Care Northampton Limited

Da_Mar Residential Care Home

Inspection report

83-87 Moore Street,
Northampton, NN2 7HU
Tel: 01604791705
Website: None

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place over two days on the 9 and 10 October 2014. Da-Mar provides accommodation and personal care for up to 29 older people. There were 14 people in residence during this inspection, the majority of whom had a range of dementia care needs.

At the time of this inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social care Act 2008 and associated regulations about how the service is run.

At the last inspection on 22 May 2014 we asked the provider to take action to improve the management of day-to-day risks so that people received the safe care

Summary of findings

they needed, and to improve how agency staff used to cover staff sickness were briefed on people's needs. We received an action plan from the provider and this has been completed.

People said they felt safe at Da-Mar. However, we found that people's safety could be further enhanced by a more robust analysis of incident patterns, such as falls, so that where necessary more timely preventative measures could be taken to minimise the risk of reoccurrence.

People said they were happy at the home and received the care they needed. Staff were appropriately recruited, with all the necessary checks carried out and their induction training completed before they were tasked to carry out their duties. However, some training for staff who had been employed for over 12 months should be refreshed at more timely intervals so that best practice was sustained.

Staff knew their responsibilities, were kind to people and there were sufficient numbers of staff on duty to meet people's needs. However, although people said they had enough to eat and drinks, some additional care was needed to ensure that people consistently drank enough throughout the day.

People said their privacy and dignity was respected but staff needed to be mindful of unintentionally compromising respect for people by referring to them as 'love' or 'dear' instead of their preferred name.

People, including relatives and other visitors to the home such as healthcare professionals said the manager and staff were approachable, friendly, and attentive. However, arrangements for involving people or their representatives in making decisions about the running of the home needed to be strengthened.

People said they were content with their physical surroundings and said they were comfortable. The communal areas were clean and functional but lacked visually imaginative touches that would have enhanced the appearance of the living environment. One visitor commented that the home was "rather drab and in need of a facelift".

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?
The service was not consistently safe.

People said they felt safe. However, there was no demonstrable system in use for the registered manager to monitor and learn lessons from accidents or incidents that had in the past compromised people's safety. Such a system enables staff to have the information they need to proactively minimise people's exposure to potentially unsafe care or situations where accidents are more likely to reoccur.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People said they had the timely support they needed. However, the system in place to monitor how much people had drunk was ineffectual because staff did not always if the person had actually drunk what was provided. This was particularly consequential for people deemed at risk of drinking insufficient amounts.

Requires Improvement

Is the service caring?
The service was caring.

People said the staff were friendly, kind and caring. They said they were well treated. We observed staff conscientiously attended to people when they needed assistance.

Good

Is the service responsive?
The service was responsive.

People said they received the support they needed that was important to them as an individual and that staff knew what they liked and disliked.

Good

Is the service well-led?
The service was not consistently well-led.

People said the registered manager did a good job of getting the staff to provide them with the care they needed. However, we found the registered manager needed to arrange for people, or their representatives, to have more of a say in the day-to-day running of the home by providing, for example, regular participatory meetings.

Requires Improvement

Da_Mar Residential 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 unannounced inspection took place over two days on the 9 and 10 October 2014. Our team consisted of two inspectors, an 'expert-by-experience' (ExE) and a specialist advisor who had professional experience of working with people with dementia. The ExE in our team also had personal experience of caring for a relative with dementia.

Prior to our inspection, we reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about incidents in the home that the provider is legally required to inform us about, such as an accidental injury requiring treatment from a healthcare professional in order to prevent prolonged pain, or any abuse or allegation of abuse.

We had asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well, and includes details of any improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During this 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 because their dementia had impaired their ability to communicate verbally. We also undertook general observations in the communal areas within the home. We viewed five bedrooms with the permission of each person.

We spoke with five persons who used the service, four visitors to the home including two healthcare professionals and two relatives. We also spoke with six staff including the registered manager, four care staff and the cook.

We reviewed the care records of five people who used the service and six staff recruitments files. We also reviewed the records relating to the management of the home and the quality assurance of the service provided.

We looked at the overall appearance of the physical environment and took into account people's experience of using the facilities such as whether they felt physically comfortable in the home and liked their surroundings.

Requires Improvement

Is the service safe?

Our findings

When we inspected the home on 22 May 2014 we required the provider to take proper steps to manage risk appropriately. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we saw that the provider took timely action to improve this area of care. We found, for example, that this person's risk assessment had been promptly reviewed and the person had taken up the offer of a ground floor bedroom that suited their needs and enabled them to continue to retire to their bedroom whenever they liked and without the risk of falling on the stairs. They said they were happy to change their room once the potential consequences of falling on the stairs had been explained to them by the registered manager. We found that whenever people's needs had changed the care provided by staff had been reviewed to take into account the management of new risks. When we spoke with staff they knew what they needed to do to manage assessed risks so that people felt safe.

Following our inspection on 22 May 2014 we issued the provider with a warning and required them to take action to ensure that the water temperatures within the home were continually regulated by an effective thermostatic control system. This related to a non-continuing breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. On 1 March 2014 a service user suffered a scald to their thigh whilst being showered because the temperature of the water was too hot. At this inspection we found that the hot water temperature was being continually monitored and were within safe parameters. The provider had fitted the required equipment to regulate the water temperature.

We found that staff were appropriately recruited so that people were safeguarded against the risk of being cared for by persons unsuited to, or previously barred from, working in a care home. The staff we spoke with knew how to recognise and respond to abuse or allegations of abuse. One staff member was unfamiliar with the term 'whistleblowing' but was able to describe a protective course of action they would take if they witnessed or were concerned about poor practice that compromised people's safety.

We saw that incidents affecting people's safety had been reported and recorded appropriately as safeguarding matters. During this inspection, however, we found there were no verifiable arrangements in place to enable the manager to monitor recurring safeguarding incidents. One person had fallen frequently over several weeks and at the time each incident was appropriately dealt with by the staff but there had been no analysis of why this was happening. When concerns were subsequently raised about the frequency of falls the manager took action. Staff received refresher training on the prevention of falls within the home to minimise the risk of unsafe care potentially arising from a lack of vigilance.

The people we spoke with said they felt safe because, for example, they felt reassured that the staff always knew who was in home and why they were there. One person said, "You don't just want folk you don't know just wandering around the place. That would rattle me. The staff know what is going on and that's good enough for me." All visitors were asked to 'sign in' when they entered the home and for additional security anyone stood outside the entrance door was visible on a camera monitor kept in the manager's office. Regular visitors, such as relatives, were able to open the entrance door using the keypad entry system code they were provided with or they could ring the bell and wait for a staff member to open the door. One visitor we spoke with said, "I am pleased security is taken seriously. If staff have not met me before they always ask who I have come to visit. Just sensible precautions really."

There were sufficient numbers of staff on duty to safely meet the needs of the 14 people in residence at the home. In addition to the manager there were three care staff on duty to support people with their personal care needs. The cook had called in sick on the day we inspected but appropriate contingency arrangements were in place for another staff member to carry out the cook's duties. We spoke with a visitor who said that in their experience there were always enough staff on duty to provide their relative with the support they needed. One person said, "The staff are kept busy but you don't see them having to run about. I always get the help I need."

There were suitable arrangements in place to respond to and manage emergencies safely such as fire, flooding, or power failures. The staff we spoke with were familiar with these arrangements and knew what to do if, for example, the fire alarm sounded. There was always a designated

Requires Improvement

Is the service safe?

senior member of staff available 'on call' throughout the day and night to support staff if they needed guidance. If a person needed to be admitted to hospital, for example, they were accompanied by a 'hospital passport' document. This provided healthcare professionals with essential information about that person's medical history. This information was pertinent to them receiving timely and safe professional healthcare intervention in the event of a medical emergency.

Medicines were safely managed at the home. We looked at the storage of medicines and saw that medicines were stored securely. We observed staff administering medication to people who used the service. We looked at the medication administration record [MAR] chart for four people and we saw that they had received their medication as prescribed.

Medicines were safely disposed of when people no longer required them. For example when we looked in a cabinet used to safely store controlled medicines we saw that medicine belonging to a deceased person still remained in the cabinet. The manager said that arrangements had already been made for the medicine to be collected and returned to the dispensing pharmacy. The manager also confirmed that all medicines that had been discontinued were always returned to pharmacy. We saw that an accurate record was kept of all discontinued medicines and their safe disposal.

Requires Improvement

Is the service effective?

Our findings

When we inspected the home on 22 May 2014 we required the provider to ensure that agency staff always received an adequate briefing on people's needs because we concluded that without this action Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was breached.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately. When we inspected no-one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where an application can be made to lawfully deprive a person of their liberties where it is deemed to be in their best interests or for their own safety. Although we saw evidence in staff files that there had been training provided in MCA and DoLS, not all staff were able to confidently talk about how this may impact on the way people were cared for. The registered manager acknowledged that the staff team would benefit from refresher training in this area.

Although people who could tell us said they always had enough to eat and drink the arrangements in place to monitor if people were drinking enough it was sometimes ineffectual. We spoke with staff who said that people were always regularly provided with drinks throughout the day. However, people had to ask for a drink or wait until staff brought drinks round on a trolley at intervals throughout the day. There were no drinks available that people could help themselves to. Although staff said they kept a record of when people last had a drink the record was not always effective as a measure of a person's actual fluid intake. When, for example, we reviewed the records of two people with dementia who consistently needed encouragement to drink enough we found the amount they had actually drunk had not always been recorded.

When we spoke with people who were able to tell us they confirmed they always had enough to eat. A snack bowl was available in the lounge for people to pick and choose from independently. No-one said they were hungry or thirsty and the lunchtime meal portions were good. People had the choice of an alternative meal and we heard staff ask people if they had enjoyed their meal, had eaten enough, or if they would like a second helping. People were not rushed when they ate their meal and those that needed assistance with eating their food.

New staff had received an induction that equipped them with the information and basic skills that enabled them to work effectively in the home. However, some skills, such as moving and handling practice, needed refreshing by way of timely training so that staff used updated techniques in line with current best practice. We saw that this had been arranged.

We saw that job performance appraisals for each member of staff were scheduled to take place at intervals throughout the year. Staff said they had regular supervision meetings with the registered manager to review how effectively they were doing their job. However, one staff member had been in post for approximately six months but had not yet had a supervision meeting with the registered manager. All the staff we spoke with described the registered manager as "very supportive" and felt they were encouraged to do a good job. They said the registered manager worked 'hands on' with people so they knew the day-to-day routines and the demands placed upon the staff to care for people effectively.

We saw that people had access to healthcare professionals, including community based nurses, speech and language therapists, and a dietician. We saw that there was a document in place for paramedics, GPs, and other healthcare professionals to make pertinent advisory comments when they visited the home. We saw that these documents effectively supplemented information also recorded in people's care plans or daily care notes so that people effectively received the healthcare they needed.

Good

Is the service caring?

Our findings

The people we spoke with said they were always treated considerately and with kindness by the staff. When we saw staff interact with people their manner of approach was patient and good humoured. We saw staff had conscientiously attended to people when they needed assistance or were observed to be in discomfort. Overall, we found the service provided by the staff to be caring. However, people had not always been protected from discrimination because of their condition.

When we reviewed people's care plans, for example, we saw that they included people's preferred name. However, staff had not always used people's names and sometimes addressed people, albeit kindly, as "love", "darling", or "sweetheart". One person said the staff were "lovely" and their view was the staff that used such words were being friendly and caring. They said they liked that. The tone of voice used by staff when they used such words was 'soft' and conveyed a feeling of warmth and kindness. However, using such words may not always show respect for people's status, age or gender.

People who were unable to verbally express their views were at ease in the presence of the staff that supported them. We also saw other people smiling and joking with staff. Staff audibly encouraged people who struggled to do things for themselves. We saw that staff, although busy, were purposeful and unhurried. People were not 'rushed' to do things. One person described the staff as "very patient and always kind".

People's privacy was respected. Staff were mindful that a person's bedroom was their private space. One person who chose to remain in their own room said, "I like it that way. They leave the door open for me so I can see what is going on, but if I want peace they come and close it for me." They also said, "I am always being asked if I want to join in with things but honestly I just prefer my own company. I do what I like and they [the staff] respect that, so I'm happy enough." We saw that this person's room had been personalised with their belongings, including photographs and other mementos that had value to them. They said this helped them "feel at home".

We saw staff knock on doors and, for example, pause to listen for an invitation to 'come in' before going into people's bedrooms. We saw that bedroom and toilet doors were kept closed when staff attended to people's personal care needs.

A visitor we spoke with said that they were always made welcome at the home. They said, "There are no unnecessary time restrictions. I visit when I want to but I try to avoid busy times when the staff are serving meals, although even then I am welcome." They also said "My relative is no longer able to express themselves. They keep me involved in everything and always let me know if anything has happened."

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission and their care plans had been regularly reviewed so that people continued to receive the care they needed. Care and treatment was planned and delivered in line with people's individual preferences and choices. People's care records included, for example, details of how staff should support people to avoid them becoming anxious or distressed. The staff we spoke with knew, for example, who responded particularly well to words of encouragement and reassurance whenever they became upset. They were also familiar with the less obvious 'triggers' that were likely to require them to use distraction techniques to avoid conflict between people. We observed staff use gentle persuasion to quietly redirect a person out of someone else's bedroom before the occupant became annoyed with their uninvited 'visitor'.

People received the personalised support they needed. We observed one person asleep in their armchair when lunch was served in the dining room. Rather than waken them unnecessarily and bring them to the table staff let the person sleep, the meal was kept hot and was later offered to them when they awoke. Staff had already requested a visit from this person's GP because they were concerned that the person had lately become progressively sleepier. This showed that staff had been mindful of the person's needs at the time and had not allowed the lunchtime routines to compromise that person's care.

People's personal history and preferences were also included in their care plans so that staff had an insight into what was important to the person, ranging from where they liked to sit in the lounge or at the dining table, to their choice of clothes and when they usually wanted to go to bed.

When we spoke with staff they also had a good knowledge of people's past history, such as their family background, their previous occupation and where they had lived before they were admitted to the home. This insight enabled staff to personalise the care they provided to each individual, particularly for those people who were less able to say how they preferred to receive the care they needed. We observed two female residents with dementia were provided with dolls. We saw they were kissing and cradling the dolls and talking to them. Both people appeared to take great comfort from the dolls and chose to carry them around with them.

The care records we reviewed also contained information about people's expressed religious beliefs, if any, and whether they required practical support to enable them to follow their faith. Arrangements had been made, for example, for a priest to visit a person in the home. The registered manager said that, if requested, they would explore practical options for worship with each person according to their individual religious needs and faith.

The registered manager kept a record of complaints received and what had been done about them. A relative said, "I have complained before, little niggles really. The manager always listens and does something about it. I'm happy with that and if I wasn't I can always go to the owner, although I have never needed to."

Those acting on behalf of people unable to complain or raise concerns on their own behalf were provided with written information about how and who to complain to. We saw that the public noticeboard had information about using the Local Authority complaints procedure if that was appropriate. Those people who were able to tell us said that the staff always encouraged them to speak up if they were unhappy or worried about anything.

Activities were arranged to suit people's preferences, such as bringing in external entertainers to sing or play music. People had participated in creating art pictures that were displayed in the entrance corridor for visitors to see and enjoy. There was evidence that an activity had taken place in preparation for Halloween, with pictures and hats that people had made. One person said they liked the quizzes organised by staff because the small prizes to be won made it good fun. We saw residents in the lounge enjoying a game of bingo, winning sweets and chocolate bars. The registered manager said that activities were not timetabled simply because people liked the spontaneity of the staff coming up with new ideas for activities everyone could join in with.

We found, however, the emphasis was upon communal participation in group activities and apart from staff engaging people in conversation or reminiscence there little evidence of staff promoting individual activity. There was, for example, an absence of reading materials around

Good

Is the service responsive?

the communal lounges that people may have liked to browse through. The registered manager said that staff regularly discussed ideas for activities at team meetings, not only to stimulate people's interest but also to help people relax. Staff said that the challenge they faced was sustaining people's enthusiasm even after they had initially expressed an interest in, for example, reviving a hobby they had once enjoyed. The staff were, however, motivated to continue to work at this so people were enabled to retain an interest in pleasurable activity.

Requires Improvement

Is the service well-led?

Our findings

People had little opportunity to be actively involved in making decisions about the running of the home. In part this was because some people's condition precluded this but, for example, when the carpeting in the lounge was replaced people were not asked for their opinion about the colour or pattern they might like to see fitted. People's families or friends were always welcome at the home but there was no evidence that meetings were convened for them to be involved in decisions about the running of the home. People had been given the opportunity to express their views through a simple survey of what they liked and disliked the service they received. However, for people that were unable to express themselves in this way there was no evidence that alternatives had been explored, such as the use of advocacy or a significant other person to speak on behalf of people.

We were told by people who used the service, by the staff, by relatives and other visitors, that the registered manager was popular, approachable, and hard working. Staff said the registered manager readily got involved in day-to-day care duties and had a good knowledge of people's individual care needs. Staff and relatives told us there was an open culture at the home and any concerns that were reported to the registered manager were dealt with appropriately. Staff also said that the registered manager had ensured they were familiar with the whistle-blowing policy so that poor practice or concerns about people's care did not go unreported. Staff knew about the role of the Care Quality Commission (CQC) as an external regulator, as well as the Local Authority's role in investigating safeguarding matters and commissioning and reviewing people's care. We saw that the registered manager worked positively with the Local Authority's quality monitoring officers when they had identified improvements that were needed to ensure contractual obligations with the service commissioners were met.

People received a service from staff that were encouraged by the registered manager to provide 'homely' care. One staff member said, "I would be happy for my relative to be looked after here." However, apart from making sure that people received the day-to-day care they needed from staff, the registered manager had no demonstrable arrangements in place to explore other ways of enhancing the quality of people's care.

People benefited from receiving support from staff that liked their job and had a registered manager that valued them. A visitor said, "The last thing you want are staff with long faces. It makes everyone miserable. I think the manager does a great job holding it all together. The staff actually smile and that brightens everyone's day." The registered manager said that regular meetings were convened with staff to review the service provided. However, although staff confirmed these meetings took place the outcomes and actions agreed had not always been recorded for monitoring progress on implementing identified improvements. For example, the registered manager had identified there was a need to improve upon the frequency of staff supervision meetings held with individuals throughout the year to review their training needs and work performance. We found, however, that the registered manager was unable to provide us with an overview of the progress that had been made towards achieving this, other than to confirm that it was a work still in progress.

People were cared for by staff who received the guidance they needed from a registered manager that knew their responsibilities. There were systems in place to ensure that incidents affecting people's welfare were recorded and reported to the appropriately, for example to the Local Authority service commissioners. Safeguarding issues were notified immediately and acted upon in a timely way.

People were assured that improvements to their living environment, such as repairs, or routine maintenance, were carried out in a timely way. There were systems in place to audit the quality of care provided and to monitor risks. These included audits of medicines, people's care plans, and risk assessments. However, some audits simply contained a list of dates when pertinent documents had been reviewed. It was not always clear from these audits if there had been improvements made or if no changes were required. Other audits included checking that the equipment used in the home had been maintained according to service schedules, such as hoists, electrical appliances and fire detection systems. The provider had arrangements in place, for example, for a director of the company to visit the home regularly to meet with registered manager and review the progress on implementing previously agreed action plans for improvements. However, the registered manager said that although this support was valued it predominantly focused upon general maintenance issues. The registered manager

Requires Improvement

Is the service well-led?

said that they valued the opportunity to explore how well they were doing their job but this had not always been forthcoming because of the narrow focus of the meetings with the director. The registered manager saw this as something that required improvement so that, in the longer term, people benefited from a service that was demonstrably well-led.