Mrs T Hibberd

# Dennyshill Care Home

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on 21 September 2015 and was unannounced.

The service provides accommodation and support for up to nine adults with a learning disability and/or dementia. At the time of the inspection there were nine people living in the home, some with complex care and communication needs. The provider who was also the registered manager lives on site. Most of the people had severe learning and physical disabilities including mobility needs, and limited or no verbal communication skills. We were able to engage in short conversations with four of the people. As we were unable to communicate verbally with everybody we also relied on our observations of care and our conversations with people's relatives and staff to help us understand their experiences.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. At this service the registered manager is also the registered provider. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008

# Summary of findings

and associated Regulations about how the service is run. Everyone was positive about them, and felt they were approachable, caring, and committed to the service and the well-being of people there.

At the time of the inspection the service was not fully meeting its requirements in relation to protecting people's human rights, where people lacked the mental capacity to make certain decisions about their care and welfare.

People received care and support in line with their individual care plans from staff with the necessary skills, experience and knowledge. People appeared very comfortable with the staff who were supporting them and we observed that staff treated them with kindness, dignity and respect. The registered manager deliberately chose staff with the values and compassion she felt were essential in caring for vulnerable people. Care plans consistently reiterated the importance of providing person-centred care and guided staff in how to do this, particularly in relation to communication. This meant that people were able to build meaningful relationships with staff and express their preferences. People at the service, relatives and health and social care professionals praised the caring attitude of staff. One person said, "Everybody is so nice and kind". Relatives told us they were very happy with the care provided. One person's relative said "I just think we are really blessed and really lucky to have them in here". Another health professional told us, "The interactions with staff were heart-warming. It's the nicest place I've been to for a long time. It really was a home for people".

People's relatives said they were always made very welcome and were able to visit the home as often and whenever they wished. They said the service was very good at keeping them informed and involving them in decisions about their relatives care.

Care plans contained detailed information to help staff understand the non-verbal ways in which people communicated. We observed staff always checked with people before providing care or support and then acted on people's choices.

There were enough staff deployed to meet people's complex needs and to care for them safely. The majority of people chose not to go out into the community or engage with activities. Staff therefore spent time socialising with people within the home.

Staff received appropriate training to support people's mental and physical health needs. People received their medicines safely and were supported by a range of external health and social care professionals.

The service's quality monitoring systems enabled the service to maintain high standards of care and to promote continuing service improvements.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

# 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 safe.

There were sufficient numbers of suitably trained staff to keep people safe and meet each person's individual needs.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe.

**Good**

**Is the service effective?**
The service was not always effective.

People's rights were not always protected because where people lacked the mental capacity to consent to aspects of their care or treatment the service did not always act in line with current legislation and guidance.

People received effective care and support from staff who had received appropriate training and had the experience, skills and attitudes to support the people living at the service.

People were supported to maintain good health and had access to healthcare services.

**Requires improvement**

**Is the service caring?**
The service was very caring.

People were treated with kindness, dignity and respect.

The staff and management were exceptionally friendly and considerate.

Staff had a very good understanding of each person's communication needs and the ways they expressed their individual preferences.

People and their relatives were supported to maintain strong family relationships.

**Good**

**Is the service responsive?**
The service was responsive.

People and their relatives were involved in the assessment and planning of their care.

Care plans and risk assessments contained clear and up to date information for staff about how to understand and support people's individual needs.

People were encouraged to give feedback which was acted upon.

**Good**

# Summary of findings

**Is the service well-led?**

Good

The service was well led.

The service promoted an open and caring culture centred on people's individual needs.

People were supported by a motivated and caring team of management and staff.

The provider's quality assurance systems were effective in maintaining and promoting service improvements.

# Dennyshill 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 21 September 2015 and was unannounced. It was carried out by one inspector. Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other data and enquiries. At the last inspection on 7 October 2013 the service was meeting essential standards of quality and safety and no concerns were identified.

We were able to have limited conversations with four people who lived in the home. To help us understand people's experiences of the service we observed how people were supported and also had conversations with their relatives and the staff. During the inspection we spoke with the registered manager and three other members of care staff. We reviewed four care plans and other records relevant to the running of the home. This included staff training records, medication records, quality assurance and incident files. We spoke with three people's relatives to gain their views on the care and support provided by the service and four health and social care professionals who supported people at the service, to ask for their views about the quality of care provided.

Good

# Is the service safe?

## Our findings

People told us they felt safe at the home and with the staff who supported them. This view was shared by relatives. Comments included, "[person's name] used to live in the doctors, but now they are on less medication than they've ever been. They must feel safe and secure. I just think we are really blessed and really lucky to have them in here".

Risks of abuse to people were minimised because the registered manager made sure that all new staff were thoroughly checked to make sure they were suitable to work at the home. She told us that she highly valued the personal qualities of care staff, and had therefore offered employment to people she already knew who she felt had the right approach to working with vulnerable people. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records.

Staff told us, and records seen confirmed, that all staff received ongoing training in how to recognise and report abuse. All staff had a clear understanding of what may constitute abuse and how to report it, even if the concerns were about another family member working at the home. They told us, "You have to be willing to speak up or you are in the wrong job". A newly employed member of staff told us; "The manager told me that if I see anything of concern at all to ring the [safeguarding team] number on the board in the kitchen. If I see staff do anything that I don't think is right, I should go and speak to the manager so that she can sort it out. If I am concerned about the manager, I should ring the safeguarding team".

Staff knew what to do in emergency situations. For example, all staff had received training in how to respond to one person who had epileptic seizures and how to provide the required medicines. Information about anybody at risk was shared verbally at the staff handover, and recorded on the daily notes. This information was reviewed at least monthly by the registered manager, who updated the care plans and risk assessments as necessary. Care plans supported staff to provide safe care, containing written information about potential risks and clear direction in how to keep people safe. For example, one person who chose not to wear their glasses, liked to walk around the home. The care plan advised care staff to ensure that all areas of the home were kept free from obstruction due to the risk of them falling or tripping. Care plans also provided clear guidance for staff to enable them to recognise when one person, who could not communicate verbally, might be distressed or in pain.

There were sufficient numbers of staff deployed to meet people's complex care needs and to keep them safe. One person told us, "There are definitely enough staff. People come quickly at night if I ring my bell". There were three care staff on duty in the morning when it was busiest, two staff in the afternoon and one waking member of staff overnight. The registered manager lived on site and was available to provide support as required and in an emergency. Staff told us that staffing levels had been increased as the needs of people at the service had changed. The current rota was working well. The stability of the staff team meant that agency staff were not used. This meant that all staff knew people at the service well and had a good understanding of their individual needs.

Medicines were managed safely. They were delivered by a pharmacist in individual blister packs for each person and kept in a locked cupboard in the kitchen. There was a smaller locked cupboard within this cupboard where the medicines that required additional security were kept. The key was held by the senior staff member on duty. We looked at all medicines administration records (MAR) and saw that they had been correctly completed with two staff signatures on the MAR sheet for controlled drugs. A medication audit had been completed by an external pharmacist in January 2015, and the recommendations made had all been actioned by the time of the inspection. These had included the introduction of a policy on covert medication and the use of homely remedies; that staff should sign to say they had read the medicines policy; and that there should be two staff signatures on the MAR sheet for controlled drugs.

There were effective arrangements in place to manage the premises and equipment and all relevant checks were up to date. There were plans for responding to emergencies or untoward events, and fire checks and drills were carried out in accordance with fire regulations. New emergency evacuation procedures had been adopted following an independent fire risk assessment. People had individual personal protection evacuation plans (PEEP's), which took account of their mobility and communication needs. This meant, in the event of a fire, staff and emergency services staff would be aware of the safest way to move people

Good

# Is the service safe?

quickly and evacuate them safely. One person with capacity who chose to stay in their room liked their door open during the day. Their care plan documented that they had agreed to have it closed at night due to the fire risk.

The home was clean with no odours. Staff told us, “We pride ourselves on the fact that it is clean”. A relative told us, “The standards are very high, it’s always immaculate”.

The laundry was done on the premises by staff and there were systems in place to keep soiled items separate from clean laundry, which minimised the risk of cross contamination. There was a regular clinical waste collection.

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. The registered manager reviewed and analysed the accident and incident report book regularly. This allowed her to understand causes and identify any wider risks, trends and preventative actions needed to keep people safe. She shared her findings with staff.

Some people at the home were supported by the service to manage their money. We saw that there were safe systems in place for handling and storing cash. Records were kept of all transactions, and balances were recorded.

Requires improvement

# Is the service effective?

## Our findings

The service was not always effective. People's rights were not being protected in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. (DoLS). A relative told us that their family member did not have the capacity to understand risk, and they had been concerned that they may try to leave the home. The registered manager had told them that in this situation, it would be the family's responsibility to bring them back, which demonstrates a lack of understanding of the DoLS process. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The Supreme Court judgement on 19 March 2014 widened and clarified the definition of deprivation of liberty. If a person is subject to continuous supervision and control, is not free to leave, and lacks capacity to consent to these arrangements, they are deprived of their liberty. This meant that some people at the home required an assessment under DoLS, but had not been referred. The service was therefore not meeting its requirements.

Some care plans contained capacity assessments and best interest processes related to decisions such as the use of bed rails, and the purchase of a specialist chair. However, this was not the case for everybody. For example, one person who was 'not always able to understand or make the right decisions', sometimes refused their medication and support with personal hygiene needs. The care plan stated that, "There are times when no amount of walking away or persuasion will help and staff can do nothing but ensure [the person's] personal safety". The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. This ensures that their human rights are protected. Although in this instance the person's family were kept informed of the difficulties, there was no documented best interest process or decisions in the care plan.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staff had the experience, skills and attitudes to support the people living at the service. New staff completed a two month induction process, in which they got to know people at the home and their families, shadowed other members of staff and completed essential training in areas like fire safety, medication, health and safety, and food hygiene. The newest member of staff was going to undertake the new Care Certificate. This qualification ensures that all staff have the introductory skills, knowledge and behaviours needed to provide safe, high quality and compassionate care.

There was a comprehensive rolling training programme for all staff which ensured that their knowledge and skills remained up to date in key areas such as first aid, moving and handling and safeguarding. Specific training had been arranged to support staff in meeting the changing needs of people at the service, for example when a person who had been there for a long time developed dementia, or when someone began to have seizures. The registered manager told us that she would arrange training for staff to update their knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Care staff had also learnt from visiting health professionals, for example a physiotherapist showed them how to provide physiotherapy to a person at the home. A community nurse was coming in to do some teaching about diabetes and insulin. The provider supported staff with continuing training and development such as vocational qualifications in health and social care. Staff received formal supervision every six months and this was documented in staff files. Staff told us that this was adequate, as they were a small team working together, so issues were discussed as they arose.

Food was prepared on the premises by care staff. There were always two choices available, and if people didn't want the food on their plates they could have something different. The service catered for people with special dietary needs, for example a diabetic diet, or a pureed diet with the ingredients blended separately so that people could taste them. One person told us," The food is very good and my favourite is roast dinner. You choose what you want but they would get you something else if you didn't

Requires improvement

# Is the service effective?

like it. I always eat in my room". A relative told us;" [person's name] loves the food and eats everything, and they are very fussy about their food! It's important to get the portion control absolutely right or they won't eat anything. It's good to see them eating so well".

We saw that people received good portions and appeared to enjoy their meals. Some of the people were able to eat their meals independently whereas others required one to one staff support. Where people required support, staff assisted them to eat their food at an appropriate pace and no one was rushed. We heard staff encouraging people to eat their meals and engaging people in friendly banter throughout the meal time period. They continually checked to see if people were happy and whether they wanted more to eat or drink.

The most nutritionally vulnerable people were weighed monthly, and food and fluid monitoring charts completed when necessary, for example if someone was unwell or had been losing weight.

Care plans contained clear guidance for staff about the support that people needed with eating. For example, one person's care plan stated, "[the person's] food must be of a soft consistency and cut up into small pieces or mashed… [the person] has a habit of ramming food into their mouth and is at high risk of choking. Only give them a little at a time if they are feeding themselves".

People were supported to maintain good health and had access to healthcare services. For example, GP's and Community Nurses called frequently, a speech and language therapist visited some people with swallowing difficulties and a physiotherapist was working with another person at the home. A visiting health professional told us, "I think it's a lovely home. The staff are very friendly and contact us appropriately as needed. They also feed back to the nursing team about how people are. They provide a good quality of care… I have no concerns. There is nothing they could do better". Care plans contained the minutes of multi-disciplinary review meetings, which the registered manager had attended and contributed to.

Good

# Is the service caring?

## Our findings

The service was very caring. The registered manager appointed staff based on their values and compassion, which she felt was more important than 'masses of qualifications.' One person told us; "Everybody is so nice and kind." Comments by relatives included, "They treat [person's name] like a person, rather than a person with dementia", and, "Staff support [the person] well. They are approachable and friendly. They take notice and care". Quality Assurance questionnaires completed by relatives described staff as kind, caring, attentive and professional, "The care your establishment took over [person's name] was exemplary and I include each and every person". Another person wrote, following a respite stay, "My sincere thanks for the care and kindness I have received in your home ". A health professional told us, "The interactions with staff were heart-warming. It's the nicest place I've been to for a long time. It really was a home for people".

Throughout the day we observed staff caring for people in a very friendly, considerate and patient manner. For example, we saw that staff explained to people what was on their plate when they gave them their lunch. One person was having difficulty standing up to walk to the dining room, even with staff encouragement and reassurance. Staff saw that they were struggling and asked if they would prefer to stay where they were to eat their meal.

All staff were friendly, open, and person centred in their approach. When asked about the people in their care they talked about them in a respectful and compassionate way. They told us about the importance of asking people before any care is given, and involving people in decision making as much as they are able. Comments included, "I always tell them what I am about to do and get their permission before doing anything", and," It's important to show them respect and to give the same kind of care that you would give to your own family". They were aware of the importance of respecting people's dignity and privacy, for example, ensuring that doors and curtains were closed before providing personal care. They understood the importance of spending quality time with people. A person had told a member of staff that morning, "You don't know what it means to have my hair done properly".

Staff had good knowledge of people's individual needs, likes and dislikes. For example, they understood how to provide personal care to a person with dementia, explaining that they would reassure them and tell them what they were doing at every stage of the process. Staff were supported by the care plans, which guided staff to work with people in a person centred way. One person's care plan stated that staff must ask [the person] first if they wanted their face wiped before taking it upon themselves to do it for them. Another person at the service with capacity to make day to day decisions, found verbal communication difficult. Their care plan gave clear guidance for staff about their specific communication needs, stating, "It is very important not to walk away from [person's name] until they have made themselves understood. They will very often say, "It does not matter", but it does matter and it is important that they are given time and are able to make themselves understood". This meant that the person was able to have full and meaningful relationships with staff who understood and respected their choices.

People were supported to maintain ongoing relationships with their families. Relatives were encouraged to visit as often as they wished and told us they were always made to feel very welcome. The registered manager told us that she asks staff," to make a point of having a chat with families who are visiting". One relative said "They don't mind what time you come in". Another relative told us that staff sometimes visited them at their house, to check that they were happy with the care being provided and if they thought there was anything they should be doing differently.

Good

# Is the service responsive?

## Our findings

Before a person moved into the home, the registered manager met them to carry out an assessment in liaison with their care manager. This gave them an understanding of the person's support needs and whether the home could meet them.

Each person had a personalised care plan which was completed by the registered manager. Relatives told us that they and the person whose care plan it was, had been consulted and involved according to their capacity to understand and contribute. This involvement was documented on the care plan. One family member had written that they "…have discussed with [person's name] at length, and they are very happy with it".

Care plans and risk assessments contained clear information for staff about how to understand and support people's individual needs. They were reviewed monthly and updated if necessary. They included information such as how the person liked to be addressed, their history, emotional and spiritual needs, and whether they had the capacity to make their own choices. This helped staff to provide person centred care and to understand people's likes and dislikes. One person's care plan stated that the person had, "…very clear ideas and likes to make their own decisions and choices... They hate being patronised and treated like a baby".

There was guidance for staff in relation to people's specific communication needs, for example, one person used Makaton or a book with pictures and symbols that they pointed to. This meant that people who were unable to communicate verbally could express themselves to staff and be understood. A member of staff told us, "If [person's name] wants something, they will grab your hand and show you. You need to take time. You get to know them and their ways. Everyone is so different".

Care plans also supported staff to promote people's independence while minimising risk. For example, one person's care plan said that they liked to decide the water temperature of their shower. "Staff will assist them to make this judgement to ensure no risk of scalding themselves due to water being too hot."

People's bedrooms were comfortable and furnished with own furniture and personal possessions. One relative told us; [person's name] has settled better here than anywhere else. She likes nesting and having all her things around her". There were two shared rooms at the home. The people in them and their relatives were happy with this arrangement and felt that it was positive for them.

In the afternoons care staff spent time socialising with people. Some people enjoyed sitting outside on the decking watching the birds and wildlife. A relative told us; "When it's nice, [person's name] sits out on the balcony for quite a while. A member of care staff always sits with them". A 'pamper' person visited the home every week with a foot spa to do massage and paint people's nails. A hairdresser visited every two weeks and there was occasional karaoke and board games. There had been a music therapist but people hadn't been interested. Although one person attended a day centre regularly, staff told us that many people living at the home chose to stay in their rooms and didn't like going out. This was confirmed by people and their relatives. Comments included, "She doesn't want to do anything at her age. She likes to sit in her room and watch TV. She likes her own little space" and, "I like to be on my own". A health professional told us that a person who spent all their time in their room didn't want to do anything else and that this was "normal for her".

The service had an appropriate policy and procedure for managing complaints which was given to people and their families when they moved in to the home. No complaints had ever been received. Relatives told us that they raised any concerns directly with the manager, or any of the staff, and that any issues raised had been acted on immediately.

Good

# Is the service well-led?

## Our findings

During the inspection we saw seven completed quality assurance questionnaires by relatives and two by visiting health professionals. All were very complimentary about the registered manager and the service. One relative told us; “If I went to the manager I know she would act on it immediately.” Another said, “Oh yes, the manager does a good job. There are other people I’ve seen visiting. She always talks to everybody and asks them what they think their relative would like”. This view was shared by staff who told us that there was an open and transparent culture at the home. “The manager really does care. She is supportive to staff. You only need to ask. If she could help you she would do. You can go to her with absolutely anything”.

The registered manager told us, “My ethos is that I like the home to be their home. Because of the staff team I’ve got, chosen because of their values and compassion, it’s run like a family. This is a family environment, and I treat people the way I like to be treated”.

The registered manager believed that it was important to invest in the fabric of the home in order to provide a good quality service. For example there was a new carpet in the hallway and equipment such as nursing beds, and aids which helped people to mobilise. She planned to redecorate bedrooms as they became available.

The registered manager, who was also the provider, lived on site and was very involved in the day to day running of the home and decisions about people's care and support. She was on hand to provide support and guidance to the small staff team as the need arose. Staff told us that they would have no hesitation in asking her for help if they needed it. This close oversight by the registered manager meant that staff had a clear understanding of their responsibilities and the ethos of the home.

The registered manager had an effective quality assurance system to ensure they continued to meet people’s needs effectively. She had commissioned an external independent quality assurance programme, which carried out annual health and safety compliance audits and provided continued support with policy and human resources issues. There was also an annual medicines audit carried out by an external pharmacist. The registered manager carried out a monthly audit of people’s daily records, care plans and risk assessments. The Accident and Incident report book was reviewed regularly and findings shared with staff. Relatives and visiting health and social care professionals were invited to complete Quality Assurance questionnaires, although there was no formal mechanism for gathering the views of people who use the service. The registered manager told us, “They’ll let us know if there is something they don’t like, or if there is anything they want to discuss and improve. Feedback is informal, it comes through the family”. This was confirmed by relatives that we spoke to.

There were three or four staff meetings a year which provided a forum for staff to raise concerns or put forward ideas about improvements to the running of the home. Staff felt that the registered manager listened to their suggestions and gave examples of when she had acted on them, for example related to the need for increased staffing levels in the mornings.

The majority of people living at the home did not wish to be part of the local community, but preferred to stay at home, apart from one person who attended a day centre several times a week by taxi. Links were encouraged however, with families visiting, neighbours popping in for a cup of tea and the occasional coffee mornings to raise money for charity.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Where a person lacked mental capacity to consent to care and treatment, the service did not always follow a best interests process in accordance with the Mental Capacity Act 2005.(13)(4)(d)<br><br>The service was depriving people of their liberty for the purpose of receiving care or treatment without lawful authority. 13(5) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.