Bupa Care Homes (CFChomes) Limited

The Donnington Care Home

Inspection report

Wantage Road
Newbury
Berkshire
RG14 3BE

Tel: 01635521272

Date of inspection visit:
06 September 2016
07 September 2016

Date of publication:
12 October 2016

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

Summary of findings

Overall summary

This inspection took place on the 6 and 7 September 2016. The inspection was unannounced on the first day and announced on the second day.

The Donnington Care Home is a detached Victorian building that has been extended and converted over the years into a fully modernised care home. The home is surrounded by its own grounds and is situated near Newbury within West Berkshire. People have their own bedrooms with en-suite facilities and use of communal areas that include an enclosed private garden. The people living in the home need care and support from staff at all times. Some of the people live with dementia and other health related conditions. The service is registered to provide care and nursing care for up to forty people. There were thirty-five people in residence during our visit.

There is a registered manager running the service. 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. The registered manager was present throughout the inspection.

There were robust processes in place to monitor safety when giving people their medicine. The recruitment and selection process helped to ensure staff of good character supported people. Staff knew how to recognise and report any concerns they had about the care and welfare of people to protect them from abuse. There were enough staff to meet people's needs safely.

Staff had received health and safety training that included medicine management and administration and had attended specialist training such as dementia care. They were supported to obtain health and social care qualifications. However, not all staff had taken the opportunity to access short specialist training courses that were provided by external professionals, to meet people's specific needs. They said they had to do the training in their own time. This had proved to be a miscommunication amongst the staff team and was rectified by the registered manager during our visit to encourage staff training and development.

People's care plans were up to date to reflect their care needs and identify individual risks. For example, to promote falls prevention and person centred care. However, two people had missed healthcare appointments that had not been identified within the staff handover or through the review of their records. The registered manager initiated improvements at the time of our visit to advocate best practice to promote and meet people's health and welfare needs at all times.

People's nutritional needs were met with meals that were appetising and cooked to meet individual needs. Staff treated people with respect and kindness. People were encouraged to live a fulfilled life with activities of their choosing and were supported to keep in contact with their families.

The service had taken the necessary action to ensure they were working in a way that recognised and maintained people's rights. They understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent issues, which related to the people and their care.

People, their relatives and staff told us they felt listened to by the registered and deputy manager who had promoted a positive culture within the home. There were systems to regularly assess and monitor the quality of service people received. These included various formal audits and quality monitoring visits by one of the organisation's area managers and by external professionals to promote the well-being and safety of people who use the service.

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 were supported by staff of good character who knew how to protect people from abuse.

People received their medicine safely.

There were sufficient staff with relevant skills and experience to keep people safe.

The provider had robust emergency plans in place, which staff understood, to promote people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always helped to see health professionals to promote their health and well-being. Improvements were initiated at the time of our visit to and meet people's health and welfare needs at all times.

People were supported to eat a healthy diet.

People's individual needs and preferences were met by staff who had received the training they needed to support people.

Is the service caring?

Good

Staff treated people with respect and dignity and promoted their privacy and independence as much as possible.

People responded to staff in a positive manner and there was a relaxed and comfortable atmosphere in the home.

Is the service responsive?

Good

Staff knew people well and responded quickly to their individual needs.

People's assessed needs were recorded in their care plans that

provided information for staff to support people in the way they wished. These were being reviewed to promote person centred care.

Activities within the home were provided for each individual.

Is the service well-led?

Good

The service was well-led

The registered manager and staff were open and approachable.

People, their visitors and staff had confidence that they would be listened to and that action would be taken if they had a concern about the services provided.

The registered manager and provider had carried out formal audits to identify where improvements may be needed and acted on these.

The Donnington 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 the 6 and 7 September 2016. It was carried out by one inspector and was unannounced.

Before the inspection the manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR and at all the information we had collected about the service. This included previous inspection reports and information received from health and social care professionals. We also looked at notifications the service had sent us. A notification is information about important events, which the service is required to tell us about by law.

During our inspection, we observed care and support in communal areas of the home and used a method called Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with the registered manager, clinical lead/deputy manager, activity coordinator, chef and 13 staff. We also received feedback from a local authority care quality officer and health care professional.

We spoke with 10 people and the families of five people. We looked at eight people's records and records that were used by staff to monitor their care. In addition, we looked at 10 staff recruitment files. We also looked at staff training records, duty rosters, menus and records used to measure the quality of the services that included health and safety audits.

Good

Is the service safe?

Our findings

People told us they felt safe and said, "I would feel confident to speak with staff if I was worried", "I can talk to them (staff) and if not I would speak with my daughter." Their families told us they had never seen anything they were not comfortable with. Adding, "I feel (name) is safe and the staff are nice", "I never go out of here feeling (name) is unsafe."

People were protected against the risks of potential abuse. Staff were able to provide a robust response in relation to their understanding of safeguarding. They had received safeguarding training and were fully aware of the provider's whistleblowing policy, known by staff as the, "Speak up" policy.

The organisations safeguarding policy referred to the speak up policy as a means for staff to obtain the information they needed to report. The safeguarding policy stated that the "contact detail of the local safeguarding team must be available for staff." However, this was not detailed within either of the policies, or within a speak-up picture easy read format. Speaking with staff identified that they were unsure of who they would go to externally if they had a concern, but were confident that they would be listened to within the organisation. They said, "We all feel we can go and talk to either (names of the registered or name of the deputy manager) they are really good and listen", "If we were not listened to, we would escalate up to the regional manager."

The provider had effective recruitment practices, which helped to ensure people, were supported by staff of good character. They completed Disclosure and Barring Service checks to ensure that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. References from previous employers had been requested and gaps in employment history were explained. The provider carried out checks to ensure people were being cared for by nurses who were registered on the Nursing and Midwifery Council register to practise in the UK.

There were sufficient staff to meet people's care needs safely. The registered manager told us that staffing levels were determined by people's care and support needs and were such that they allowed staff to engage in recreational activities. People we spoke with felt there were enough staff, as they did not feel rushed when receiving care and support. This was echoed by staff who said, "Staff numbers have improved recently following the recruitment of care staff", "With limited use of agency staff, it's easier to promote continuity of care." The introduction of a high dependency bay (HOB) where staff were present at all times, had promoted people's safety by reducing the risk of falls. The staff team consisted of registered manager, clinical lead, registered nurses and care staff. In addition, there were housekeeping, maintenance, administration, kitchen, activity staff and volunteers.

Health and safety audits where undertaken to promote the safety of people and others. These included infection control and fire safety. The service was awarded a rating of five from the environmental food safety standards on the 26 August 2016. The home was clean and well presented with no offensive odours. Staff used protective clothing to provide people with personal care. Colour coordinated bags and bio gradable bags for soiled laundry were used along with recommended detergents that guarded against the risk of

infection.

People's care plans included assessments, which identified risks to the individual. The risk management plans were incorporated into the care plan together with the identified risk and instructions of how to minimise the risks to the person. For example use of bedrails, risk of people developing pressure sores and risk of falls.

People were given their medicines safely by staff who had received training and had their competency assessed annually in the safe management of medicines. The service used a monitored dosage system (MDS) to support people with their medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records were accurate and showed that people had received the correct amount of medicine at the right times.

Requires Improvement

Is the service effective?

Our findings

People described staff as "very nice and very friendly." Comments from their relatives were not dissimilar and included, "It's such a relief, staff really could not be better and (name) has virtually not fallen at all since she got here", "I've never seen any of the staff being anything other than absolutely wonderful and supportive."

Staff described the staff team as supportive and said that they worked well as a team. Comments included, "I've progressed here and feel valued", "If I was unsure about anything I would go to a team leader as I have great confidence in them." Staff received support through supervision and appraisals to routinely discuss their learning and developmental objectives. They told us that there were regular staff meetings and that they felt confident to raise issues for discussion.

The manager and staff worked in partnership with external health and social care professionals. A health care professional told us that they had found the staff team, "incredibly helpful and conscientious".

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Examples included referrals to the occupational therapist and dieticians. Staff had up to date knowledge of people's current needs and were able to explain how they supported them. However, the outcome of two people's referrals to health care professionals had not been monitored by staff to ensure each person was supported to attend follow-up appointments. The registered manager and staff felt that they could not intervene on decisions made by people's relatives who had been appointed as their lasting power of attorney in health and welfare. This had resulted in a person who required dental treatment suffering prolonged pain and waiting longer than they should have. This raised further discussion in relation to the registered manager and staff team's duty of care and what was in the best interest of the individual. Immediate action was taken by the registered manager to improve communication at handovers between staff and improve processes of monitoring people's healthcare appointments to promote their health and well-being.

The staff team understood and supported people's rights under the Mental Capacity Act 2005 (MCA). 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. The registered manager understood and followed the requirements in the DoLS. The service had made one DoLS application, which had been authorised. DoLS were reviewed at the prescribed intervals and the paperwork was held on individual's records.

There was a comprehensive induction programme and training had been developed for staff to meet health and safety, mandatory and statutory training requirements. This had included training to support specific individual's needs, such as dementia care. The registered manager informed us that staff training was underpinned by a training needs analysis completed by the provider's learning and development team. Stating that specific training outside of that provided by the provider was sourced locally. However, staff told us that they felt guilty when taken off the floor to complete e-learning (virtual on-line courses). Comments included, "I feel guilty if I am taken off the floor to do my training as this reduces the number of staff on the floor", "If we do it (e-learning) at home it is in our own time". They told us they could not claim the time back. The home's training plan identified health and safety and specialist training such as care of a person with dementia, which most staff had completed.

Staff attendance of training, which they referred to as "optional" was limited. For example, training provided by the care home in-reach team (health care professionals who provide services that includes working with staff to enhance their skills and improve their confidence by building on existing good practice). Training that had been offered included falls prevention, dementia and catheter care. Staff told us that "optional training" was completed in their own time and this discouraged attendance. They stated, "If we choose to attend optional training it impacts on our personal time", "They should make the optional training compulsory as I think we would all benefit." The registered manager specified that extra hours were provided to cover training and reiterated this with the staff team to encourage participation in training opportunities.

Although staff attendance for falls prevention training was low, there had been a marked decrease in the number of falls people experienced. For example, a monthly audit completed over a period of 10 months showed a steady decrease of falls from 14 to under two. Staff spoke enthusiastically about the success of introducing a high observation bay (HOB) to promote falls prevention. People were given the choice to move to the HOB (a semi-circle area of five rooms with a nursing station that enabled staff to closely monitor people at high risk). This had not affected people's right of choice. For example, whether they wanted to stay in their room within the HOB or join others within the community areas of the home.

People's nutritional needs were assessed by means of a nationally recognised assessment tool. Any individual nutritional requirements were included in their care plans. People were weighed regularly and records were kept to monitor any significant weight loss or gain. A food diary was used for people who were at risk and not sustaining a balanced diet. Support of the dietician was sought, as required. People told us that they never felt hurried to finish a meal and could enjoy their food. Comments included, "I have arranged to have my meals in my room; sometimes they bring it a bit early but that's okay.", "Yes, the meals are very good and I'm always given a choice of two things." The chef manager stated, "There are set menus, but we recognise that some recipes are not enjoyed by particular clients and so we adapt these to suit individual needs".

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included, "I do like living here. Everything is nice about it and it has a good glow", "Oh yes, they (staff) love me and I love them, we love each other actually" and "It's nice living here, the (staff) are very good, attentive and caring. They are very helpful and will do anything for you."

A person's relative told us that in their observation staff always treated people with dignity and respect. The relative stated, "They are courteous and very considerate. I've no fault in them at all."

The home was spacious and allowed people to spend time on their own or within the communal areas if they wished. People's bedrooms were personalised with items of their choice. Considerations had been taken to promote their privacy when alone in their room or alone with their visitors, such as staff knocking on doors before entering.

People were asked for their permission before staff undertook care or other activities. Staff were aware of people's needs, likes and dislikes. During our visit, they had addressed people appropriately in a warm and friendly manner and encouraged them to make decisions. Staff were attentive towards people, such as acknowledging people when they passed by. We could see that people felt valued as they and staff laughed and joked with one another in a polite and caring way.

Staff were able to provide a good account of people's needs in a very respectful and caring way. People's care plans centred on their individual needs and on the choices, they had made. A 'resident of the day' programme promoted positive relationships between staff and people. The registered manager stated this enabled staff to gain an understanding of people's history as well as becoming familiar with their cultural needs.

Staff spoke of group meetings that were arranged to support them when they experienced the death of a person. They said this had helped them to except the loss of people and of personal loss. Additionally a person and their family spoke of a memorial garden within the home and of an annual service to light a candle for people they had known who had lived in the home. They and staff commented that this was a way of enabling everyone to come together and pay their respects to people they had become friends with."

Care plans enabled the person to express their views, preferences and wishes about future care and inform the service of advanced decisions. Do not attempt cardio-pulmonary resuscitation forms were appropriately completed and signed by the GP, where appropriate.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs and listened to what they had to say. Comments included, "It's a very active home", "When I ring they don't leave me waiting too long", "If I use a call bell they come quite quickly" and "You get all of your washing done and the home is nice and clean".

People's needs were reviewed on a monthly basis through a process referred to as a resident of the day, and as required. Where necessary, health and social care professionals were involved. People's care plans clearly explained how they would like to receive their care, treatment and support. Comments from people's families included, "They assessed (name) prior to her coming into the home, but the wheelchair she had impacted on choices made.", "It was too bulky and could not be pushed". They highlighted their concern to the registered manager and stated, "(Name) was reassessed and now has a new chair and is much happier." Another example was of a person who attended an outpatient appointment and felt sure their treatment plan should have been updated. The clinical lead contacted the person's GP, with the person present. This gave the person the reassurance that no further action was required.

The handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. However, due to the nature of the handover some information had been missed. The registered manager had taken immediate action to promote positive communication of people's changing needs. This included introducing a single handover amongst all nursing and care staff positions as opposed to separate handovers.

People told us that there was a range of activities they could be involved in within the home. They were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities, people were supported to maintain hobbies and interests. Comments included, "(Name of activity coordinator) arranges things for us to do, like this morning we have some entertainment.", "I plan to go down later, as I prefer to stay in my room in the morning as there are some very informative programs on TV.", "(Name of the activity coordinator) is absolutely excellent, we have a laugh and a joke." The activity coordinator commented on adjustments being made to suit people's individual needs and progression of technology. Stating, "I've noticed the change over years as people come in with tablets and mobile phones. A café was introduced once a week for people and their relatives and for people who previously attended the home for respite. They told us that this had been successful as they could, "mix and engage in conversation with others".

People and their relatives attended meetings and were encouraged to have a voice about decisions made in the home. A health care professional stated, "The patients I have been involved with were uncomplaining about the care they received at the home. I also attended a relatives meeting one evening and equally they seemed very positive about the care their relatives received."

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been one complaint since our last inspection. This had been investigated thoroughly within the timescales set out within the provider's complaint policy and procedure.

Good

Is the service well-led?

Our findings

There was a registered manager at the Donnington Care Home who registered with the Care Quality Commission (CQC) on 1 October 2013. People who use the service, their relatives and staff described the registered manager and deputy manager as open and approachable. A person's relative stated, "Personally I like the open door policy, and I also have a good relationship with the staff."

People had opportunities to feedback their views about the home and quality of the service they received. They told us they felt listened to and felt confident that the registered manager, deputy manager and staff would act in their best interest should they have a concern or complaint.

The registered manager and deputy manager were committed to ensure people's needs were met. However, further improvements were actioned during our visit to advocate acceptance of duty of care responsibilities in people's best interest. This had generated an action plan by the registered manager to improve auditing processes of people's records and staff handovers.

The registered manager was working closely with the care home in-reach team and local authority to ensure staff received the support and training they needed to meet people's individual needs.

Staff told us that staff morale had increased since recruitment of new staff and since the introduction of a high dependency bay to promote the prevention of falls. Staff said they felt valued and were supported to access development opportunities to bring them up to date with current best practice. The registered manager had informed staff during our visit that training was not to be taken in their own time, which was to encourage further take-up of learning opportunities.

There were thank you cards pinned to a board for people, visitors and staff to see and a log of compliments that included, "Thank you for a lovely respite stay". There was a memorial board of people who used to live in the home that was welcomed by people and their relatives and had contributed to the positive culture within the home.

Overall quality assurance systems were in place to monitor the quality of service and to promote people's safety. These included audits by external professionals and internal audits of people's medicine, infection control, fire safety, staff welfare and of the care and treatment people received.