

Embrace (South West) Limited

Dunollie Nursing Home

Inspection report

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Date of inspection visit: 19 and 20 February 2015

Date of publication: 22/05/2015

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 19 February 2015 and was unannounced. We last inspected this service on 10 February 2014 and found breaches of Regulation 20 Health and Social Care Act 2008 relating to record keeping. There were no further breaches of this regulation at this inspection

Dunollie Nursing Home is a care home with nursing and a rehabilitation service providing accommodation for older people, people with a physical disability and people living with dementia. The service has 58 beds in total which are located across three areas; the main house, the

garden wing, which is an extension to the rear of the property, and the Lodge which is a separate house within the grounds. There were 49 people in residence on the day of the inspection

The service is a large converted building and is over three floors around a central hallway in the main building. There is a corridor connecting the garden wing to the main building which is also over two floors. The Lodge is

Summary of findings

a separate house within the grounds. Staff have to leave the main building and walk outside to access the Lodge. There are large gardens with outdoor patios and areas for seating and parking for visitors.

There was a registered manager at Dunollie Nursing Home. 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.

Peoples call bells could not be heard in every area of the building and there was no system in place for staff working in The Lodge to access support if they could not reach the telephone. The provider is looking at ways to address this issue.

We found that staffing levels were inconsistent and had not being sustained at night which meant that people's needs were not always met in a timely manner. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which

corresponds to regulation 18(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People who used the service told us they felt that they were cared for by staff who were trained to carry out their role and staff knew people well.

Staff were trained and supported by senior staff.

People had mixed views about the food but we saw that people received a well-balanced diet with support from staff where it was needed.

Care plans reflected the person's needs, wants and preferences and were reviewed at least annually but more often when needed.

The service was not always well led. Policies and procedures were in place but not always followed and we have recommended that the provider look at how guidance around dementia friendly environments is more accurately reflected in this home.

There was a quality assurance system in place to ensure that standards and quality were maintained.

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?

This service was not safe. We found that staffing levels were inconsistent and had not being sustained at night which meant that people's needs were not always met in a timely manner. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people we spoke to told us that they felt safe living at this service but

Medicines were managed safely.

Peoples call bells could not be heard in every area of the building and there was no system in place for staff working in The Lodge to access support if they could not reach the telephone. The provider is looking at ways to address this matter.

Requires improvement



Is the service effective?

This service was effective. People who used the service told us they felt that they were cared for by staff that were trained to carry out their role and staff knew people well.

Staff were trained and supported by senior staff.

People had mixed views about the food but we saw that people received a well-balanced diet with support from staff where it was needed.

Good



Is the service caring?

This service was caring. People said that staff were kind and caring.

We saw that staff knocked on people's doors before they entered and spoke to people respectfully.

People were given choices and they told us that staff listened to them

Good



Is the service responsive?

The service is responsive. Before people became resident at Dunollie an assessment was carried out to make sure that the service could meet their needs.

Care plans reflected the person's needs, wants and preferences and were reviewed at least annually but more often when needed.

People knew how to make complaint or raise concerns and the records we saw showed that those complaints are responded to by the service.

Good



Summary of findings

Is the service well-led?

The service was not always well led. We have recommended that the provider look at guidance around dementia friendly environments to more accurately reflect their own policy.

Policies and procedures were in place but not always followed.

There was a quality assurance system in place to ensure that standards and quality were maintained.

All the staff we spoke with told us they felt supported by the registered manager and that they enjoyed working at Dunollie.

Requires improvement



Dunollie Nursing 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 19 and 20 February 2015 and was unannounced.

The inspection team was made up of one inspector, a specialist advisor who was a registered nurse and two experts by experience whose expertise was in adult health and social care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out the inspection we reviewed the Provider Information return (PIR) and looked at notifications the Care Quality Commission (CQC) had received from the service. Before the inspection, the provider 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 went on to speak with a representative of the local authority quality and contracting team and a care team

manager who told us that they had no concerns about this service. We then spoke with two registered nurses from the local hospice care homes team who told us that they had some concerns because the service was not accessing the training and support they provided and no one who used the service had been registered with their service. We decided to look at this area of care as part of our inspection.

During the inspection we spoke with 23 people who used the service and nine relatives. We also spoke with two registered nurses, five care staff, two domestic staff, the cook, an activities organiser, the registered manager and the area manager as well as one visiting professional. We observed a lunchtime period in the Lodge and the main house dining room as well as observing how meals were served to people in their rooms. We accompanied the nurse on a medicine round to observe the administration of medicines and also checked the storage of medicines. We looked at the care records and risk assessments for seven people and looked at their medicine administration records. We inspected records relating to the running of the service such as policies and procedures, audits and maintenance checks carried out and seven staff employment and training records.

We visited the Lodge which was separate building from the main house run separately by allocated staff although the whole site is under one registration with the CQC and is managed by one registered manager.

Is the service safe?

Our findings

This service was not safe. Although most of the people we spoke with told us that they felt safe, one person told us, “I am not very impressed with the time it takes to get someone to take me to the loo. I have known it be 45 minutes and of course it can sometimes be too late. I don’t think it’s right that we have to wait like that and it is embarrassing when it happens.” This person went on to say “I am not convinced I am as safe as I should be due to the time it takes people to answer the buzzer.” Another person said “Oh I definitely feel safe here, I didn’t at our house but I know people are about and they come if we need them” and a third person said, “I feel very safe, I like to shut my door at night and they don’t pop in as I asked them not to disturb me but I know I only have to ring my buzzer and they will come.”

As we moved around the service we noted call bells were left within reach of people. However the call bell in the sitting room was attached to the wall and people sitting in there were unaware of it. This meant that people may not have known how to summon assistance if it was needed. In the main building people told us that it could be quite a long time before call bells were answered which meant that people’s needs were not always met in a timely manner.

One person told us “You sometimes have to wait at night as they can be over in the other part of the building.” One relative suggested there may be a shortage of staff saying that “Sometimes they don’t answer the call bell for ages and it can be too late for my [relative].” We checked the time it took staff to answer call bells and we saw that they were answered promptly during the day of the inspection. Staff did tell us that the call bell could not be heard in all parts of the building. We observed that this was the case and discussed this with the registered manager and area manager because this meant that people who used the service and staff may not be able to summon assistance when it was needed potentially putting people at risk.

When we checked the staff rotas we saw that care staffing was consistently sustained during the day because when there were any shortages of care assistants there were ancillary staff who could cover those shifts. They had been appropriately trained so had the skills required. This did mean however that their own roles were not always carried out. For instance on the day of the inspection the person

who normally organised activities had to work as a care assistant. This meant that people had no activities organised during the morning although there was a visiting singing group in the afternoon which was prearranged. People’s social needs were not always being met. People using the service and staff confirmed this happened regularly.

Normal staffing in the main building at night was one nurse and three care assistants according to the rotas we looked at but on at least eight occasions in January we saw that there was one nurse and only two carers on duty. Staff confirmed that usually there were three care assistants at night and that there had been occasions when there were only two care assistants. They also told us that it was very difficult to meet people’s needs when that happened as the building was so large. We spoke to the registered manager who looked at the rotas and supplementary online system to check this and confirmed that there had been only one nurse and two care assistants on those eight occasions. In addition there was one care assistant working at night in the Lodge. We considered that on those occasions where staff was reduced it was unsafe for people who used the service because of the main house and garden wing being separated and the size of the building. This was further complicated by the fact that staff were working alone in The Lodge and so if extra assistance was needed by them a staff member would have to leave the main house.

We found that staffing levels were inconsistent and had not been sustained at night which meant that people’s needs were not always met in a timely manner. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four negative concerns had been received by CQC through the share your experience form. Three of these commented on staffing levels saying that there was not enough staff on duty. Three safeguarding alerts had been received by CQC and two of them were related to poor staffing levels. The third alert related to end of life care that one person received. All of the issues were referred to, and had been investigated by, the local authority.

Staff were aware of how to raise a safeguarding alert and could explain to us what procedure they would follow. We looked at how the staff in the Lodge would contact the main house in the event of an emergency. Their only means

Is the service safe?

of contact was a telephone so if they were unable to reach the telephone they had no way of contacting the staff in the main house. This meant that they were not safe working alone in this area of the service because they did not have any other means of raising the alarm if they needed to do so.

We discussed this with the registered manager and area manager and hand held two way radios were implemented to ensure that people who used the service could receive assistance immediately enabling staff to summon assistance. We have since being informed by the managing director that an assessment of the situation has been undertaken and there are plans to introduce a new system to enable staff in The Lodge to access assistance from the main house at any time.

Staff had been recruited safely. We looked at four staff files and saw that there were two references in place as well as checks to determine whether or not people were suitable to work in a care home carried out by the Disclosure and Barring service (DBS). The DBS carry out criminal record checks. This meant that the registered manager was doing all that they could to ensure people's safety by making sure that people employed by the service were suitable to work in this environment.

When we looked at people's care plans we found that risk assessments were in place, as identified through the assessment and care planning process. However, they were

not always regularly reviewed and evaluated which means that risks identified may not be reflective of people's needs in order to keep to them safe. The risk assessments were specific to the person and included the assessment of risks for areas such as falls, moving and handling, nutrition and skin. Where there was a risk the service used a validated tool to assess that area. An example of this was the use of the Waterlow tool to assess a person's risk of skin damage. This meant that staff were aware of the risks to people but were not always proactive in recording when the risk had changed which could have an impact on people's safety.

We saw that people's safety and welfare had been considered when the fire risk assessment had been written but this would need updating when the new system for communication between the main house and the Lodge is put in place. The regular checks of fire alarms and fire fighting equipment and safety checks of mains services such as gas and electricity had been carried out and were up to date. Equipment for the use of people who used the service such as hoists were maintained regularly. This meant that people could be sure that the registered manager was doing everything possible to maintain a safe environment.

Senior staff administered medication and we saw that they did so safely. Medicines were received, stored and disposed of correctly and there were records of each action which meant that people's medicines were managed safely.

Is the service effective?

Our findings

People told us they received an effective service. People who used the service said they felt that they were cared for by staff that were trained to carry out their role. Staff we spoke with during the inspection had a good knowledge of the individuals they supported and were able to give us information about people's needs and preferences which showed they knew people well.

Staff at the service completed an induction and had the opportunity to shadow a more experienced member of staff when they started working for the organisation. This made sure they had the basic knowledge needed to begin work. They were encouraged to go on and complete a national vocational qualification in care at levels 2 or 3 to develop their knowledge. We saw that people had completed or were undertaking these courses.

Staff completed most of their training online but for practical skills such as moving and handling people they attended a face to face session. Staff received training that was appropriate and reflected the needs of people who used the service. We saw that staff had undertaken training in moving and handling, infection control, safeguarding of vulnerable adults, fire safety and Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). There was also evidence of training and supervision in staff files demonstrating that staff received support and guidance from more senior staff. This meant that people who used the service were supported by staff that had the skills and knowledge to care for them.

The MCA sets out the legal requirements and guidance around how to ascertain people's capacity to make decisions. DoLS provide legal protection for vulnerable people who lack capacity to make their own decisions and are deprived of their liberty in their best interests. Staff we spoke with demonstrated a good understanding of MCA and DoLS. We were told by the registered manager that no DoLS authorisations were in place but they were aware of their responsibilities and knew how to make an application.

People who used the service received effective care from staff and everyone told us they believed that their healthcare needs were being met. One person said "I was unwell one time and the member of staff phoned over to the main house for the nurse, she had a look and then she

phoned the ambulance. If I need to see a doctor they will fix it up." Another person said "If I need the doctor I just ask for it, the nurse will come and if she feels I need it the doctor will come. If I had a hospital appointment they (the staff) would take me and stay with me, they are very good."

However, those people who had a life limiting condition and received palliative care, although supported appropriately had not had involvement by other clinical specialist nurses for advice and support. The provider information return completed by the registered manager told us that nurses at Dunollie worked closely with St Catherine's hospice but the care homes team at the hospice expressed concern that a service of this size had no one registered with their team. This meant that staff were not always up to date with best practice guidance. The registered manager told us that they had worked consistently with the hospice team until quite recently but as teams had changed the impetus had been lost. They spoke with the care home team at St Catherine's hospice during the inspection in order to discuss what types of conditions that people who used the service may have that could be supported by the care homes team. They arranged for a member of that team to visit Dunollie and give advice and support in order that those people that needed specialist care would be supported by clinical specialists in the future.

The care plans we inspected were found to be detailed and gave a good overview of people's needs and the support they required, which meant that people's needs were met and the care was person-centred. The care planning system was found to be a simple system which was easy to follow. We saw that staff had accessed other health professionals when it became necessary. For instance one person was underweight but we saw that a dietician had been involved in their care and they were prescribed supplements to enhance their diet. Other people also told us they had access to the doctor if they needed it.

There were mixed comments about the food. One person said, "It is not to my taste." Another person said "Foods good, you don't really get a choice but if I have something I am not bothered about they (staff) would get me something else."

We saw that the menu for the day was on the notice board in The Lodge and displayed on the tables and on a board outside the dining room in the main house. The menu on the first day of inspection was chicken chow mein. This was

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chosen to reflect the Chinese New Year which had been discussed as part of the activities within the service. However, the menu was not displayed in pictorial or alternative format which would have benefitted those people living with dementia or those with sensory loss. This did not disadvantage people as staff explained what was for lunch to everyone.

The food was served at properly set tables in the dining area which gave a family feel to lunch time. The napkins did not afford much protection for peoples clothing as they were small paper ones and the television was left on in The Lodge lounge area and was quite intrusive for some people whilst they ate. There was not much interaction between people who used the service and we saw that staff did not have the time to converse with people to encourage social interaction and enhance the experience for people.

Most people received the support they needed from staff when eating. One person did have some difficulty cutting up their food and no assistance was offered but when they requested salt after being left with their meal they were unable to open the small packet but staff offered assistance. A second person was given their meal on a plate with a guard, their food was cut up by staff and they were able to eat their meal with no problem.

The two experts by experience joined people in separate dining rooms for lunch and reported that the food was flavoursome and portion sizes good. When we spoke with the chef they were able to tell us about special diets they catered for and how people had their food presented. This meant that people received sufficient nutritious food in the form that was best for their needs. We also saw that people were offered plenty of drinks throughout the day.

Is the service caring?

Our findings

People said that staff were kind and caring. One person said, “When I was here last time the staff were very caring and understanding. We built up a good rapport.” Another person said, “I feel we could talk to people (staff) if we needed. I feel they would listen and deal with the issue.”

We observed that there was a friendly atmosphere between staff and people who used the service and we saw examples throughout the day of staff having meaningful and positive relationships with people living in the home.

Our observations showed that staff had a good knowledge of people and their preferences and we saw an excellent example of this and how it assisted one member of staff to communicate with a person who was unable to speak to them using their shared interest to aid communication. People were spoken to in a friendly, polite and respectful way. People were well dressed and we saw one person going out to the hairdressers.

We saw that staff knocked on people’s doors and called out to people before entering. One person told us, “Staff always

ask before they come in.” Another person said, “Staff will always check it is OK to come in, they usually call me to ask.” They went on to say “I feel the staff listen to me, we have a laugh.”

A relative told us “She [relative] doesn’t usually leave her room but it’s her choice. The staff always ask before entering, she has the door open so she can see staff passing by.”

The service had an open visiting policy and encouraged families to maintain their relationships. We saw several relatives visiting during our inspection.

When asked if people were listened to and encouraged to make suggestions one person said, “Yes, I am on the health and safety committee. We had a meeting in January. I have my say there.” The health and safety committee met quarterly and discussed the service and any improvements needed. The committee included people who used the service to make sure they had a voice. Another person said, “Most staff generally listen to me.”

We saw leaflets advertising advocacy services but did not see that anyone had an advocate. This was because people were in the main supported by their families. Families of people we spoke with told us that they are always made welcome by staff and that they could come to visit whenever they wish.

Is the service responsive?

Our findings

The service was responsive. People said that they felt that their individual needs were being addressed. One person told us, “I agreed my care plan. I am very used to those as I have been in hospital many times.” They went on to say, “I am very pleased with the care I have received.” They explained they had been in before for respite care and had chosen Dunollie to come back to above other places.

Before people became resident at Dunollie an assessment was carried out by the manager or deputy manager to ensure that the service was able to meet that person’s needs. We saw that the care plans were reflective of the person and each person had a care plan that was personal to them. The care plan had been written in consultation with the person or where that was not possible their families or representatives.

We saw that the care plans were reviewed each year and in some but not all cases the person who used the service was involved in the review. In some cases there was evidence of some reviews by the persons care coordinator and we saw that where people needed changes to be made to their care plans between reviews this was recorded at the time it was implemented This meant that people’s needs and preferences were taken into account when planning care.

We were told that people were encouraged to maintain hobbies and interests and the service employed a person

to organise activities. However on the day of our visit there were no activities taking place until later in the day and the activities organiser was working as a care assistant. Staff told us that this was common practice. One person who used the service told us, “They only put things on 1 or 2 days a week and if the activities person isn’t there nothing gets done. It is definitely one area they could improve. They could do with more entertainment.”

People living in the Lodge did not appear to know that a choir had been organised for the afternoon but one person told us, “I like to be in my room but I do go across there sometimes if I want.” We saw that the choir was well attended. We did not see any meaningful activity carried out for or with people living with dementia. This meant that people were not consistently supported to maintain their interests and hobbies and that the service was not supporting this area of peoples care as well as they could although this did not appear currently to have a detrimental effect on people who used the service.

Leaflets outlining how people could make a complaint were given to people who used the service and displayed in the entrance. We did not see any documents in alternative formats to enable people who were unable to read them access to the information. There had been five complaints made to the service in the last twelve months which had been dealt with within 28 days. We saw records of the complaints and actions taken which meant that the service responded appropriately to complaints following their own policy and procedure.

Is the service well-led?

Our findings

The service was not well led. While there were some positive features of the management of the service but the services policies were not always up to date or implemented appropriately and this impacted on the quality of care for some people living at the home. Some efforts had been made to involve people living in the home in improving quality but it was not always evident that audits were used to improve the service or that appropriate use had been made of the feedback mechanisms.

All the staff we spoke with told us they felt supported by the registered manager and that they enjoyed working at Dunollie. Staff told us, "There have been improvements in the last year or so" and, "There were some problems here a couple of years ago but it has improved a lot." They said that they felt confident that the registered manager would act if they had any concerns. One staff member told us, "We're a good team." We saw that the staff worked well together and approached the registered manager and nurses throughout the day to ask for advice or guidance.

Records showed that staff received regular supervision and staff confirmed this which showed that they were supported by senior staff.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us that the registered manager was approachable and had a regular presence in the service. During our inspection we spoke with the registered manager. They were able to answer all of our questions about the care provided to people which showed they had regular contact with the staff and the people who use the service.

We saw that the registered manager led by example and was keen to improve the service. During the inspection we told the registered manager that some people were not been supported as they should be by the care homes team at St Catherine's hospice and they telephoned the hospice soon afterwards to arrange for someone to visit Dunollie.

The Quality Assurance manual produced by European Care, now Embrace said, "Every person we support deserves high quality care and support." The registered manager and area manager monitored the quality of the care provided at Dunollie by completing regular audits.

These included audits of medicines, dining experience and infection control. They evaluated these audits and created action plans for improvement, when improvements were needed. An annual improvement plan was also devised by the management team and actions set out for completion with a named responsible person and dates for completion. Quality monitoring visits were completed by the area manager. The registered manager told us that they were supported by a senior management team. The provider also sends out a weekly newsletter providing information and care practice updates for staff.

We saw satisfaction surveys in the dining room which asked people who used the service and their visitors for their opinions about the dining experience. However, none of these had been completed. Resident and relative meetings were held at Dunollie where people could discuss areas of concern or be involved in the planning at the service. People who used the service were also involved in the running of the service through membership of the health and safety group. These meetings were minuted. This meant that there were some systems in place for capturing people's views about some areas of the service.

Staff meetings were held regularly and minuted. Staff told us the meetings were an opportunity to raise new ideas and raise any concerns. They told us they believed their opinions were listened to.

There was a system in place for recording accidents and incidents. This meant there was a clear record of any incidents that had occurred. We saw these were properly recorded and there was evidence to show they were acted on to improve or prevent repetition.

There were emergency plans in place for all individuals. For example people had personal emergency evacuation plans (PEEPS) telling staff how to support individuals in the event of fire. This meant that people would be supported effectively in the event of a fire.

We saw that policies and procedures were in place but some needed updating to reflect current legislation or guidance. For instance there was a policy and procedure for MCA and DoLS but this was out of date. It had been written in June 2013 and since then there had been changes following the Supreme Court judgement in March 2014 about who should have an authorisation in place which should be reflected in the policy and guidance in place for staff. Following the inspection we were told that

Is the service well-led?

all policies and procedures had been updated in 2014 to reflect legislative changes on a company internet hub. We were not shown these documents on the day of our inspection.

Also, the policy for dementia care stated, “ Embraces approach to dementia care is consistent with the common values; principles and standards that apply to all individuals and the standards laid down in the: National service framework for older people, Charter of rights for people with dementia, NICE quality standard for supporting people to live well with dementia (2013)”. However, we found that although staff knew people well

they were not always demonstrating best practice as detailed in the policy we looked at. For instance we saw that two people were not supported through meaningful activity. We also saw that the environment although safe did not support people living with dementia or sensory loss by use of pictorial or tactile signage and adaptations. This meant that the registered manager was not applying the policy set out by the company.

We recommend that the provider look at current good practice guidance around dementia friendly environments.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
Treatment of disease, disorder or injury	This corresponds with regulation 18(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.