Avery Homes RH Limited

Darwin Court Care Centre

Inspection report

Wissage Road
Lichfield
Staffordshire
WS13 6SP

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17 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 16 and 17 March 2016. This was an unannounced inspection and was the first inspection under the new provider who registered with us in March 2015. Darwin Court Care Centre provides accommodation and support for up to 112 people. On the days of our inspection there were 86 people using the service. The service is divided into six units across three floors. Some of the people living there had nursing care needs, and some were living with dementia.

The home had a manager in place who was in the process of registering with us. 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.

We found that people did not consistently receive support from staff who knew them well and staff were not always aware of some people's support needs. Consent to care was not always sought in line with legislation and guidance. Some people did not have the capacity to make certain decisions, and it was not always clear how decisions had been made in their best interest or who had been consulted.

We found that people were not always cared for in a dignified, compassionate way, and there were times when their privacy was not respected. There was a lack of consistency in involving people with decisions and the planning of their care.

People did not consistently receive care that was individual to them and responsive to their needs. Opportunities for people to follow their interests and engage in activities varied.

There was a lack of consistency in the leadership and management across the units, and people told us that the quality of the staff varied. Care records were not always up to date and accurate and this made it difficult for staff to be clear about people's support needs.

People told us they felt safe living there and staff understood how to protect people from harm and abuse. Risks were managed and there were sufficient staff to keep people safe. Medicines were managed so people received them safely and as prescribed. People were supported to maintain a balanced diet and have access to healthcare services when needed.

People told us and we observed that some staff were kind, caring and compassionate. We also saw that some staff responded well to people's needs and engaged positively with them. People knew how to raise any concerns or complaints and we saw that the provider had addressed complaints in a timely manner.

Staff told us that the availability of training had increased and the quality of the induction had improved. Some staff had received supervision sessions and we saw that this had been planned for others.

We saw that the provider had implemented some changes since the manager had been appointed. A recruitment drive was in progress to increase the numbers of permanent staff; work was in progress to improve the quality of the care records; regular quality audits had been introduced; and opportunities for people to share their experiences had been implemented.

You can see what action we told the provider to take at the back of the full version of the report.

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 told us they felt safe and staff were aware of how to protect people from avoidable harm and abuse. Risks to people's safety were assessed and where risks were identified, the care records we looked at had plans in place to guide staff on how to minimise the risks. There were sufficient suitable staff to keep people safe and medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found the provider was not consistently working within the principles of the MCA. People did not always receive care from staff who had the knowledge to meet their needs. Some areas had been adapted to meet the needs of people living with dementia, but others had not. Supervision was not consistently available to support staff, but the induction programme and training was viewed positively. Consent to care was not always sought in line with guidance. People were supported to maintain their health and their nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw that positive caring relationships were not always developed and people were not always treated in a respectful way. We saw that people's privacy and dignity was not always considered. People were not always enabled to make choices about their care and support. People's relatives and friends were able to visit when they chose.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found that people did not consistently receive care that was individual to them and responsive to their needs. We saw that opportunities for people to follow their interests and engage in

stimulating activities varied. People knew how to raise concerns and complaints, and the provider responded to issues raised.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We found there was a lack of consistency in the leadership across the units and how they each strove to deliver high quality care to the people who used the service. Care records were not always up to date and accurate. People spoke positively about the changes in management. The provider had a visible presence and had introduced audits and trend analysis to drive improvement.

Darwin Court Care Centre

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 visit took place on 16 and 17 March 2016 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor and two experts by experience. A specialist advisor is a person who has professional experience in a particular area of work. This specialist advisor was a registered mental health nurse who had experience of working with older adults and people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was with older people and people living with dementia.

We had asked the provider to send us a Provider Information Return (PIR) but due to technical difficulties beyond the provider's control, and despite them trying to rectify matters, this had not been received prior to our visit. 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. However, we offered the provider the opportunity to share information they felt was relevant. We reviewed other information we held about the service. We looked at information received from people that used the service and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We spoke with 25 people who used the service and 21 relatives and friends. We also observed the care people received in the communal areas of the home so we could understand people's experience of living there. We also spoke with 15 members of care staff, the manager and regional manager.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at 16 people's care records to see if they were accurate and up to date. We reviewed three staff files to see how staff were recruited. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I've always felt safe." Another told us, "I'm 100% safe. I feel as safe here as I did in my own home." One relative we spoke with said, "There's no problem with safety." Another relative told us, "I feel I can go away and not worry about what's happening." People told us the environment helped to keep them safe. One person said, "Only the right people can get in." A relative told us, "People aren't put into vulnerable situations. It is secure." This demonstrated people who used the service were suitably supported.

Staff we spoke with were aware of how to protect people from harm. Staff knew about the different types of abuse that could happen. One staff member said, "I would look out for changes in a person's emotions and personality, for example if they became more withdrawn. That can indicate that something is wrong." Another member of staff told us they would look out for any bruising or marks and would listen to what people were telling them. Staff told us they would report any concerns to their line manager on the unit, and if needed would report to the head office. Staff were aware of the whistleblowing policy and said they would be confident to use this if needed. This is a policy to enable staff to report any concerns anonymously. We saw that appropriate safeguarding concerns had been made to the local authority and we had also been notified as required.

We observed staff using equipment to transfer people in a safe way. Staff explained to people what was happening as they were moved in the hoist and also asked them to keep their arms tucked in and not hold the straps. We saw that people's moving and handling risk assessments had been updated and staff were aware of any changes and what they needed to do. We saw that people had an up to date evacuation plan in place in case of emergency which staff were aware of. We saw that potential risks to individuals were managed to protect people from harm. Some people who used the service were at risk of developing sore skin. We saw that these people had the appropriate equipment in place, such as special mattresses, to minimise the risks. One relative told us, "The staff check the mattress to make sure it's on the right setting." We saw that the pressure on the mattresses we looked at was set according to the recommendations given. Which meant that any risks to people were considered.

We found there were sufficient staff to keep people safe. When people's assessments showed they needed one to one support to keep them and others safe, we saw that these were in place. One relative said, "There's always someone sitting with them." We saw that when people needed two members of staff to support them when transferring this happened. We saw that people's call bells were usually responded to quickly. One person told us, "The staff do come quite quickly when I use the call bell in my room."

We saw that when staff started working in the service, recruitment checks were in place to ensure they were suitable to work with people. This included police checks and references. A DBS provides a check relating to any previous criminal records. One staff member told us, "All my checks were completed before I could start working here." We saw that the provider had taken action when staff had not worked in a safe manner and this had been dealt with by their disciplinary processes. One staff member said, "Some people have been dismissed; there has been a shake up."

People we spoke with told us they received their medicines on time. One visitor told us, "I've been here when they do the drug rounds and my friend has been given them." We saw that medicines were kept securely so that only authorised people could have access to them. We observed medicines being dispensed from the treatment room and being taken to people on the unit, one at a time. One staff member explained, "It is safer doing it this way. I think that having the medicines trolley out on the unit could pose a risk for some people." We saw that the medicines administration records were completed for each person. There was also a photograph of the person who used the service on their record sheet to ensure that people received their medicines that had been prescribed for them. We observed staff giving explanations and reassurance to people when they were given their medicines. This demonstrated people's medicines were managed so they received them safely and as prescribed.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We found the provider was not consistently working within the principles of the MCA. Even though people had capacity assessments in place and their capacity was considered regarding the care planning process, these assessments were not decision specific and did not clearly demonstrate if the person had capacity or not. Where people had fluctuating capacity, for example with personal care requests, this was not clearly demonstrated within their assessment. Some people had 'do not attempt cardio pulmonary resuscitation' documents in their files but in some cases there was no evidence from the decision maker as to why this would have been in their best interests. It was also not evidenced in the care records how the person (if they had capacity) or the families had been involved with this decision and how people had been consulted. Staff we spoke with had varied knowledge about the MCA. Some were able to demonstrate a good understanding, while others were unable to tell us about the key principles and how the Act impacted on their day to day work.

This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people did not consistently receive support from staff that knew them well or had the knowledge and skills to carry out their role. For example, one person needed to use equipment to enable them to transfer from their chair. The incorrect item was brought to them. The person said, "They've used all sorts recently; I don't care what they use as long as I can get to the toilet." Another person told us, "I think they need more experienced staff; they are few and far between." Another said, "Some of the carers are competent." One staff member told us, "It's not good, only a couple of staff are permanent. We always have the same couple rushing around as the others don't know the people." Other people spoke more positively, and one person told us, "They know where and when I need support." One relative said, "The staff know what they are doing."

Staff were not always aware of some people's support needs. For example, we saw that one person had their drinks thickened. The staff member supporting them told us, "I'm not sure why they have their drinks thickened; we have just always done it like that." There were no recommendations in the support plan from the speech and language therapist to indicate why the person needed their drinks like this. However, another person needed their drinks to be of a 'custard consistency' as they were at risk of choking. Staff were aware of this, we saw this happened, and the persons records reflected these recommendations and explained why they were in place.

We saw that some of the units had been adapted to meet the needs of people who live with dementia. For example, there were memory boxes by their bedroom doors that would assist them to identify their room. However, other units were decorated sparsely with no signage or visual clues to help people know where to go.

Not all the staff we spoke with said they had received supervision sessions or appraisals. However one staff member told us, "I will be getting additional training so I can supervise the care staff on the unit." Staff recognised that supervisions were important as this would give them the opportunity to develop their skills and identify any support they needed. Staff told us they received ongoing training to equip them to do their jobs. Staff said they completed an induction programme when they started their role. One told us, "The induction has really improved since the new provider took over; its lots better."

We saw that where people lacked capacity to consent to their care and were under continuous supervision, applications had been made and some authorisations had been approved regarding DoLS. This meant that when people were restricted, this was being done lawfully.

We saw people were supported to maintain a balanced diet. One person told us, "I have regular drinks throughout the day. They come round with the trolley every couple of hours." Another said, "There's plenty of food. I get what I need." We observed people being supported to have their food and drinks if they were not able to do this themselves. We saw staff offer extra portions to people.

Staff understood people's dietary requirements and information in people's care files included an assessment of their nutritional needs. Where assessments identified people were at nutritional risk we saw that monitoring charts were in place and completed to ensure people could be referred to specialist service as needed. For example, one person had been referred and seen by a dietician who had provided guidance on the support and diet required for this person. We saw that staff followed this guidance and the risks had decreased.

We saw people's health care needs were monitored and referrals were made to other healthcare professionals when needed. One person told us, "I see the chiropodist regularly." Another said, "I arrange to go to the dentist or opticians myself and one of the carers will help me." Visitors confirmed they were kept informed of any changes in their relative's health or other matters. One told us, "The staff got the appointment sorted out and their health needs are met." Another said, "They will always ring to let me know if the doctor has been needed."

Requires Improvement

Is the service caring?

Our findings

We observed a lack of consistency and consideration in how staff cared for people. For example, we saw some staff entering communal areas speaking with each other but not acknowledging the people who lived there. We observed some staff leaning over people when they spoke with them and standing by the side of people when they supported them to have their meal which could have been intimidating for people. When people had one to one support, we saw some staff did not engage or interact with the person they were supporting; they would sit and observe them but not talk with them. We saw that when some staff did communicate with people it was limited and usually to do with the task in hand. One person who had been waiting to be supported with their personal care and was therefore uncomfortable told us, "I feel like screaming. It makes me feel like a piece of rubbish." This meant that people were not always treated in a dignified manner.

We also watched some staff move people in their adapted chairs without engaging with them or explaining what was happening. We saw some staff did not respond to people who were becoming anxious or when people asked questions and it was only when people became more verbally aggressive did the staff intervene. During one lunchtime, we watched one staff member support a person to eat their lunch. At no time did they speak with them or let them know what was happening or describe what they were eating. The person had their eyes shut and the only way they knew food was near their mouth was when the spoon touched their lips. This meant that staff did not always support people in a caring way.

We found that some staff talked about the people who used the service in ways that were not caring or compassionate. For example, talking about people as 'the softs' when referring to people who had a soft diet recommended due to their risks of choking. We also observed staff talking loudly in the corridors about 'who had been done' (referring to meeting people's personal care needs) and then saying the names of people who still needed support. This meant that people were not always treated with dignity and their privacy was not fully respected.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of consistency when involving people with decisions and planning of care. One person said, "I would like to look after my medicines by myself, but I wasn't offered the chance to do this." A visitor told us, "My relative knows what they're talking about, and when they said that they hadn't had breakfast, the staff didn't listen and told us they'd had it. But it turned out they hadn't." This showed that the staff had not listened to what the person had been saying. We saw that staff did not always enable people to make choices. For example, we observed some staff asking other staff members what people would want to have for their lunch rather than asking the person. We observed staff asking people to sit down even though they wanted to stand up and have a walk around. During lunchtime, no one on one unit was given the option to have gravy or cream on their meals. This meant that some people were not given the opportunity to be in control of their lives.

However, we did see some staff encourage people to make choices. For example, we observed one staff member help a person make a decision about their meal by showing them the two options plated up. The person was then able to make a choice. The staff member did this in a caring and fun way, which the person appreciated. We saw that staff did cut up food for some people so they could manage their meal independently. Some people used specialist equipment to enable them to eat and drink more independently.

We also observed and were told about some staff who had developed kind and compassionate relationships with the people who used the service. One person said, "The staff are excellent, really friendly. I couldn't fault them." One relative told us, "The staff are friendly and kind and look after [person who used service]." Another said, "The staff on this unit are really lovely." We observed one staff member reassuring a person living with dementia that their lunch was already paid for and they need not worry. We saw staff offer gentle reassurance to one person by stroking their arm and holding their hand. We observed some staff talking with people and laughing together and sitting on stools so they were at eye level with the people they were spending time with. We observed some staff straightening peoples clothing after being transferred in the hoist. One relative said, "The staff will shut the door if they are assisting with personal care." We saw that people were dressed individually reflecting their personal taste. This meant that sometimes people's dignity was respected.

We saw that people were encouraged to maintain relationships that were important to them. One relative said, "I'm always made to feel welcome whenever I visit." We saw over that people visited at various times of the day and there were no restrictions as to when they could arrive. The provider had made the reception area welcoming and there was a kitchen area where people could make refreshments.

Requires Improvement

Is the service responsive?

Our findings

We found that people did not consistently receive care that was individual to them and responsive to their needs. For example, during one lunchtime observation we saw that a staff member recognised that the person who used the service was not sitting close enough to the table, and so moved their chair in. However, this member of staff did not see that the person was not able to manage the larger items of food on their plate. The person was then trying to pick up the food unsuccessfully so only ate the smaller items. After 20 minutes, the staff member returned, recognised the problem and then cut the food up into manageable pieces. By this time, their meal was cold.

We were told that the staff did not always have time to give support to people unless it was to do with a personal care task. One person said, "It really helps me to have some time to talk to people. It reduces my anxieties. But this doesn't happen much." Another person told us they liked to spend time chatting to others, but did not have the opportunity to do this as the other people on the unit had limited verbal communication. We did not observe them being supported sit in the reception area which is where they said they liked to be.

We also found that some people who would have been able to contribute to their support plans had not been given the opportunity to do this. One person said, "I didn't know that I had a care file. I've never seen it before." When the person informed a staff member that some of the information included in their file was incorrect, they were told that the information could not be changed until another professional had agreed to this. The person told us, "They wouldn't even make a note of what I'd said." However, another person said, "I'm aware of my care plan, and the staff go through it with me now and again."

We saw that opportunities for people to follow their interests and engage in stimulating activities varied across the units. One person told us, "There are no activities for me here." Another person said, "I'd like to go out more. There is a mini bus available, but apparently there's no one to drive it." A visitor told us, "My relatives care needs are met, but their social needs not so much." One staff member said, "I'd like to see more activities for the residents. We don't have that many and people are bored." We observed some people sitting without any personal items by them, such as a book. When a member of staff gave one person an option to do some craft work, the person said, "No I don't want to do that, I like to sew." However, they had no materials to do this. We saw one person was positioned with their back to the television so they would not have been able to watch it even if they wanted to.

We also observed some responsive care. One person said, "I love to dance." The staff member then put on some music and we watched them dance together. Another person told us, "Sometimes we go downstairs; the classical guitar was very good and they did a clothes sale." One visitor said, "I know my relatives been out to the Cathedral and a tea room, so they do get to go out. They also get to watch the sport on TV which I know they like." There was an activities co-ordinator employed and we observed an activity they had organised which was well attended by people, though not many were seen to join in. One person told us, "I enjoyed the Easter activities; we made bonnets and did some painting."

People who used the service and their relatives told us they knew how to raise any concerns or complaints. One person said, "If I wasn't happy I would complain to staff." A relative told us, "I would complain to the manager, but I've not had to." Another said, "We know there's a new manager and would raise any issues with her." We saw there was a complaints process in place and the provider had responded to issues in a timely manner. We saw that relatives had attended meetings with the manager to discuss specific issues and concerns. The provider had recently started to have meetings for the people who used the service and their relatives. The manager said, "There had been no residents or relatives meetings, but we had the first one at the beginning of March. There's another booked for next month." We saw that the manager had sent out an action plan to people to inform them of the changes they were implementing following this meeting.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and regional manager told us that they were in a period of transition from the previous provider's paperwork to theirs. They had found that some people's information was not correct, and so they were working to rectify this. However, staff shared concerns regarding the care plans during this time of transition. One staff member told us, "The information is difficult and confusing." We saw there was contradictory information in people's care plans. For example, one person was described as being both continent and incontinent. Another person was described as needing to walk with a frame, but further records stated they were able to walk independently. We also saw that key information was missing from some people's files. For example, people who were receiving end of life care did not always have information explaining how the staff should support them in their last days. This meant it was difficult for staff to be clear about people's support needs.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of consistency in the leadership across the units. One person told us, "They need team leadership on the floor. There is no guidance." Another said, "There needs to be more team work so they can work more effectively." One staff member told us, "I prefer working on this unit; it's more organised. The other one always seemed so chaotic."

We found there was a lack of consistency in how each unit strove to deliver high quality care to the people who used the service. People we spoke with told us there was a lack of consistency in the quality of the staff available. One relative said, "There isn't consistency with the staff and there will be a number of different people. So you don't get to know them." Another told us, "There are enough staff numbers, but the quality varies greatly." One staff member said, "We don't have regular staff to hand over to. There's no continuity for the people that live here." The provider told us they were currently undergoing a recruitment drive to fill the large number of vacant care posts.

The home was going through a period of transition; the manager had been recruited recently and there had been changes to the senior management team. One staff member said, "We've all been going through a difficult period of change." Another staff member told us, "The new providers are on the ball. There is going to be a big difference. They have high standards." Generally, people spoke positively about the changes. One member of staff said, "The new management team is better; we're getting more training now." Another told us, "The manager is fair and approachable. She is good and I want her to continue." We were told that the management team had a visible presence on the units. One relative said, "There have been changes, but I know who the new manager is." One staff member said, "I always have senior staff coming onto the unit to see how I'm doing."

We observed the morning meeting where each unit lead and other staff team co-ordinators (such as catering and housekeeping) shared information with the manager. The manager told us that the nurse on duty for each unit would then share this information with their respective staff team. One member of staff

said, "As carers, we're not involved with these handover meetings. But the nurse or senior carer will tell us what we need to know." The manager told us they had recently introduced these handover meetings to ensure that important information was shared and acted on.

We saw the provider had introduced quality audits that covered various aspects of the service. Together with the manager, they had started to analyse any trends and had already put some actions into place. For example, they had implemented an accidents and incidents audit and had set a target to improve and update the care plans each month. We saw that supervisions had been planned for the staff. They recognised that this was an important way to drive improvement in the quality of the care people received. The manager told us they had started a weekend cover rota that the senior staff would be doing. They explained that this would ensure that there was management presence across the week.

We saw that meetings had taken place with the people who used the service and their relatives to discuss any concerns and explain proposed changes. The manager was actively encouraging feedback from people and had just introduced a 'You Said, We Did' board in the reception area. This would enable people to see what actions had taken place in response to their requests. The manager demonstrated understanding about their responsibilities and had reported any notifiable incidents to us in a timely manner.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005. Where people were unable to consent, information in the capacity assessments was sometimes contradictory and best interests decisions were not evidenced. It was not clear how people or others who were important to them had been involved with some decisions. Staff were not always familiar with the principles and codes of the Mental Capacity Act 2005. Regulation 11 (1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to the care and treatment for each person using the service were not always fit for purpose. Regulation 17 (2) (c).