Care Quality Commission

Mr & Mrs A Mangalji
The Devonshire Care Home

Inspection report

213 Malden Road
New Malden, Surrey KT3 6AG
Tel: 020 8949 0818
Website: www.thedevonshirecarehome.com

Date of inspection visit: 6 and 9 March 2015
Date of publication: 27/05/2015

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?	Good

Overall summary

This inspection took place on 6 and 9 March 2015 and was unannounced. At our last inspection in May 2013 the service was meeting all the standards we looked at.

The Devonshire Care Home provides residential care and support for up to 33 people. The service specialises in meeting the needs of people living with dementia. At the time of our visit, 31 people were using the service and there was a registered manager in place. 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 while using the service. We found that the provider took appropriate steps to protect people from the risk of abuse and discrimination and any allegations of abuse were reported and followed up. Staff received training about safeguarding people from abuse.

People were protected from foreseeable harm because risks to them were assessed and managed appropriately. There were clear instructions for staff about how to manage risks. Staff followed policies about keeping

Summary of findings

people safe from harm whilst promoting their rights and independence. Managers responded promptly to safety concerns raised by other agencies such as local authorities.

There were systems in place to continually review and adjust staffing levels depending on the needs of the service. This ensured there were enough staff to keep people safe. People confirmed this. Staff were appropriately vetted to help protect people from the risks of being cared for by unsuitable staff.

People received their medicines as prescribed and medicines were stored appropriately. Staff ensured medicine supplies were up to date so they did not run out.

People were satisfied that the environment was clean and staff took precautions to protect people from the risk of infection. For example, they carried out daily housekeeping checks to ensure cleaning was done thoroughly.

Staff had the knowledge and skills required to provide people with effective care. This was developed through training, discussion and other methods. People benefited from several examples of learning from research and guidance being put into practice.

Consent to care and treatment was sought in line with legislation and guidance. This included following the relevant procedures under the Mental Capacity Act 2005 when people did not have the capacity to consent to decisions about their care. The provider followed the requirements of the Deprivation of Liberty Safeguards (DoLS). These are procedures designed to ensure that people receiving care and treatment are not deprived of their liberty without good reason.

People were happy with the food that was provided at the home. They were offered a variety of nutritious meals to meet their needs and preferences. Staff sought and followed guidance from relevant professionals where people had special nutritional needs. They took action to ensure people's healthcare needs were met by facilitating regular contact with medical professionals and promptly following up any concerns about people's health.

The environment was designed to meet people's needs, specifically in relation to mobility and dementia. This included facilities designed to aid orientation and reminiscence. The home was furnished and decorated in a way that was appropriate to the needs of the people who used the service.

Staff were caring and developed positive relationships with people. People spoke positively about the staff and said staff took the time to get to know them. They had different ways of doing this for people who were not able to communicate verbally, including speaking with their relatives and observing people for non-verbal signs. People had a settling in period when they first started to use the service to help manage anxiety around the transition and to help staff get to know people. Staff interacted with people according to what was appropriate for their communication needs.

People's dignity and independence were promoted because staff followed individual care plans telling them what each person's care preferences and abilities were. Staff supported people in a way that respected their privacy as far as possible, such as supporting people to eat in private if they requested it.

People had personalised care plans, which staff followed to help ensure their individual needs were met. The care plans took people's preferences and diverse needs into account. Staff supported people to participate in a choice of group and individual activities that were meaningful to them. The provider had plans to introduce further activities and facilities in response to people's requests and life history. Where people did not wish to take part in activities, staff ensured they spent time with them to help protect them from the risks of social isolation.

People knew how to complain and were confident to raise concerns with managers. Managers responded to these in a timely manner and took action to prevent reoccurrence of issues that had caused concerns where this was necessary.

The service had an open and inclusive culture in which people felt comfortable approaching senior staff and managers. The leadership structure was clear. Managers involved people in the day-to-day running of the service by seeking and acting on their feedback on a regular basis.

Summary of findings

Managers used a number of tools, checks and audits to assess, monitor and continually improve the quality of the service. These included accidents and incidents analysis, policy updates and daily checks of the environment, food and care provided.

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?

Good

The service was safe. People felt safe and the provider had appropriate arrangements to help protect people from foreseeable harm and abuse. Staff had received training in safeguarding people from abuse. People had individual management plans about risks specific to them so staff knew how to keep them safe.

There were enough suitable staff to keep people safe. The provider carried out checks on new staff and regularly checked that staffing levels were sufficient to meet people's needs.

Medicines were appropriately stored and administered. There were systems in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective. Staff received training and support to help provide care in line with best practice and current research. The provider followed procedures to ensure consent to care was sought and obtained in line with legal requirements.

People received a variety of nutritious food and any additional support they required to meet their nutritional needs. Staff supported people to access healthcare services as required.

The home environment was specifically designed and maintained to meet the needs of people with reduced mobility and dementia.

Is the service caring?

Good

The service was caring. Staff took the time to build positive caring relationships with people and communicated with people in ways that were appropriate to them.

Staff supported people in such a way as to respect and promote their privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive. People had personalised care plans, which took into account their diverse backgrounds, needs and preferences. They benefited from a variety of activities to occupy their time.

People knew how to use the complaints policy and raise informal concerns. Managers responded promptly to these and took action to prevent them from arising again.

Is the service well-led?

Good

The service was well-led. People knew who was in charge and felt comfortable approaching managers if they wanted to talk with them . Managers involved people in the running of the service by regularly asking for, and acting on, their feedback.

There were a number of regular audits and checks to enable managers to assess, monitor and continually improve the quality of the service. Managers followed up any issues identified by these in a timely manner.

The Devonshire Care 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.

This inspection took place on 6 and 9 March 2015 and was unannounced. We told the provider we would be returning on the second day. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications about events and incidents that services are required by law to inform us of. We also spoke with representatives from the local authority safeguarding team.

During the inspection, we spoke with five people who used the service. Because not everyone was able to tell us about their experiences, we also 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 three members of care staff, the manager and deputy manager and one of the two partners of the provider organisation. We looked at four people's care plans, three staff files and other records relevant to the management of the service such as incident and complaints records.

Good

Is the service safe?

Our findings

The provider took appropriate steps to protect people from abuse and avoidable harm. One person told us, “I’m quite satisfied that I am safe.” We saw that people appeared well-dressed, clean and in good health. People’s care plans contained information about how to protect them from discrimination, including any prejudiced views people might hold against other people or groups of people using the service. Staff received training in safeguarding people from abuse and were able to describe the different types of abuse and their signs, including how they might show differently for different people who used the service, and knew how to report suspicions or allegations of abuse. The service had safeguarding and whistleblowing policies and procedures in place so staff had access to the information they needed to report any concerns about potential or apparent abuse.

We discussed with managers some concerns that had been raised by social services about staff using inappropriate moving and handling techniques to lift people. They told us a moving and handling assessor had visited the home to give advice. The home had acquired a new hoist and people who needed to use it had their own slings so they had access to the equipment that was assessed as being appropriate for them. Care plans had been updated within the last month to include details of moving and handling equipment that people had been assessed as requiring and how to safely assist each person to move. There was also information about mobility equipment each person used, such as walking frames, and how staff should check to make sure the equipment was safe. This helped to protect people from falls and accidents around the home.

Individual risks to people were considered and management plans were incorporated into their care plans to help protect them from foreseeable harm. For example, people whose assessments indicated that they were at risk of acquiring pressure sores had management plans in place and had regular pressure area checks. To help support people’s freedom, the service followed a policy on risk taking which included guidance on supporting people to take day-to-day risks in order to maintain their quality of life. Staff gave examples of how they did this.

People we spoke with felt there were enough staff to meet their needs and we observed that people were not left waiting for long periods when they required assistance. One person said, “I don’t find that things are not done because there are not enough staff. It’s very good.” Managers explained how staffing levels were set according to the needs of the people using the service. They told us they were currently advertising for more staff so they could increase levels and better meet people’s current needs. They told us all staff including domestic staff were trained in providing care so they could cover in emergencies. We confirmed this by looking at training records. Rotas showed that the staffing levels set by the provider were met and that there were always senior staff on shift. We saw a monthly staffing review that the provider carried out to assess how much staff time was required to meet the current needs of the people using the service. Staff documentation showed that appropriate checks were carried out, including references and criminal record checks, to protect people from the risks of being cared for by unsuitable staff.

One person told us, “Everything is done right with my medicines. [The staff] are marvellous.” Each person’s care plan contained details of medicines they were taking, including names, dosages, times to be given and who had prescribed the medicines and for what reason. There were personalised guidelines for people about how staff should administer their medicines according to their preferences whilst ensuring that pharmacy instructions were followed.

Staff were familiar with the medicines policy and procedure and we observed that they followed these when administering medicines. Medicines were stored appropriately and there were systems in place to ensure stock levels were maintained so medicines did not run out. Records showed that people received their medicines as prescribed.

People told us they were satisfied with the cleanliness of the environment. When we visited, the home appeared clean and tidy and free from malodours. We saw examples of precautions taken to protect people from the risk of infection. For example, there were signs in the bathrooms reminding people to use appropriate hand washing techniques and there were clinical waste bins in all bathrooms. These were emptied regularly and we saw a large bin in a secure location outside the building that was used to store the waste until it was collected. There were daily housekeeping checks to ensure cleaning was done.

Good

Is the service effective?

Our findings

People told us they were satisfied with the level of knowledge and skills of staff. We saw several examples of how the service worked to deliver effective care based on best practice and research. Staff, including senior staff, received training in caring for people living with dementia. We heard examples from several staff of how they "enter the reality" of people who were experiencing distress or discomfort because their dementia caused them to believe they were in a different time or place. They did this by discussing the situation with the person as if they were both in that time or place. Staff told us about research suggesting that people living with dementia benefitted from tactile and visual aids and props and we saw people spontaneously engaging with realistic dolls and imitation cats and dogs, which they appeared contented and happy with.

The partner we spoke with told us they were studying for an advanced degree in dementia care and used the knowledge they were acquiring to inform staff and make positive changes to the care provided. For example, they told us about a course in consent and dementia. They said staff were applying its principles, such as not arguing with people or contradicting their beliefs, to make sure people did not feel pressurised into consenting to care that they did not want. We saw evidence that they discussed principles of good practice with staff and passed on their knowledge at staff meetings.

Consent to care and treatment was sought in line with legislation and guidance. We saw information in care plans about people's capacity to consent and make significant decisions about their care. For some people, staff were instructed to involve them in any discussions about such decisions. For those who experienced cognitive or other impairments that could affect their decision making, there was information about how they were affected and what this was likely to mean in terms of their mental capacity. We saw an example where a person's capacity had been assessed to make a healthcare related decision and they were found to lack the capacity. Their family and relevant professionals had attended a 'best interests' meeting to decide on the best course of action for that person.

Managers told us they made applications under the Deprivation of Liberty Safeguards (DoLS) for people with dementia whose mental capacity may have been affected. DoLS are procedures services must follow to ensure that people are only deprived of their liberty as part of their care if this has been found to be in their best interests. At the time of our visit, not all assessments had been carried out because the local authority had a waiting list but the majority of applications had been granted.

One person told us, "The food is good" and another said, "I'm quite happy with the food." We looked at a sample of menus and saw that a variety of nutritious meals were offered. We saw that choices were available and people ate different things for their main meal. We saw staff sitting with people and chatting with them during mealtimes. They explained that this was to make mealtimes a pleasant social event but also so they could monitor how much people were eating and ensure they had enough.

People's needs were assessed in relation to diet and nutrition, including an assessment of people's recommended calorie intake, to help ensure they received an appropriate amount of food. We saw examples of people who had been assessed as being at risk of malnutrition or dehydration and these people's intake was monitored on food and fluid charts to make sure any issues with this were recorded. Some people had specific needs around eating, for example those who experienced swallowing difficulties. These people had received assessments from relevant healthcare professionals and there were guidelines in their care plans about how to support them to eat and drink safely. Staff had received training from an organisation that specialised in nutrition to help them meet people's needs.

There was evidence that people were supported to attend appointments with healthcare professionals when required. The reasons for these were documented and upcoming appointments were noted to help staff ensure they were not missed.

We observed that people were free to move around the home and grounds as they pleased and were not restricted to parts of the house. Bathroom doors were painted a different colour from other doors and there were signs to help people find bathrooms if they became disorientated. We also saw a board with today's date, a clock and pictures showing which staff were on duty. This helped people remain oriented in time and to recognise the staff who were on duty if they needed assistance.

Good

Is the service effective?

We saw a variety of pictures and posters around the home including period items such as 1950s advertisements. There was a staff picture board showing the names and roles of each member of staff and a wall with photographs and pen pictures of each person using the service, including information about their home towns, interests and former careers. This was designed to assist with people's orientation and help them remember who each person was and also to promote conversations and relationships between people using the service.

Good

Is the service caring?

Our findings

Throughout our visit we observed staff supporting people in ways that indicated positive caring relationships. Staff often took time to chat with people about their interests and encouraged people to socialise with each other. Some people had developed close friendships and these were noted in care plans so staff were aware. One person told us, "The [staff] are lovely." Another said, "They're very nice here. They look after me well." People told us that they had developed positive relationships with staff and enjoyed being supported by them.

We observed staff interacting with people in ways that indicated that they knew people well enough to know how to meet their individual needs. For example, staff approached one person whose facial expression had changed and who was indicating discomfort and asked them discreetly if they needed to use the toilet. The person confirmed that they did and staff supported them accordingly.

We observed staff speaking with different people with varying levels of complexity to reflect their different communication needs. We saw staff telling people if a meal or activity was about to start so people knew what was happening next and could decide whether to participate. They offered people choices in ways that were appropriate to their communication styles.

Care plans took into account people's individual cognitive and communication needs and contained guidance for staff about how to support them to make decisions about their care and support. This included whether people usually wished to participate in residents' meetings where they could express their views. If they did not, care plans instructed staff to encourage them or their relatives to complete questionnaires.

The service took steps to ensure that people's wishes around the end of their lives were known so these could be respected at this time. People had advance care plans on file, which showed staff had discussed their preferred funeral arrangements, any religious needs, and if they had any preferences about where they wished to spend the end of their lives.

Care plans contained information to guide staff on how to ensure each person's privacy and dignity was maintained. For example, one person had a tendency to wear dirty clothes and staff were instructed to ensure the person had access to clean clothes and was prompted to change when required. Another person's care plan stated that they preferred to eat meals in private because they were embarrassed about their loss of ability and independence around eating. We observed that this person was not present at the communal meal and staff confirmed they had supported the person in line with their wishes.

We observed staff offering different levels of support to people in line with their individual needs. One person often presented as anxious and staff provided reassurance and guidance to them often. This reflected information given in the person's care plan. Other people received support only when they requested it and this helped to promote their independence.

Good

Is the service responsive?

Our findings

Care was planned and delivered in a way that recognised and supported people's individual needs. People had personalised care plans with detailed information about how they preferred to be supported and how they liked to spend their time. This was written in people's own words where possible and took into account people's own perspectives about their care even if they did not agree with professional opinions. Records showed that staff adhered to the personalised plans. The care plans we looked at had all been reviewed within a month of our visit and changes had been made where required to ensure they contained up to date information about how to meet people's needs. Care plans took into account people's diverse and cultural needs, for example whether they preferred to receive personal care from male or female staff and information about any religious activities they wished to take part in.

Managers told us people were invited to come to the home with their relatives for tea before moving in so they could decide whether the home was right for them and staff could meet them and get to know them. This included gathering information about people's life history and interests, where possible. The home had a 'wraparound care' admission system where people new to the home had the same staff with them continually for at least 72 hours. This was intended to help people settle into the home and assist staff to gather personalised information about them to inform their care plans.

The service provided a variety of activities to meet people's social, cultural and individual needs. Some people's care plans stated whether they habitually read particular newspapers and we saw people receiving these. Staff told us one person had enjoyed painting as part of their previous career and we saw objects they had painted in the garden. Managers told us they had plans to set up a workshop and this would include the opportunity to spray-paint car parts. We also saw evidence that the service was in the process of acquiring a 'pop-up pub' in the home where drinks would be served. This was intended to ensure people were able to take part in the same meaningful activities they had enjoyed before arriving at the home.

The home employed an activities worker and we saw them engaging people in different group activities throughout the day. Although the home had regular activity sessions, staff recognised that not everybody would want to participate in every activity. The activities worker told us that if people did not want to join in, they encouraged them to take part in individual activities like listening to music. We saw that each person had their own music storage device with their favourite music stored on them so they could listen to it when they pleased. We heard people singing along and saw people dancing with staff while listening to music in the communal area. Other people were chatting together. The home had recently acquired an old-fashioned television set and some DVDs of 1950s television programmes for the communal lounge, although a modern television was available in another part of the home.

There were systems in place to help protect people from the risks of social isolation. For example, staff told us they visited people who stayed in their rooms during the day at least hourly. One person's care plan stated that they preferred to stay in their room but with the door open so they could see people coming and going. We observed that this was the case and spoke with the person, who told us they were happy with the arrangement. Care plans took into account people's relationships with family, friends and other people who used the service and contained information about how to support people to maintain these.

The service had systems in place to learn from people's experiences, concerns and complaints. People told us they were confident that the provider would listen to any concerns they raised. The local authority safeguarding team told us that the service was receptive and responsive to any concerns they raised, making sure any issues were dealt with in a timely manner. We looked at records of concerns and complaints held by the service. Managers had documented the action they had taken including plans they had put in place to prevent reoccurrence of the event that caused the concern, if appropriate. Where concerns were raised by people using the service or their families, there was evidence that the service had responded directly to the person or relative, including meeting with them if appropriate to discuss the issue.

Good

Is the service well-led?

Our findings

People benefited from an open and inclusive culture within the service. People told us they knew who was in charge and that managers were open and approachable. They told us they always felt able to discuss their care with those in charge. Staff also told us they felt comfortable speaking up at team meetings, that everyone was treated fairly and that any conflicts were always resolved quickly. Records showed that the meetings were well attended.

We saw evidence that people were involved in the day-to-day running of the service. One example was menu evaluations, where staff asked people to answer questions or fill in forms about their opinions of the food provided at the home. We reviewed a sample of these and feedback was positive. Records from residents' meetings showed that staff asked people for their views and involved them in decisions about the service. Staff told us they were also asked for their opinions.

The service had a clear vision and values, which staff said were a strong part of the home's culture and consistently described them to us. These included listening to people. The service used residents' meetings and questionnaires to gather people's views. We heard several examples from staff and people using the service of suggestions that people had raised about what they would like to see in the home and changes that were being made as a result.

Managers used records to help them monitor any patterns or trends in incidents, adverse events and staff absences. They used these to form action plans about how to keep people safe and improve the service.

At the inspection, we spoke with the manager, deputy manager and one of the two partners who make up the provider organisation. They told us the manager was planning to retire shortly and the deputy manager was in the process of working towards taking over the role. The deputy manager was also working towards gaining an advanced qualification in social care. Staff felt that the transition was being managed appropriately and in a controlled way.

The service had a number of policies and procedures to help staff deliver high quality care. These had been updated within a year of our visit and included policies on maintaining people's privacy and dignity, supporting people to make choices and about consent and capacity. There was evidence that these were discussed at staff meetings so staff were enabled to support people consistently to agreed standards.

Managers carried out daily checks to make sure the care provided was of high quality. They observed care and identified whether any further staff training was required, and we saw evidence that this was followed through if this was the case. There were audits of menus and activities people participated in so managers could monitor whether people received a suitable variety of food and meaningful activities. We also saw housekeeping, maintenance and menu checks, audits of the amount of time people spent with their key workers and checks of people's personal care records to ensure these were being filled in correctly and agreed with people's planned care. We saw some examples of where managers had identified and addressed shortfalls.

Staff told us their managers used supervision to help drive up the quality of their work by giving them targets to work towards and providing individual feedback about their work. Managers also used feedback from surveys of people and their relatives to drive improvements. For example, 10 out of 21 people who responded to the 2014 annual questionnaire felt that the laundry service required improvements. As a result the provider had employed a laundry manager to address the problem and all of the people we spoke with during our visit told us this aspect of the service had improved.