identify the concerns we found.

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

● The registered manager and the operations manager were open and honest with us during and after the inspection. However, we could not always be assured that unexplained injuries were investigated internally, to identify what went wrong and how lessons could be learned.

Working in partnership with others

● Feedback from relatives was mostly positive about partnership working. Comments included, "They said that an optician had been to visit the home and that he has glasses now, but I have never seen them. He always likes to have glasses and a handkerchief on him but I have never seen him with either.", "He has had his feet done by a chiropodist who came to the home and has had his eyes tested.", "They phone you up if there is an 'event'. They phoned me this week to say that she has a cracked heel and they are looking into how it can be treated and that it will need a new prescription from the GP.", "If there is anything wrong they send for the doctor straight away. She has had a urine infection recently and I was informed about it.".

● We requested feedback from seven professional organisations including local authorities. One local authority responded and told us they had no concerns about the quality of care provided.

● Relatives told us they were involved in their loved one's care reviews. Comments included, "I have discussed her care plan. We have had one review of it on Zoom with a member of staff.", "I had a care plan review over Zoom at Easter. It was very much a two-way process. I could ask questions.", "It has been updated recently. Once a year they review it and email you a copy of the updated plan."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care was consistently person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's needs were assessed and plans implemented to reduce the risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance systems and processes were in place to consistently identify potential areas of concerns and to drive improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff at all times.