Barchester Healthcare Homes Limited

Derham House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on November 2016. After that inspection we received concerns in relation to end of life care. As a result we undertook an inspection to look into those concerns on 24 July and 24 August 2017.

Derham House is registered to provide accommodation for 64 people who require nursing or personal care. Bridge unit provides nursing care whist Foxhall unit also known as "Memory Lane" provides dementia care. On the day of our visit there were 62 people living at the service.

During our visit, there was a registered manager in place, who had already handed in their notice of resignation. 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. A few days after the inspection we received a notification to confirm that the registered manager had resigned.

People told us they felt safe living at Derham House. There was an on-going safeguarding case which had been reported and was being dealt with by the appropriate authorities. Staff had attended safeguarding training and were aware of the accident and incident reporting procedures in place.

There was a complaints procedure which was known by people their relatives and staff. Complaints were monitored monthly and investigated and resolved in a timely manner with the exception of two ongoing complaints.

Staff were supported by means of regular supervision and training. Staff had recently undergone refresher end of life training and were able to explain lessons learnt from recent end of life care.

People told us they were treated with dignity and respect by staff who were polite and caring. We observed staff encouraging people to maintain their independence.

There were shortfalls in the way in which some mental capacity assessments, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and bedrails risk assessments were completed.

Care plans mostly reflected people's holistic needs. However, we found repositioning charts did not always specify how often people needed to be repositioned in order to reduce the risk of developing pressure sores.

The service was not always well led. Some records were not always accurate or up to date to reflect the care needs or the care delivered. These were mainly fluid balance charts and food charts which although we could see care being delivered it was not always recorded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and their relatives told us they felt safe. Although there had been concerns about safety, staff had learned and were aware of the procedures to follow to keep people safe.

Risks were managed appropriately.

Is the service effective?

Requires Improvement

The service not always effective.

Mental capacity assessments were not always accurate and up to date.

People were supported to maintain a balanced diet. They were supported to access healthcare services when required.

Staff were supported by means of regular supervision, meetings and training.

Is the service caring?

Good

The service remains caring. People told us they were treated with dignity and respect by staff who were kind and polite.

People were supported to maintain their independence.

Staff had undergone training to enable them to support people and their relatives during end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were reviewed and updated regularly. However other records such as fluid balance charts were not always accurate.

People told us they were involved in planning their care.

There was an effective complaints systems known by staff although two ongoing complaints were yet to be resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although people and their relatives told us the manager was approachable and had brought stability they were leaving the service.

There were some shortfalls in maintaining accurate records of care delivered.

Derham 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.

We carried out an unannounced comprehensive inspection of this service on November 2016. After that inspection we received concerns in relation to end of life care. As a result we undertook an unannounced comprehensive inspection to look into those concerns on 24 July and 24 August 2017.

Before the inspection, we looked at information from notifications and local authority monitoring reports. We spoke to the local safeguarding team and reviewed current action plans.

We spoke with eleven people, nine relatives, three nurses, two managers, a GP and seven staff. We looked at eight care plans, six fluid charts, seven turning charts, two catheter care records and six food diaries. We looked at the training matrix for all staff, a supervision matrix and 25 training certificates. We looked at compliments and feedback from people and their relatives including the latest satisfaction surveys and actions plans. We also looked at staff meeting minutes and resident and relatives meeting minutes and personal emergency evacuation plans.

Good

Is the service safe?

Our findings

Prior to the inspection we received concerns about safety of people relating to actions taken following safeguarding incidents. We looked at falls logs and safeguarding notifications. We found steps had been taken to investigate and act on action plans following safeguarding investigations. There were ongoing safeguarding action plans in place which were known by staff. Appropriate measures had been put in place such as support for staff to report incident and accidents and debriefs following end of life care to ensure staff reflected on what went well and what could have been improved.

We saw minutes reflecting the nature of debriefs that took place. Additional safeguarding training had been put in place for staff to ensure they understood their responsibilities in relation to safeguarding people from avoidable harm. Staff were able to explain the steps they would take to report and record any allegations or witnessed abuse and told us they would not hesitate to raise any concerns. They were aware of recent incidents and steps taken to reduce the risk of recurrence.

People told us they felt safe. One person told us, "I like it here, it's quite safe in my opinion." Another person said, "I feel safe here." A relative told us, "The staff put me at ease as it was a very difficult decision to put [person] in a care home." Another relative said, "They look after [person] well and let me know if there are any concerns." A third relative told us, "They are very welcoming and engaging, I walk out thinking [person] is safe."

Medicines were managed safely by staff who had received appropriate training. One person told us, "I receive my medicine with my meals like clockwork." Another person told us, "They always bring my tablets and inhalers when I need them." There were procedures in place to ensure people's pain was managed. We saw as required medicine protocols in place for regular pain relief. Staff were aware of the procedures to take to ensure people received pain relief in a timely manner. They showed us the process followed to request pain relief medicine for people nearing the end of their life.

People told us there were staff around to support them. One person said, "Someone is usually around, if not I just press a button and they come." Call bells were answered promptly during our visit. There was ongoing recruitment to fill the remaining vacancies since our last inspection. Regular agency staff were being used to fill in the gaps. We spoke to two agency staff who had both been given an induction and were aware of people's support needs. Some people and their relatives knew the two agency staff on duty by name and told us they were very helpful. We found safe recruitment practices were in place to ensure that only staff that had undergone the necessary checks were employed.

We observed staff following appropriate moving and handling procedures when assisting people from chair to wheelchair using moving and handling equipment. They spoke to people throughout the moving and handling procedure and told us they had attended moving and handling training. We also saw records to confirm moving and handling training had been completed.

Risks to people were assessed and mitigated. Staff were aware of the personal evacuation plans to be used

in the event of a fire. They showed us bath records with temperature recordings to prevent the risk of scalding. Choking risk assessments were in place for people with swallowing difficulties and we saw staff sitting them up in appropriate positions before assisting them to eat their meals.

Requires Improvement

Is the service effective?

Our findings

We looked at this in response to a concern that staff had not received appropriate training and were not aware of people's current dietary plans. People and their relatives told us staff were able to support them effectively. One person said, "Staff come when I call and help me accordingly." Another person said, "They [staff] seem to know what they're doing. If there is a new face there is usually someone familiar about." A relative told us," The [staff] have been excellent. The care is second to none. Brilliant in my opinion."

Since our last inspection staff had received additional end of life training and told us that debrief sessions were completed after end of life care was delivered. We saw minutes to confirm debrief sessions occurred. We spoke to staff about recent end of life care delivery and they were able to explain to us how they worked with different members of the multidisciplinary team such as the GPs and dietitians. The nurses were up to date with syringe drivers for pain relief. In addition they told us of how they supported families to be comfortable and stay overnight during people's last days. We saw 'thank you' cards confirming this. One read, "Thank you very much for looking after [person] especially in the last days of her life."

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.

Staff sought people's consent before delivering care. They had recently attended Mental Capacity refresher training and were aware of their responsibilities. However; we found that although capacity assessments were completed for specific decisions, some of them were over a year old and needed to be reviewed. For example, a bed rail risk assessment for someone who lacked capacity had not been completed properly to indicate if a best interest's decision had been made specifically for the bedrails. Two covert medicine authorisations did not specify how each medicine was to be given. Similarly a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form had not been completed fully. We recommend best practice guidelines are followed in line with the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found these with the exception of the bedrail risk assessment were being met.

People were supported to maintain a balanced diet. One person told us, "The food is very good." Another person said I enjoy the food. If you don't like what's on offer they give you an alternative." We saw in the kitchenettes within the serving areas there were lists of people's nutritional requirements. This ensured all staff knew people's special dietary requirements such as puree and thickened fluids. We observed and

found people on special diets were given food that met their specific requirements. People chose to eat in their rooms or within the dining rooms or communal areas. Those who required support were assisted at a pace that suited them. Drinks were offered at regular intervals and mouth care offered. However, the food and drink intake was not always recorded.

People told us they could see a doctor when they needed to. One person said, "The doctor comes every week or whenever you need them." Another person told us they attended regular check-ups for their medical condition. We saw evidence of regular GP visits to review people. On the day of our visit a regular GP visited to review a person whose condition had deteriorated. They told us they worked well with staff at the service. We saw evidence of medicine reviews and escalation to medical teams when people required support to maintain their health.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind, polite and understanding. One person told us, "They are very good to me. We can have a laugh and a decent conversation." Another person told us, "so far they have all been good to me." A third person told us "The staff is lovely. They come when I request for help. So far they have been very good."

People were treated with dignity and respect. We observed staff speak to people in a polite manner and wait for people to finish before clearing their plates. They waited for people outside the bathroom where appropriate in order to give them their space and privacy. They conversed with people before delivering support and explained what they were about to do.

Staff were aware of people's hobbies, preferred names and professions and used this knowledge to engage with people. In one of the lounges there were regular bouts of laughter as staff laughed and joked with people. In another lounge people engaged in karaoke whilst others played tambourines. A person who was now nonverbal and had a love for music was happily engaged in listening to their music via headphones.

People were supported to maintain their independence. One person told us, "I go to my room when I want." Another person told us, "I do as much as I can without any help and then call for assistance for things I can no longer do myself." We observed that mobility aids were kept within reach. People were encouraged to mobilise at their own pace to the dining room or to the bathroom by staff who were patient and attentive.

People were supported to have a comfortable and pain free experience during the last days of their life with the exception of an ongoing case where there had been a breakdown in communication. We saw a memorial table for a recently deceased person in one of the lounges and a lot of thank you cards from relatives of recently deceased people. Some of the comments read, "It was especially comforting to my family to know that [person] was cared for so well," To all who cared for [person]. Thank you for being there where we could not be." and "We are grateful for the care and attention you gave to [person] In particular the comfort [person] received in the last few days." Staff had recently attended further training on how to support people and their relatives during end of life care.

Requires Improvement

Is the service responsive?

Our findings

We looked at this in response to a concern that people's care needs were not always updated in a timely manner. People told us they were involved in planning their care especially when they first moved in and at care plan. Care plans were reviewed monthly. They included people's future aspirations, physical, emotional and social needs. However for people who had been assessed as needing regular turns, this was not always specified on the care records we reviewed leaving people at risk of not receiving pressure area care in a timely manner. Similarly there were no individual fluid targets for people on fluid charts based on their weight. This meant there was no effective way of monitoring if people were receiving their required intake. We spoke to the new manager about this. They were aware of this and were in the process of trying to address the standard of record keeping.

Care plans were to be reviewed using a resident of the day system. However we noted on the second day that one out of four care plans had not yet been reviewed and two others were not fully reviewed to reflect people's current needs. Care was not always designed in a way that achieved people's preferences and did not always ensure their needs were met.
This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the activities provided. One person told us, "There is always something going on. I choose what I want to do." Another person told us, "We went on an outing the other week. When the weather was nice. There was an open day a month or two back." On the day of visit there was a birthday celebration where the chef had provided a birthday cake and the family had access to a private room to celebrate. Another person had gone out for a coffee with a relative. We saw some people did gardening while others watched a film. Other activities included an active knitting club, pet therapy, flower arranging, a baking group and regular pamper days. Other people enjoyed using their electronic devices to surf the internet. In addition the service had portable devices and we saw people using to listen to music of their choice.

There were effective complaints procedures in place. People and their relatives were able to express their concerns and felt they would be listened to. One person told us, "I can raise any issue with the manager and staff." Another person said, "So far so good. No complaints. I would tell the management if I had any cause for concern." A relative told us, "They listen to any concerns and try their best to address them promptly." We looked at complaints since our last inspection and found they were investigated and resolved with the exception of two ongoing complaints. Where possible, learning from complaints from issues such as cleanliness of some rooms and supporting people to eat was evident on the days of inspection.

Requires Improvement

Is the service well-led?

Our findings

The current systems in place were yet to address the issues of maintaining an accurate, complete and contemporaneous record in respect of each person. Although people's records were stored securely, there were shortfalls in the way some records were completed. We noted that a clinical development nurse had started to work two days a week within the service for a period of six weeks in order to improve record keeping. However, they had only completed the first week on the first day of inspection. On the first and second day of inspection some capacity assessments had not been updated for over a year. Two out of four fluid balance charts did not show the target fluids for the day based on people's weight and were not completed properly on both days of inspection.

Similarly food charts were not always completed properly showing exact quantities of food eaten. Some turn charts did not always indicate how often people should be repositioned. One body map showed two bruises from a recent fall but this was not on the falls log or risk assessment. This left people at risk of inconsistent care delivery as records were not always specific and did not always reflect the current care delivered. This also showed the current systems in place to monitor the quality of records of care delivered had failed to identify and resolve current shortfalls in capacity assessments, food charts, turn charts and fluid balance charts.

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

People and their relatives told us the manager was visible and approachable and had made improvements to the way in which the service was run. One person told us, "[Manager] is always about asking how things are." A relative told us, "[Manager] brought in stability after we went through a rocky patch when the original manager left. It's definitely an open door policy." During the first day of inspection the registered manager was on the units at several intervals and people and relatives knew them by name. Staff we spoke with told us the registered manager was supportive. On the second day of inspection a new manager was in place. People, relatives and staff confirmed the new manager was visible and approachable.

On the day of our first visit there was a registered manager in place who had already handed in their resignation notice. Shortly after our inspection we received a notification that there was no longer a registered manager in place. However, a new manager had started on the day of our second visit and yet to start the registration process. A new deputy who had started on 10 July 2017 had resigned. There had been no deputy manager since our last inspection. In addition, this was the third registered manager in a period of two years. This made staff uncertain and did not always ensure a consistent approach to the way in which the service was run. One staff member told us, "We had just begun to understand how this manager works it would be a shame to have a change again."

Staff were aware of their roles and responsibilities and told us they had been supported by the manager. An action plan showed support in human resource management for the management team. Identified risks related to safeguarding incidents had been actioned and addressed. People, staff and relatives, with the

exception of two on-going complaints, were satisfied with their involvement and the communication within the service. We saw minutes from relatives and residents meetings and found issues such as new staff, food and activities were discussed. A suggestion box was also visible for people to make comments about any improvements. Staff had been retrained face to face in end of life care planning and supervisions and meetings had been held to discuss communication, confidentiality and team working. Staff we spoke with were happy with the support given and told us that little things like more car parking space made a difference.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always designed in a way that achieved service user'S preferences and did not always ensure their needs were met. Regulation 9.2 (B).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The current systems in place were yet to fully address the issue of maintaining an accurate, complete and contemporaneous record in respect of each service user. Records such as capacity assessments, turn charts, fluid balance charts and food diaries were not always completed properly. Regulation 17. 2 (c).