

P Parmar

Dudley Court Care Limited

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We inspected this home on the 12 and 13 August 2015. This was an unannounced inspection. Dudley Court Care provides accommodation for a maximum of 22 adults who require personal care. There were 21 people living at the home when we visited. The home is set out over three floors with a lift to provide access to all floors. All of the rooms were single bedrooms each with its own sink. Shared shower-rooms and toilets were located on each floor of the home.

At the last inspection in June 2014 we found that the provider had breached the Health and Social Care Act 2008 in relation to the assessing and monitoring of the

quality of the service. Following that inspection we asked the provider to send us an action plan informing us of the action they would take to address the breach. The provider responded to the last inspection report with some detail of audits that had been requested. At this inspection we saw that although some improvements had been made they were not comprehensive. The changes had failed to address concerns relating to management of risk and improving quality aspects of the home.

There was a registered manager at the service. A registered manager is a person who has registered with

Summary of findings

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.

People living at the service told us they felt safe. Staff knew how to recognise when people may be at risk of harm and were aware of the provider's policy for reporting any concerns.

People, relatives and staff we spoke with told us there were enough staff to meet people's needs. However, we observed that staff were not always deployed effectively in order to meet people's needs. After the inspection we were informed that staff were usually available to sit and engage with people living at the home. Staff received training to enable them to provide safe and effective care that met people's individual needs. Robust recruitment checks were in place to ensure new staff were suitable to work at the service.

People had received their medication safely. We observed people being supported with their medication in a dignified and sensitive way. The majority of medication was safely and securely stored, and prompt action was initiated to obtain a separate medication storage fridge.

Staff we spoke with had received training on the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). However we found that there was a lack of understanding amongst staff and the registered manager about how to support people in line with this legislation.

People had their healthcare needs met and when people's needs changed the service was pro-active in seeking advice from the appropriate healthcare professional.

People were happy with the care they were receiving and spoke highly of the staff. People were treated with respect and kindness.

Care plans included people's preferences and care was reviewed and changed as people's needs changed. However, people were not always involved in these care reviews. Although some aspects of people's cultural needs were met, people's cultural diversity had not been fully recognised in relation to how they would want to receive their care. Following this inspection assurance was provided that the issues of cultural needs had been addressed with individual people living in the home.

People and their relatives felt able to raise any concerns they had with the registered manager and felt assured that any concerns would be resolved quickly.

Systems to monitor the quality and safety of the service were not robust. Although there were some systems in place they were not sufficient in measuring the quality of the service people were receiving.

The provider was not meeting the requirements of the law in respect of some regulations. 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 not always safe.

People were not always protected from avoidable harm. Risks to people had not been consistently managed to keep people protected and safe.

The majority of medication was stored in a safe location but the temperature was not monitored as required.

Staff were not always deployed effectively in order to meet people's needs.

Staff knew how to recognise and act on the signs of potential abuse.

Requires improvement



Is the service effective?

The service was not always effective.

People were supported by staff who had skills and knowledge to meet their needs.

People were supported to maintain their health.

People were supported to eat and drink sufficient amounts to maintain good health.

People's legal rights were not consistently supported by the home.

Requires improvement



Is the service caring?

The service was caring.

People and relatives felt that staff were caring. Staff knew people well.

People were not always involved in making decisions about their care.

Good



Is the service responsive?

The service was not always responsive.

People told us that staff responded to their needs although they were not always involved in reviewing how their care needs were to be met.

People had access to group activities but their diversity had not been recognised.

People felt able to raise concerns.

Requires improvement



Is the service well-led?

The service was not always well-led.

Quality assurance systems were not robust or effective and had failed to identify where improvements were needed in the management of risks.

Requires improvement



Summary of findings

People were not actively consulted about decisions relating to developments or improvements that could be made to further improve the service.

The registered manager was not fully aware of their responsibilities under the Health and Social Care Act.

Dudley Court Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 12 and 13 August and was undertaken by one inspector.

We visited the home and spoke with seven people who lived there, five members of staff, two relatives, two healthcare professionals, the manager and the nominated individual for the service. After the inspection we spoke with two more relatives.

Before the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us and any other information we had about the service to plan the areas we wanted to focus our inspection on. We also contacted the local authority who commission services from the provider for their views of the service.

We looked at records including three people's care plans and medication administration records. We looked at three staff files including their recruitment process. We also sampled records from training plans, residents' meetings, staff meetings, incident and accident reports and looked at the provider's quality assurance records to see how the service assessed and monitored the quality of the service.

Is the service safe?

Our findings

People who we spoke with told us that they felt safe. Comments from people included, “Oh I definitely feel safe here,” and another person said “I feel 100% safe.” Four relatives that we spoke with told us that they felt their relative was safe at the home.

Staff we spoke with had received safeguarding training and were able to describe the types of abuse people were at risk from. Staff were able to tell us the provider’s safeguarding procedure and described action they would take to keep people safe. Staff said they would report any concerns to the manager. Records confirmed that staff received safeguarding training to ensure they were knowledgeable about safeguarding practices.

We looked at how people would be supported in an emergency situation. Staff we spoke to gave inconsistent accounts of what to do in the event of a fire and were unaware of any identified individual support needs of people in the event of a fire. People were at risk of receiving inconsistent support from staff in the event of an emergency.

We found that prompt action was taken after people had experienced falls to check on their well-being. However, there was no subsequent action taken to review and audit such incidents to identify any preventative action to reduce the chance of falls happening again. People were at some risk of not being protected from avoidable harm.

People were supported to receive medication in a dignified and sensitive way. We saw that staff explained what medicines the person was taking and staff asked people if they needed their ‘as required’ pain relief medication. When a person had chosen to get out of bed a bit later than usual we saw that staff were responsive to their needs by delaying their medication times for the rest of the day. The majority of medication was stored in a lockable medication trolley, although the temperature of this medication was not monitored which meant that medicines may be stored in an unsafe way. Medication that needed to be stored in a

fridge was being stored in the kitchen fridge which meant that it was not held securely. Whilst the community pharmacist had not identified this as an issue in the home, the registered manager advised that a separate medication storage fridge would be obtained promptly to ensure that medication was secure and safe. The medication records for one person showed that they had refused medication they needed to manage their health conditions, and although this had been recorded there had been no further steps taken to monitor the person’s health.

People who used the service and their relatives told us that there were enough staff to meet people’s needs. Staff at the home felt there were enough staff on each shift. The registered manager told us that she worked out staffing levels depending on people’s needs. Although there were no agency or bank staff used at the service the registered manager told us that the staff worked out cover for any staff absences to ensure designated staffing levels were maintained. We saw that although there were sufficient numbers of staff on each shift they were not always deployed in an effective way to meet people’s needs. During our visit we observed people been left unsupervised for substantial periods of time, and witnessed a person had spilt a drink over themselves although staff were unaware. On another occasion conflict arose between people in the lounge which resulted in one person becoming distressed when they were shouted and sworn at by another person. On occasions known risks to people had not been consistently managed to keep people protected and safe. After the inspection we were advised that staff usually spent time sitting and engaging with people living at the home.

There were processes in place for safe staff recruitment which had been followed. The processes included obtaining Disclosure and Barring Service (DBS) checks to ensure that people employed were safe to be working to support people. We found that further steps had been taken to ensure staff were suitable to support people who used the service.

Is the service effective?

Our findings

People who used the service said the staff had the skills and knowledge to meet their care needs. Relatives we talked to told us that staff were knowledgeable and understood people's specific needs and used this knowledge to support people appropriately.

Staff we spoke with felt supported in their role. Staff told us that they received regular supervisions with the registered manager. Records we looked at informed us that supervisions occurred every three months. The service had an external trainer who provided scheduled training to staff. This trainer communicated with the registered manager on a regular basis in order to inform the registered manager when training was due. There were systems in place to reschedule training when staff failed to attend the original session. When people's needs changed the manager contacted the trainer to provide the staff training in this area. Staff told us that if they needed more support in a certain area then they could speak with the registered manager who would then book the required training. Staff meetings took place every six months and included sharing information about safeguarding and whistleblowing. Daily communication occurred between staff via a communication book which detailed any changes in people's health care needs. Staff could then use this information to support people appropriately.

Staff we spoke with had received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). However we found that there was a lack of understanding amongst staff and the registered manager about supporting people in line with the requirements of the MCA and DoLS. There was a common statement in all individual records which demonstrated the lack of consideration of people's individual capacity and some restrictions were being imposed without appropriate assessments or formal authorisation being in place. The

lack of individual assessment information meant that people were at risk of receiving inconsistent support and there was a risk that people's rights had not been protected.

People we spoke with told us that staff offered them daily choices and we saw staff responding to these requests effectively. We saw staff seeking consent around medication and before supporting people with meals.

People were supported to eat and drink sufficient amounts to meet their needs and maintain good health. People told us that the, "Food is nice" and "If I don't like the food the cook finds me an alternative." Relatives told us that they saw people were given a choice of food and staff provided extra support to those who needed encouragement to eat. We saw that people received the correct support to meet their needs in a dignified way. One person we spoke with told us that they didn't get to choose the food that was served to them and they were unsure what was for dinner that day. On the second day of the inspection we saw staff asking people what they would like to eat. We spoke with the chef who told us that there was a menu plan but people were asked what they would like to eat at residents' meetings. We saw that staff were responsive to a person's request to have their dinner later on as they were going out for the day.

People told us that staff supported them with their healthcare needs. One person told us that when they were unwell, "If I wanted anything staff would help me get it." People saw healthcare professionals regularly to maintain their health. We found that people had their healthcare needs monitored regularly so that if any changes occurred then referrals could be made to the appropriate healthcare professional promptly. We found that the registered manager was proactive in referring people when their healthcare needs changed. This meant people were supported effectively to meet healthcare needs. Healthcare professionals we spoke with told us that the service were quick to alert them if they had any concerns, and that the service acted on any advice given.

Is the service caring?

Our findings

People told us that they felt cared for and we saw that staff interacted with people in a kind and compassionate way. Comments from people included, “Staff are very good”; “The staff want the best for you, they are great”; and “All the staff are very caring.” Relatives told us that the staff are “Absolutely fabulous” and “The care people get is great.”

People we spoke with gave examples of caring practices the service carried out such as being able to get up when they wanted and having breakfast in their bedroom if they requested it. One relative told us that the service had helped a person make friends when she started using the service. These friendships had made a big difference to her quality of life at the home.

Staff we spoke with told us that “Looking after people is the best bit of working here.” Staff spoke of the importance of making the service special and homely for people who lived there. We saw that people were treated with respect and kindness when staff interacted with them. Staff were able to recall people’s life histories and gave examples of how they used this information to support people in their everyday care.

People were not always treated with respect on issues related to planning how their care was to be provided, because they were not always supported to make

decisions about their care. We found that there was limited evidence of people being involved in planning or reviewing their care. Relatives told us that they were involved in care reviews.

People and relatives we spoke with told us that they could visit when they wanted to. One person told us that “At no point are visitors discouraged. They are made most welcome with a cup of tea or coffee” and relatives commented that “I can visit anytime.” When relatives found it hard to visit they told us that the service kept them informed on the phone regularly. The manager told us that she had arranged advocacy services for one person who didn’t have any family.

People were supported to express their views about the service in residents’ meetings. We saw that these meetings took place regularly and allowed people to discuss and make decisions about activities and food choices. Within these meetings people were also reminded about how to raise any concerns they may have. We saw that people were involved in decisions about new furniture in the home via these meetings and people we spoke with confirmed they had chosen the colour of the new chairs in the lounge.

One person told us how they were supported by staff to retain their independence. Relatives told us that staff were very respectful and treated people with dignity. A visiting healthcare professional gave us examples of how they had observed staff supporting people in a dignified way whilst preserving their right to privacy.

Is the service responsive?

Our findings

People told us that they felt the service responded appropriately to their care needs. We saw that when staff were available they acted promptly to people's requests for support. We saw that initial care plans included people's individual support needs and their likes and dislikes. We saw that these care plans had been reviewed and had been changed as and when people's healthcare needs had changed.

People gave us examples of how staff had responded to their needs. One person told us that "I mentioned I love newspapers and they arranged for it to be delivered." Another person told us that staff had helped them resolve a problem they had. People told us about the choices they had been given and staff we spoke with told us about the importance of offering choice.

Staff spoke of the importance of recognising people's individuality when providing care. Relatives told us that they were involved in care planning and the home involved them in care reviews. From reviews of the records we saw that whilst people had been involved in determining their initial care and support needs they had not always been involved in their on-going care reviews. The registered manager advised that reviews of care plans were often undertaken only with relatives of people using the service.

We saw that there was an activity schedule in place. The registered manager had given people options of possible group activities they could do and had then organised them accordingly. The home had regular visits from an outside source who came in and carried out exercises with people who wanted to join in. This meant that the home saw the importance of people trying to stay physically active. We saw staff explaining to people what activities

were due to happen that day and staff told us that people could refuse to take part if they wanted to. The registered manager told us that she arranged for a vicar to visit the service. However, the registered manager was unable to clearly demonstrate what actions had been taken to support the needs of people who had different cultural needs from the majority of people living in the home. Although some aspects of people's cultural needs were met the service did not recognise how a person's culture would impact on every part of having their care needs met. The registered manager provided limited examples of how the service met people's diverse cultural needs and stated that family involvement was required to meet some of the person's needs. Following this inspection assurance was provided that the issues of cultural needs had been addressed with individual people living at the home.

People were able to tell us who the registered manager was and we saw that she was available to help and had contact with people around the home during the day. People told us that they could raise a concern or complaint with the registered manager and knew that it would be responded to. Relatives that we spoke with told us that they would not hesitate in contacting the registered manager if they had any concerns and felt assured that these concerns would be resolved quickly. Staff told us that if they had any concerns then they felt able to approach the registered manager but also felt confident in speaking to the provider if they felt the concern had not been resolved appropriately. We saw that the complaints procedure was available in a written format in the hallway. We saw that when residents' meetings took place, people were reminded of how to raise a concern. The registered manager told us that there had not been any formal complaints made in the last year.

Is the service well-led?

Our findings

At our last inspection in June 2014 we found that the provider had breached the Health and Social Care Act 2008 in relation to assessing and monitoring the quality of the service and managing risks. Following that inspection the provider was asked to send us a plan detailing what action they would take to address the breach we found. The provider responded to the last inspection report with some detail of audits that had been requested. We saw that although some improvements had been made they were not comprehensive and had failed to address the need to monitor the risk of falls with the aim of reducing the occurrences.

We looked at the provider's systems in place to manage risks and to monitor the safety and quality of the service. We found that although there were systems in place they were not robust. A residents' survey had taken place but it was not clear when this had happened and the information gathered through the survey had not been analysed to identify what actions to take in order to improve the quality of the service. This survey had not been completed by all of the residents and no action had been taken to gain the views and opinions of people who had not responded to the survey. When we asked the registered manager about how they would gather the views of all people they had advised that they would speak to the person's relative. A staff survey had taken place but few staff had responded. The information that had been provided had not been analysed to identify improvements that could be made and one response identified an issue that had been outstanding and had still not been resolved. The systems in place to assess compliance with the regulations and to ensure that due regard was given to the views and feedback from people using the service and other relevant people were not comprehensive or effective.

The issues related to the governance and lack of effective systems in place to manage the risks to people and monitor the quality of the service represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager followed requirements to inform the Care Quality Commission of specific events that had occurred in the home and had worked with other agencies to keep people safe. However, the manager had little knowledge of her responsibilities under the Health and Social Care Act 2014. She was unsure of changes to regulations and the introduction of Fundamental Standards. The home had few links to external groups to help them keep up to date with developments of best practice within the care sector. The registered manager advised that she had relied on the training provider to keep her up to date with social care developments.

Although the registered manager spoke of wanting to develop the service there were no clear plans in place of how this would be achieved.

People we spoke with told us they were happy with how the service was managed and staff felt supported within their role. People and staff knew who the registered manager was and felt able to approach her if they had any concerns. Staff told us that the registered manager was available to support people and staff throughout the day in the home.

People spoke positively of the registered manager and comments included, "The manager is very good, she wants the best for people", and "The manager is always available."

Staff we spoke with told us they felt able to raise concerns with the registered manager and told us that they were involved in suggesting ways of improving the service.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not have robust and effective systems in place to manage the risks and monitor the quality of the service. Regulation 17(2)(a)(b)</p>