Parkcare Homes (No.2) Limited

Devon House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8 May 2018 and was unannounced. Devon House is registered to provide accommodation for up to 11 people who require nursing or personal care and treatment of disease, disorder or injury. There were eight people living at the service on the day of the inspection. People who lived there needed support due to acquired brain injuries or neuro-disabilities.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The previous comprehensive inspection took place on 12 and 14 September 2017. At that inspection we found five breaches of regulations. These related to safe care and treatment, consent, safeguarding, notifications of significant issues to CQC and governance of the service. We carried out this comprehensive inspection to ensure the requirements of the regulations were now being met and that the provider had implemented their action plan.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and were happy living at the service and that staff were kind and caring.

We found medicines were safely managed and risk assessment documentation was in place to provide guidance to staff in managing risks.

The service had appropriate documentation in place in relation to consent and compliance with the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service had improved procedures and systems so people were safeguarded from abuse. When incidents occurred, they were dealt with appropriately and relevant organisations were notified including CQC.

Staff understood people's needs and preferences and care records reflected these.

Person centred activities took place at the service and people told us they enjoyed them.

Recruitment of staff was safe. Staff told us they felt supported and regular supervision and appropriate training took place to support staff in their role.

People were supported to eat well, and were supported by the service and other health professionals to lead healthier lives.

The management of the service had changed since the last inspection and relatives praised the changes at the service since September 2017. Audits were taking place locally and at provider level, to ensure quality standards were checked and improved. These included medicines, care records and building safety. Complaints were dealt with promptly.

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. Risk assessments were in place to guide staff in their caring role.

Recruitment of staff was safe.

Medicines were managed safely.

Staff were familiar with safeguarding systems and people were safeguarded from abuse.

Is the service effective?

Good

The service was effective. Staff received regular supervision and training to support them in their role.

People were provided with a healthy and balanced diet.

Staff understood issues of consent and the service was in compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People were provided with good health care and referrals to external health professionals took place appropriately and in a timely way.

Is the service caring?

Good

The service was caring. We saw kind interactions with people and people confirmed staff were kind.

People's independence was promoted by staff.

People's cultural and religious needs were met by the service.

Is the service responsive?

Good

The service was responsive. Care plans were extensive, up to date and personalised.

There were a wide range of personalised activities both at the service and in the wider community.

There was a complaints process in place and we could see complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well led. There was a new registered manager, and the day to day running of the service was undertaken by the service manager who provided good leadership. They provided good leadership and there was an open and transparent culture at the service.

Systems and processes were embedded at the service so management tasks were organised well.

There were regular audits taking place both locally and by the provider and the quality of the service had improved.

Devon House

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.

The inspection was carried out on 8 May 2018 and was unannounced. The inspection team comprised of two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who use/live in the service, the registered manager, the service manager, two registered nurses and three care staff. We also spoke with one visiting relative and two additional relatives after the inspection to get their views of the service.

We spent time with people throughout the inspection and observed lunch being served.

We looked at five staff recruitment records and care records for three people who lived at the service, including nursing records. We looked at medicine administration records for the eight people living at the service and checked stocks against records for five people's medicines.

We checked supervision and training records across the service, accident and incident logs and Deprivation of Liberty (DoLS) documentation. We checked audits were taking place and management and staff meetings were taking place. We checked the building was safely maintained, how food was stored and how hygiene was monitored at the service.

We looked at activity plans and records for people living at the service.

Following the inspection, we spoke with the activities co-ordinator and three health and social care professionals.

Good

Is the service safe?

Our findings

We asked people if they felt safe. They told us "Most of the time, yeah, most of the time" and "not too bad".

At the last inspection we identified that the service did not have robust measures in place to safeguard people; incidents were not always identified as potential safeguarding events and staff were not confident about what constituted a safeguarding concern.

At this inspection we found people were safeguarded from abuse. The service manager had ensured the provider's systems and processes were now embedded in staff practice and the service manager had notified all agencies of any potential safeguarding incidents during the preceding months and we could see that records were kept of all incidents.

All staff had undertaken safeguarding adults training. Staff were clear about signs to look out for and how to escalate their concerns in accordance with the provider's safeguarding policy. One member of staff told us the staff group "worked together to make sure people are safe here."

At the last inspection we found medicines management was not always safe. Stocks did not always tally with records and a controlled drug had been retained at the service despite no longer being prescribed to a person at the service.

At this inspection we found medicines were safely stored and stocks tallied with records; controlled drugs no longer in use or required were disposed of. We saw that one person who was prescribed an 'as required' medicine was now routinely requiring it, and the GP had been asked to review their health and prescriptions.

People who actively refused their medicine but were judged not to have the capacity to understand the consequences of their refusal, were administered their medicines covertly. We found that for people who required their medicines to be given covertly, best interests meetings had been held with health and social care professionals. However, we found people were having their medicines crushed without the approval of a pharmacist as required by the provider policy. This was important as not all medicines retain their effectiveness if crushed and some cannot be combined with specific food products. The service manager agreed to gain the advice from the pharmacist the day after the inspection to ensure covert medicine administration was safe.

At the last inspection we were concerned that not all people using the service had risk assessments in place to provide guidance to staff in their caring role. At this inspection we found that there were risk assessments in place for all people covering all identified risks. They were up to date, reviewed regularly and personalised, and set out risk levels as high, medium and low.

For example, one person had four falls in quick succession and their falls risk assessment was rated as high. One of the actions taken was hospital assessment where medical issues were ruled out. An updated support

plan set out new guidance for staff and their risk reduced to medium. This person had their potential for choking risk assessed each month. We noted that their risk was rated high for two consecutive months, and so this person was booked to have a full swallowing assessment one week following this inspection. In the meantime, the control or actions put in place included assistance from staff during mealtimes and food to be cut up into small manageable size which reduced the risk of choking to medium. We observed staff assisting this person to eat safely during the inspection. This showed us the service manager was proactively responding to risk behaviours and working to minimise accidents or deterioration in people's health occurring.

Other risk assessments included moving and handling; malnutrition universal screening tool, used to identify adults who are at risk of malnourishment or obesity and skin integrity risk assessments to minimise development of pressure ulcers. There were also risk assessments in place related to smoking; financial abuse; mattress and bed rail care and environmental risks. Each person had a personal emergency evacuation plan in place which gave clear guidance on how the person should be managed in the event of a fire in the home.

The service did not always ensure people were protected from the control of infection as we found out of date food in the fridge that had not been disposed of. We discussed this with the kitchen staff and the service manager who told us the regular chef was on leave and as a result this task had been overlooked by the chef covering this position who usually only worked weekends. The food was disposed of and following the inspection, the service manager showed us that they had put up notices in the kitchen to remind all staff of their responsibility in relation to food hygiene. They had also introduced a check list which needed signing each day to confirm all food was labelled correctly and disposed of when due. The service manager agreed to spot check the fridge to ensure this was enforced.

In other areas, the service did protect people from the spread of infection as we saw staff using protective clothing when providing personal care and supporting people with food. The bathrooms were clean as was the kitchen area. We carried out the inspection on a day after a bank holiday weekend, when the cleaning staff had not been working for three days and found the service needed a sweep throughout. The service manager told us they were reviewing the cleaning tasks for care staff working over weekends.

Staff recruitment was safely managed although at the time of the inspection some documentation had been mislaid. Head office managed recruitment documentation; it was evidenced and authorised by staff there and the registered manager was sent confirmation when all relevant checks had been successfully completed. We saw there were references on three of the five staff records. However, the provider's own recent internal audit found there were certain records which did not have evidence of references. Application forms listed potential referees but there were no copy references on the records at the service. The reference forms had been mislaid at head office. The provider placed a proforma memo on each of the records affected (five records in total) which verified the employee's good character.

We asked the service manager about this. They told us that as the original references had been mislaid, it had been suggested that as an interim a memo be placed on record based on their knowledge of the member of staff, their reliability and their performance in their job. Following the inspection the provider confirmed the outstanding references had been located at head office and were now on record at the service. In future, copies of references would routinely be held at the service..

We saw the provider carried out relevant background checks before they employed new staff to ensure they were suitable to work with vulnerable people. This included criminal checks with the Disclosure and Barring Service (DBS) and proof of right to work in the UK where required. We saw that nurse registration checks

were also carried out regularly to ensure nurses were registered with their governing body, the Nursing and Midwifery Council.

We checked accident and incident logs and could see that actions were followed up on after an incident had taken place to aid learning. For example, following one person's fall an occupational therapist was invited to review everyone's bathing equipment. This showed that learning was shared across the service to minimise future accidents taking place. The service manager also set out a Lessons Learnt bulletin for staff which highlighted learning that staff needed to be aware of following any incidents. This supplemented a provider health and safety bulletin called 'Shoulds, Musts and Best Practice' to share learning across the organisation.

We saw there were enough staff to meet people's needs and this was confirmed by rotas and people living at the service. People confirmed there were enough staff to meet their needs.

Appropriate safety checks had taken place in relation to gas, electricity, moving and transferring and fire safety equipment at the premises. Window restrictors had been regularly checked to ensure they were in place on the first floor and were functioning correctly.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a 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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as 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 the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we found that the provider had exceeded the authority given under the MCA and DoLS as two people were being visually and audibly monitored at night without appropriate permission.

At this inspection we found that the service was now working within the legal framework of MCA and DoLS, and assessment of people's capacity in relation to specific issues was recorded on care files.

Staff were able to describe to us how they ensured they were acting with the person's consent when offering support. They told us how they gave time for people to make a choice and reflected to them what they had chosen to be sure they understood.

The service supported people to eat and drink enough to maintain a balanced diet. People told us they were happy with the food. One person said "Yes" and another person gave us a thumbs up gesture. We saw people had a choice at lunchtime and the menu was discussed at meetings for residents. One person told us "There is a menu but if you tell them before 10.00am they can cook something else for you if within reason. "

We checked how the service supported a person with tube feeding directly into their stomach, percutaneous endoscopic gastrostomy (PEG) feeding. We saw that nursing staff knew how to use the equipment safely to feed this person, and a care plan stipulated what signs to look out for in relation to infection as well as how to safely clean the equipment.

One person whose care plan care plan noted a restriction of fluid intake due to a health issue did not have a fluid chart in place to monitor intake. As a result of discussion with the service manager a fluid chart was set up on the day of the inspection to monitor this person's fluid intake.

We could see that people were supported to have access to healthcare services. There was evidence of multidisciplinary working on people's care records, and evidence of referrals to speech and language therapists, occupational therapists, GP, psychiatrist and other health care professionals. One health care professional told us staff sought out the "best care they could find." They confirmed staff always followed guidance from them, and in fact, the service had sourced specialist equipment to support a person. Health and social care professionals told us staff worked in partnership with them.

Since the last inspection we saw the service had been proactive in supporting two people with communication aids and these had proved successful in aiding both people's communication. Through the commitment of staff supporting one person with language development this person was now speaking simple words. This was an example of the service advocating and working with people to achieve better health and well- being outcomes. One health professional told us "I find the staff inspiring."

Staff received regular individual supervision and training to support them in their role. We saw that all staff, including night staff, received supervision each month focused on their individual needs as well as an annual appraisal. Staff told us supervision was effective and helped them to improve in their role.

All staff had completedmandatory training, which was offered as mixture of face to face training and e-learning. This included basic life support; safeguarding adults; infection control; falls management; basic life support; Mental Capacity Act and Deprivation of Liberty Safeguards, as well as safe handling of medicines and moving and handling. There was also mandatory training which reflected the needs of the resident group such as brain injury, breakaway training, prevention and management of violence and aggression and the Mental Health act. The service manager maintained oversight of training and ensured that all training was kept in date.

Only one person responded to our question about the skills of staff. They told us "Yes" they were able to care for them. Relatives told us there had been significant improvements in the care provided since the last inspection. One family member told us "Things are just so much more professional now. There is very good communication with staff and [name] skin and hair care has improved so much." Another relative told us they felt there was such a positive change in the care provided by staff since September 2017. A third relative noted there were still differences in the skills of staff but overall the care was good.

Relatives told us they felt adequately informed and trusted the staff to provide the right support for their family member. They felt able to make contact with staff, they said, "they encourage me to contact them whenever I want to and don't make me feel like a am being a nuisance."

The building has lift access to the second floor and is suitable for people who use wheelchairs. People have en-suite rooms and there is one communal bathroom with a bath for use by people at the service. The garden is large, well-kept and has an accessible patio area. The service had recently been decorated throughout.

Good

Is the service caring?

Our findings

Everyone living at the service who was able to communicate verbally told us the staff were kind and caring to them. We observed several instances of staff being very caring towards people, and they demonstrated great patience when responding to people. One relative commented, "The staff are caring and compassionate and kind."

We saw how staff respected the privacy and dignity of those whom they supported. Staff always asked permission before they attempted to gain entry to people's bedrooms and respected how people liked to organise their own belongings. A family member told us, "I know [name] room must be really difficult to keep tidy with the amount of stuff they have but staff never complain and never move it."

We asked people if they thought living at the service felt like home. Several people told us "Yes." Another added "I can get along with people, talk to people." To enable family and friends to be involved the service had held barbecues in recent months, which were well attended and they also held one to celebrate the royal wedding in May 2018.

Staff had a comprehensive understanding of people's abilities and told us they encouraged people to make their own decisions as much as possible. They said, "I like to give people time to do things on their own, no matter how small it might be, like handing me their soap or shampoo." Care records reflected people's abilities as well as their needs.

Records showed that there were regular meetings held for people at the service to give their views. We saw that people had asked to go out more and trips out were routinely taking place. People had also asked to do gardening and by the time of writing the report we could see this had happened.

People's religious and cultural needs were met by the service. Two people who were Roman Catholic attended church regularly or if they required a priest visited. The staff had sourced a piece of equipment to support a person to pray in accordance with their religious beliefs despite having significant mobility issues. A person was offered the opportunity to attend the local mosque. An alternative dish was always offered at mealtimes for one person to avoid pork.

Good

Is the service responsive?

Our findings

People's records contained comprehensive information on the person and how to support them. Their needs were assessed before they started using the service and continually evaluated in order to develop care plans.

Detailed care plans were in place to meet people's nursing needs. For example diabetes, multiple sclerosis and PEG feeding. A catheterisation care plan highlighted the positioning, care of the tube, care of the skin around the site for prevention of infection, and signs of infection to look out for.

Each person's care plan, including those who came for respite care, was reviewed on a regular basis and accurately reflected their up to date care needs. For example, where one person's moving and repositioning needs changed, this was updated on their care plan and staff signed to confirm they were aware of this change. Another person's communication care plan gave instructions of how best to communicate with them and a third of how to safely support them when they had a seizure.

People's care plans focussed on life goals and worked towards achieving them. These were short, medium or long term goals and ranged from a short term goal of sitting in a café with a cup of coffee to a long term goal of independent travel. Family members told us they felt involved in their relatives' care planning.

Care plans reflected individual preferences and choices. They also reflected the residents' life history which helped staff to understand individual reactions and needs much better and supported staff to provide person centred support.

Staff had a good understanding of people's varied needs as reflected in care plans and made efforts to meet them. They spoke with knowledge about how to support people and understood the different personalities. For example, they knew that one person liked to drink a certain colour of drink. We attended a staff handover which discussed how each individual had been during the previous shift. We noted that some of the interventions mentioned accurately reflected that person's preference as outlined in their care plan.

A family member told us "I thought [name] needs were well met before this manager arrived recently. But since she arrived, they are even better met!" The service operated a keyworker system. This was a member of staff with particular responsibility to liaise with family members and advocate for the person. One to one meetings between the person and their keyworker took place every two months. The discussion was recorded as 'what we discussed' and 'what we decided'. For example, we saw a person expressed an interest to go out more often and subsequently saw this was planned into their monthly activities schedule.

Since the last inspection a new activities co-ordinator had been recruited and they brought energy and vitality to the role. One relative told us "She's terrific." As a result, there was an extensive programme of activities which included group and individual activities. The activities co-ordinator led a number of activities but staff also supported people with activities.

Activity plans were tailored to individuals and reflected their expressed interests. Since the last inspection for example, a person who had been a boxer in their professional life had been to a local boxing gym on occasion, and had opportunities to watch programmes related to their past interest. Another person who had been involved in acting and performing had attended shows locally and in central London. We saw there was a willingness to really engage with people and encourage them to improve their skills. One person was being encouraged to walk more, so staff were actively prompting this. Another person was improving their maths skills through games and another person was being read to.

People were now going out to numerous activities. In the week of the inspection numerous people were going out to the cinema, the local shops, local cafes and there was a trip to aircraft museum outside of London later in the week.

Individual booklets were produced each month which showed all the activities the person took part in during the month. This included a commentary as well as photographs. A family member told us these booklets were a "wonderful record of fun" and said the increased amount of activities helped to boost their relative's confidence levels. We saw one had been produced for a person who had attended the service for a respite break. These booklets were especially useful as not all the people living at the service could communicate verbally so these helped their family and friends understand what they had been involved in. Staff told us they were able to spend more time with people and do one to one activities which they told us "increases my enjoyment of the job."

There was a complaints process in place and there was a system to collate this information. We could see the service manager responded to complaints in a timely and appropriate manner. Relatives told us they felt able to talk with the manager to address issues of concern. Two complaints were outstanding at the time of the inspection and were going through the complaints process.

Good

Is the service well-led?

Our findings

At the last inspection we found a breach of regulation around the governance of the service as the provider's auditing process did not pick up all the issues of concern which we found at the inspection; care records were not always up to date to reflect the care provided and the provider could not evidence they sought feedback from all stakeholders. CQC had not been notified of significant events in line with the requirement to do so.

At this inspection we could see significant improvements in all areas of management of the service and the service was well led. CQC had received notifications appropriately in the period between the last inspection and this inspection.

Devon House had a vision for the service; to make every day meaningful for their residents; to encourage people to engage in things they used to like before they came to the service; to encourage freedom and independence and to treat and respect all residents as equal. We could see from this inspection that the staff were actively working to achieving these aims.

There had been a change in management since the last inspection; a new registered manager was in post, but the day to day management of the service was led by the service manager. We found the service manager to be open, energetic and dynamic in the management of the service. Staff confirmed there was an open and transparent culture within the home.

Since the last inspection we could see the service was working effectively with relatives and people to get their views on the service. The service manager and the local authority had held regular meetings for family members to attend, and there were regular meetings for people who lived at the service to air their views. The service had also developed an easy read document to get people's views between March and May 2018. The service manager was developing an action plan as a result of this. Some of the issues raised had included a request for more activities, more BBQ's with family members invited, and nicer napkins to be bought. The service manager could show us they were implementing the action plan and we could see on the notice board a log of what people had asked for, and how the service responded. The service also sent out a bi-monthly newsletter so family and friends could keep updated on news at the service.

Effective systems were in place to manage the quality of the service and improvements had been made in a broad range of areas including activities, safeguarding, supervision and medicines management.

Regular audits took place. These included of care plans, medicines, supervision and building safety and maintenance. We saw where actions were identified at a local level, they were followed through with dates of completion. For example, a medicines audit on 1 April 2018 had identified a new 'grab bag' for emergency evacuation was required and another audit on 8 April 2018 had identified a new first aid box was required. Both of these were in place on the day of the inspection. This showed that the systems were working effectively and the service manager and the staff team were following through on actions.

The service manager also ran regular clinical governance meetings for nursing staff which covered key areas including safeguarding, infection control, service user experience, medicines and health and safety. The service manager intended to broaden out these meeting for care staff to attend going forward.

The provider continued to audit the quality of the service and we could see there had been two provider audits in November and December 2017, with two further audits in January and April 2018. A full provider audit in February 2018 had identified issues, for example, the lack of mental capacity assessments on care records, which were put in place by the time of the inspection. A full health and safety audit had also been carried out by the provider in February 2018 and actions were either complete or in progress to completion. The service manager told us they had been supported in their role by monthly phone calls from senior managers as the service was a 'watch site'. This meant there was additional scrutiny by the provider to ensure the quality of the service improved. We could see at this inspection that the provider audits and additional scrutiny and support by senior management had been effective in supporting the day to day manager to make improvements in quality at the service.

Staff were positive about working at the service. Staff told us, "I absolutely love my job. I love working with the people here." Another told us, "I feel proud that we work well as a team to provide the best quality care." Staff told us "things have improved a lot" since the last inspection, referring to both systems at the service and the management of the service, and that the service manager was "really fair and understanding." They also told us how the service manager asked for their views on ways in which further improvements to the service could be made, "I feel as if my opinion is of value."
There was a monthly staff meeting, held at 08:00am to enable the night staff to attend and minutes were distributed to all staff. We could see these took place regularly and covered best practice topics as well as issues of importance to staff. The service manager worked with the staff team to identify improvements to be made and shared any learning from incidents.

One relative told us, "the new service manager is at the top of their game and made remarkable improvements." Another said "She's made 100% improvements." One person living at the service told us "Yeah, better well organised than it used to be." Health and social care professionals praised the leadership of the service. One told us "She [the service manager] is absolutely brilliant."