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Dulverton House

Inspection report

Dulverton House,
9 Granville Square
Scarborough, YO11 2QZ
Tel: 01723 352227

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Dulverton House on the 27 November 2014. This was an unannounced inspection. We previously visited the service on 26 November 2013 we found that there were no breaches of the legal requirements in the areas we looked at.

Dulverton House is situated in the seaside town of Scarborough. The home is on three floors and provides accommodation for up to 22 people who have personal care needs and or a dementia. The level of support provided at Dulverton House is also described in their Statement of Purpose. There is on street parking and a lift for those who have mobility needs to be able to access the upper floors. Some of the rooms have en-suite facilities. There are several communal areas for people to use.

There is a registered manager. 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.

We found that people who used the service said they felt safe. However, during the course of the inspection would

Summary of findings

found some shortfalls in this area. Staff were provided with training in safeguarding of vulnerable adults but not all of them understood their responsibility for reporting any allegations of abuse. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the full report.

We found that staffing levels were not always appropriate to provide the support needed by vulnerable people. At this inspection we found there were not enough staff available to assisit people with their meals or to ensure they were able to access activities. The staffing levels provided meant that where two staff were needed to provide care and support to one person other people were left unattended. This was a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

Staff went through a thorough recruitment procedure and completed an application form with a full history of employment as well as a check to ensure they were suitable to work with vulnerable people.

People received their medication in a safe way administered by staff who had received training in the safe handling of medicines.

We saw that staff had access to training, this training was provided on line but there was no method to determine that staff had understood what the training meant in practice. We recommend that the provider looks at how they can reassure themselves that staff had fully understood their online training.

No-one using the service had a mental capacity assessment, staff were unsure as to what the Mental Capacity Act 2005 meant. This is a piece of law that sets out guidelines to demonstrate how people should be assessed to determine their understanding of the decisions they are making. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

People told us they didn’t enjoy the meals provided. People who used the service told us their was no choice at meal times and the quality of food provided was poor. We did not see anyone being asked if they had had enough to eat, if they didn't like the meal, if there was anything else they would prefer or if they were feeling well or needed help with the meal.This was a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

We saw from records that people accessed health and social care professionals when they needed to. We spoke with three health care professionals who told us the service worked with them in a positive way to the benefit of people who used the service.

We found the environment had not been assessed for people with a memory impairment in line with current guidance. We also found that several carpets were worn and required attention. This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the full report.

All people said they felt their care needs were met. We observed that work was task orientated and individual needs were not addressed by staff unless directly requested. We also observed that staff carried out their tasks pleasantly and interacted with people who used the service but didn't show any understanding of continuous risk assessment and assessment of their mental state.

We saw that there was very little to orientate or motivate people, no newspapers or magazines and no obvious activities or people providing any sensory or mental stimulation for individuals who were vocal and willing to say what they liked and disliked. This meant the manager and staff were not taking in to account the social needs of people who used the service. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

During our inspection we found the manager to be disorganised. The office was disorganised and the manager found it difficult to locate files for us to examine. We found that the quality system was not robust enough to identify areas of improvement throughout the home

Summary of findings

meaning people could not be confident they lived in a safe environment. This is a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the 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?

Inadequate 

We found the service was not always safe.

We found that people who used the service said they felt safe. Staff were provided with training in safeguarding of vulnerable adults but not all of them understood their responsibility for reporting any allegations of abuse. Staffing levels did not always allow for people to have their social needs met.

Staff went through a thorough recruitment procedure and completed an application form with a full history of employment as well as a check to ensure they were suitable to work with vulnerable people.

People received their medication in a safe way administered by staff who had received training in the safe handling of medicines.

Is the service effective?

Requires Improvement 

The service was not always effective.

We saw that staff had access to training, this training was provided on line but there was no method to determine that staff had understood what the training meant in practice.

No-one using the service had a mental capacity assessment, staff were unsure as to what the Mental Capacity Act 2005 meant.

We saw from records that people accessed health and social care professionals when they needed to.

People who used the service told us their was no choice at meal times and the quality of food provided was poor. We did not see anyone being asked if they had had enough to eat, if they didn't like the meal, if there was anything else they would prefer or if they were feeling well or needed help with the meal.

We found the environment had not been assessed for people with a memory impairment in line with current guidance. We also found that several carpets were worn and required attention.

Is the service caring?

Requires Improvement 

The service was caring. All people said they felt their care needs were met. However they did not feel involved in the running of the home.

We also observed that staff carried out their tasks pleasantly and interacted with people who used the service.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Summary of findings

We saw that there was very little to orientate or motivate people, no newspapers or magazines and no obvious activities or people providing any sensory or mental stimulation for individuals who were vocal and willing to say what they liked and disliked.

People spoken with told us they would raise a complaint if they were not happy. However people who were not happy with their lunch meal would not complain because they did not feel it would make a difference to the quality of the meals in the future.

Is the service well-led?

Requires Improvement

The service was not always well led.

During our inspection we found the manager to be disorganised. The office was disorganised and the manager found it difficult to locate files for us to examine.

The home had a registered manager in place. We did not receive a provider information return (PIR) prior to the inspection.

We found that the quality system was not robust enough to identify areas of improvement throughout the home meaning people could not be confident they lived in a safe environment.

Dulverton 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.

This inspection took place on 27 November 2014 and was unannounced.

The inspection was led by an Adult Social Care inspector who was accompanied by an expert by experience (Ex by Ex). An Ex by Ex is a person who has personal experience of using or caring for someone who uses this type of care service. Before we visited the home we checked the information that we held about the service and the service provider, such as notifications we had received from the registered provider. The service met the areas we assessed at their last inspection which took place on 26 November 2013.

During our inspection we observed how the staff interacted with people who used the service. We looked at how people were supported during their lunch time meal. We also reviewed the care records for four people who lived at the home, staff training records, and records relating to the management of the service such as audits and policies. Before the inspection , we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgement in this report.

We spoke with all the people who used the service. We also spoke with the registered manager four members of staff, two relatives and three health care professionals about the support the people who lived at the home received.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe living at the home.

Staff were very quiet and gentle towards one person as they had a type of paranoia which manifested itself as fear and possible aggression when they comes across anything loud or startling. This approach protected them and other people who were in the same area. However, there were people who were quite noisy in terms of making repetitive meaningless noise which was distressing for others. However, all the people who used the service spoken with by the Expert by Experience displayed a degree of confusion and/or disorientation which had not been highlighted by the manager prior to these discussions.

We spoke with four members of staff about safeguarding vulnerable adults. Only one member of staff was able to tell us what should happen if a person who used the service made an allegation of abuse. Other staff told us they wouldn't believe the allegation, or they would try and sort it out themselves without referring to the proper procedure. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

We looked at the staff training matrix and saw that all had completed training in the safeguarding of vulnerable adults. However there was no evidence to show how they had been tested about their knowledge of safeguarding procedures.

The provider had safeguarding policies and procedures that reflected guidelines from placing authorities in place to guide practice. We saw that one safeguarding referral had been made to the Commission since our last inspection. This safeguarding referral was around the staffing levels for people who had some dementia. The allegation was partially substantiated.

We looked at the staffing rotas for a four week period from 24 November 2014 to 21 December 2014. The registered manager told us that there should be three members of care staff on duty each morning, two at all other times. The rotas we saw showed that there were usually two identified carers on duty each morning with the registered manager providing support as the third carer. There were 19 people who used the service and several of them had some form of dementia or memory loss. There were also people who, because of their physical needs required assistance from two carers. This meant that staff were not always available to supervise and support people in the communal areas as they were providing care elsewhere in the home. This had an impact on people's general well-being. An example of this was one person who struggled with other people in the home who displayed noisy and repetitive behaviours. One person told us "I had to ask the staff to move that person because X was getting more and more upset and they didn't do anything".

A relative told us "We are usually in the dining room, but not today. There are usually many more people in the dining room, but not today. I usually feed X in their wheelchair which is much better for their eating position than this recliner". They told us they try to come in each lunch time because there were not enough staff to assist them with their meals properly. This was a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

Care staff spoken with told us they felt at times they didn't have enough staff. They gave examples of when they were dealing with people who needed two staff to help them and this meant no-one was able to supervise the other people in the home. Or if one member of staff was doing the medication round this left one staff to look after all the people in the home. Staff did say they could call on the manager for help but did not feel this was adequate.

Staff were subject to appropriate recruitment procedures to ensure they were suitable people to support vulnerable adults. Staff recruitment information was provided to us by the registered manager after our visit, as documents were held at the provider organisation's head office rather than at the service. We saw completed application forms detailing each staff member's employment history and reason for leaving previous roles in health and social care, and two written references. Each staff member also had an Enhanced Disclosure and Barring Service check documenting that they weren't barred from working with vulnerable people.

Staff followed appropriate procedures to reduce the risk and spread of infection when providing personal care. We noted that personal protective equipment (PPE) such as gloves and aprons were available for staff to use, and

Inadequate

Is the service safe?

people who used the service told us that staff always wore PPE when providing personal care. We observed that staff gathered the appropriate PPE to wear when supporting someone with their personal care. Records showed that staff had been trained in infection control and food safety. This meant that people lived in a clean and safe environment.

We saw examples of risk assessments in care files. These covered topics such as mental health risk assessments, these were not always completed, falls risk assessment, moving and handling risk assessments and condition appropriate assessments such as skin integrity where someone was nursed in bed.

Medicines were stored and administered safely. Staff were aware of what medicines needed to be taken and when. Staff managed the medicines and we saw they were administered appropriately and recorded on the medication administration record (MAR) chart. Staff recorded stock received at the service, and this was transferred to the MAR charts at the time of our inspection. This meant we were able to ensure the stock balance was correct. Staff who worked in the home had received training in the safe handling of medication; we saw evidence of this in their training file. This meant that people who used the service received their medication in a safe and appropriate way.

Requires Improvement

Is the service effective?

Our findings

When we asked staff what support they had to complete their role they said “We’re offered on-going training and support”, “Support from colleagues” and “The manager is supportive”, “We can speak to the manager.”

We looked at the training matrix and saw that people had completed training in health and safety, food hygiene, first aid, fire safety, and safeguarding of vulnerable adults. Several staff had a national vocational qualification (NVQ) level 2 in care and welfare of people. The manager told us they had just signed up with a company to complete their training on-line. This meant staff could do their training at home. However, when we discussed training with the manager there was no evidence of any follow up training to ensure people had understood their online training. We recommend that the provider looks at how they can reassure themselves that staff had fully understood their online training.

We saw evidence that staff received supervision. Staff told us they spoke with the manager once a month and looked at how they were managing their role. They told us they found her supportive and always approachable.

Staff we spoke with couldn’t tell us about the Mental Capacity Act (MCA) 2005. This meant they couldn’t be sure that people who did not have the mental capacity to make decisions for themselves had their legal rights protected. There was no Deprivation of Liberty Safeguards (DoLS) in place for anyone using the service. This meant that staff might be making decisions on behalf of people that they should not be making; for example deciding whether people can leave the building or not.

We found that the front and back doors were locked. All of the people spoken with told us of the locked doors and when asked if they could go out, X said "I can go out in the garden if I want to but I have to go with friends"

Another person said "You can't get out without permission. You can go out with family if you ask".

A relative said "It's like a prison. There's no freedom to come and go but some do escape". They thought the building was secure, but outside "They need to make the garden secure so that people can go outside when it's nice. They need a change from being inside all the time".

We saw that there was a four week menu in place, the cook told us this was changed seasonally to allow for changes. We didn’t see any evidence that people who used the service had been asked what they wanted on the menu.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

We observed lunch and found the food did not smell pleasant and appetising. At one point, residents were singing "Why are we waiting." We saw many expressions of dislike throughout each course. The first course was soup - this was reconstituted from powder and when the staff were asked what it was by people they clearly didn't know but one said "I think it must be chicken, it's that sort of colour" No one could identify it from taste. The main course was a lamb stew. It looked most unappetising since the sinew and white membrane had not been trimmed from the meat. Many people found it difficult to eat. The apple pie and custard that followed was not to the taste of many of the people who used the service .

Condiments were put on each table as they were needed; they were not properly set with appropriate cutlery. The incomplete nature of the tables resulted in staff needing to access frequently a cupboard in one corner behind one person who was very clearly displeased at being disturbed each time something was needed from the cupboard. This also meant that they weren't giving the required attention to assessing residents' eating and giving any required assistance.

There was no menu to choose from. There was a salad alternative for one resident who ate salad every lunch time. Everyone spoken with said there was no choice and that they ate what was put in front of them.

There was quite a lot of food on the plates as they were cleared. No-one was asked if they had had enough to eat, if they didn't like the meal, if there was anything else they would prefer or if they were feeling well or needed help with the meal. This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

Earlier in the day we observed coffee being served to people who used the service. This very milky beverage was taken round the home in an open, very large, badly marked

Requires Improvement

Is the service effective?

plastic jug When asked why it wasn't in a coffee pot with a lid staff said "I don't think there is one". It looked cold and unappetising and many residents left it saying it was cold. Serving drinks in this way did not allow for people to select what hot drink they wanted.

We saw details in people's care plans when health professionals visited people, such as Consultants, General Practitioners and Social Workers. We spoke with three health professionals during our visit. They told us "We work well with the staff here; the manager calls us in promptly and appropriately. They follow our guidance and let us know if something is wrong." Another person told us "I think they do wonderful work here they are very good at getting us in (tissue viability nurse) and making sure they have the right equipment to ensure people can be cared for effectively." People who used the service told us they only had to ask and the manager sent for their GP or other health care professional they requested.

On our arrival we had a look around the home. We saw very basic signage pinned to the wall with a single drawing pin to indicate where a toilet was. We didn't see any signage that would meet the guidance provided by The National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. The service offers support to people who have dementia. There was no evidence that any advice or alterations had been made to make the environment more accessible to people with memory problems.

We also found that two carpets needed replacing or attending to for cleanliness, wear and tear and were also trip hazard due to large rucks in the carpet. This is a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us "Yes, they're really good staff. They are very kind. I've never seen or heard anyone being unkind". Someone else said "You've only got to ask for things and they'll do their best." One person told us “Staff do not have enough time to spend with people unless they are helping them with a task.”

All people said they felt their care needs were met but didn't know what those needs were. No one was aware of care planning, either those words or other ways of describing the activity. One or two said they thought that the family would be speaking to the staff about what happens to them. A relative told us "Yes, I'm involved in planning mum's care".

We observed that work was task orientated and individual needs were not addressed by staff unless directly requested. Staff ensured people were taken to the toilet at regular intervals, had drinks or were helped to get up. However, staff did not have time to spend with people who used to the service to discuss or look at personal issues they wanted addressing such as going out or attending to their personal hygiene; several people were seen to have dirty finger nails. We also observed that staff carried out their tasks pleasantly and interacted with people who used the service but didn't show any understanding of continuous risk assessment and assessment of their mental state.

The manager told us that they were looking at introducing regular meetings so that people who used the service could contribute to the running of the home. At the time of this inspection issues affecting people in the home were discussed on a one to one basis. We did not see any records to confirm this. We saw that information about Age UK and the Alzheimer’s society around the building offering support to people who wanted it.

When staff were supporting people we saw they did so on a discreet and personal basis. We saw that people were treated with dignity and respect throughout our visit.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us if they needed something then they would get it. They were not aware of their care plans but a relative did tell us they were involved in the care planning process.

We looked at four care plans and found that people's wishes had been recorded. One person had made an advance directive and staff were supporting them with this. They told us "This is what X wants they have always been independent and made their own decisions and that what they want to continue doing for as long as possible." We saw there were some personal histories in the files and this gave staff information that helped them see people as a person rather than someone who needed support.

We saw people in two lounges. In one there was a television playing. No-one was watching it and no staff member asked anyone what they might like to watch.

The other lounge had a huge television which was broken and when the manager said it was going to be mended one person asked "Which Christmas will that be then?" In this lounge the radio was playing modern pop music much to the disgust of the people in the lounge who described it as "Terrible nasty clatter".

We saw that there was very little to orientate or motivate people, no newspapers or magazines and no obvious activities or people providing any sensory or mental stimulation for individuals who were vocal and willing to say what they liked and disliked. There were some activities organised such as an entertainer, someone who came in to lead armchair exercises and staff were expected to organise some activities. However; staff told us they did not have time to do any activities as they were busy with the delivery of personal care. This meant the manager and staff were not taking in to account the social needs of people who used the service. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

People spoken with told us they would raise a complaint if they were not happy. One person told us "Oh they'd know if I had a problem because I tell them off." However people who were not happy with their lunch meal would not complain because they did not feel it would make a difference to the quality of the meals in the future. When this was raised with the manager they told us "That person complains everyday it is what they do and it doesn't matter what we do or say it doesn't make any difference." The manager told us they had received no complaints since our last inspection.

Staff told us they would report any concerns, complaints to the management of the home. We saw a copy of the complaints policy and this was available to people on their admission.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager(RM) in place. The RM had been in post for over 20 years. We did not receive a provider information return (PIR) prior to the inspection. The manager told us they had not received the request for information. We were informed her that we had sent out a reminder e-mail following the original request but she told us she had not seen either request for information.

People who used the service told us they knew who was in charge and they would go and talk to them if they needed to. Staff told us they had regular supervision and could go and talk to the manager if they needed support or had any concerns. They told us “They are fine as the manager. They are always there when you need them. They operate an open door policy.” Another member of staff told us “The manager is understanding and will help if we have any personal problems.”

During our inspection we found the manager to be disorganised. The office was disorganised and the manager found it difficult to locate files for us to examine. There were files on every surface and when we asked to look at something we were told “I was just working on that.” There did not appear to be any organised management of the manager role.

We did not see any demonstrable leadership approach to any observed activity or interaction throughout the day. There was no evidence that they was aware of staff training and development needs as they didn't offer guidance to inexperienced staff carrying out tasks. This means that support offered to people who used the service may not be in line with best or safe practice.

The manager told us they worked with the local Alzheimer's society in trying to ensure people received a good service. We did not see any evidence that the manager or staff were working towards best practice guidelines for people who had a memory impairment or Alzheimer's.

We saw that regular audits had been carried out with regard to the environment of the service . However we found several issues with the environment on our initial walk round that had not been identified in those audits. We saw a training matrix and an audit of incidents and accidents. We did not see any audits on the care plans or medication. This meant that the quality systems were not robust enough to identify areas for improvement throughout the home meaning people could not be confident they lived in a safe environment. This is a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse. 11 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times there are sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying on the registered activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person must have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

The registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration by means of a choice of menu and necessary support to enable people to eat and drink sufficient amounts for their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person must ensure that service users and others are protected against the risks associated with unsafe premises by means od adequate maintenance 15 (1) (C)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person must, so far as reasonably practicable make suitable arrangements to ensure appropriate opportunities and encouragement and support to service users in relation to promoting their autonomy, independence and community involvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users and others who may be at risk against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the service 10 (1)(a)(b)