HC-One Limited

Defoe Court

Inspection Report

Newton Aycliffe
County Durham
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Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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Summary of findings

Overall summary

Defoe Court is a care home with nursing care provided. The home is situated within its own private grounds and provides care and accommodation for up to 41 people. The home is purpose built with accommodation provided over two floors. It is located in Newton Aycliffe, County Durham and is owned and run by HC-One Limited. At the time of our visit there were 36 people living in the home.

The manager was registered with CQC but not for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

Staff were recruited using procedures to help keep people safe. Additionally staff undertook training to have the skills to carry out their role effectively and safely. However, we found staff were not always utilised correctly to meet people's needs.

The environment was not designed for people with a dementia yet over half of the people living in the home had needs related to this condition. Previously, two areas of the home were separated and run as two individual units. One was specifically for people who required support for needs in relation to dementia. However, the two units of the home had been combined. This change had caused some concerns and problems for people living in the home.

People who did not have a diagnosis of dementia were concerned about living with people with this diagnosis. One person told us about another person coming into their room and another raised comments about people's use of language. Additionally no work had been undertaken to help people with recognising different areas of the home.

People living in the home, their relatives and staff attended meetings. However, not everyone felt well informed. People had not been involved in the decision to combine the two units whilst this had impacted on their lives. Staff did not feel consulted this did not reflect an open culture in the home.

People did not always receive caring support from staff. Staff ignored people and were not respectful. This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. You can see what action we told the provider to take at the back of the full version of the report'

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. We found that correct procedures were followed if anyone had needed to be referred regarding any Deprivation of Liberty Safeguards (DoLS) queries.People were not supported to have their rights fully met when making decisions. This was because staff did not follow the correct procedures for this. However, there were risk assessments in place that helped make sure people were safe whilst they took responsibility for their lives and were independent. Additionally staff knew how to support people when there had been any allegation of harm.

People's nutritional needs were assessed and when necessary people had received professional support. However, people did not always receive good support when eating their meals. This did not help to ensure their nutritional needs were met.

People's hobbies and interests were recorded in their care files. However, people told us they were not happy with the activities on offer. Some people felt they spent a lot of time alone and we observed people spent time in their rooms alone.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the home was not always safe as staff were not always correctly deployed to meet people's needs. Although we found that staff were recruited correctly and were trained in their role.

People's rights were not fully protected. This was because staff did not follow the guidelines of the Mental Capacity Act (MCA 2005). Assessments regarding people's capacity did not evidence that all of the required areas had been addressed. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) and this applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation. This is for people who are unable to make decisions for themselves. The legislation helps to make sure any decisions are made in people's best interests.

People were supported to live their lives as they chose. Risk assessments were in place to help keep people safe and people told us they felt safe in the home. Additionally, staff were trained on recognising and handling any allegations of abuse.

However, we observed people with dementia were not supported correctly by staff. Staff were unsure how to support someone with an activity. This reflected a lack of staff knowledge about people's dementia needs.

Are services effective?

The service was not always effective. The environment was not designed for people with dementia related needs and only minor adaptations had been made. However, over half of the people living in the home had a dementia. This did not help people to be relaxed and comfortable in their home. The manager had combined the two units in the home. This meant that people who had a diagnosis of dementia were now living with people who did not have this diagnosis. However, this had caused some concerns for people who did not have dementia, for example the use of language. Additionally situations had occurred were people's dignity was not protected.

People's choices were known and staff were aware of these.

People's dietary needs were known and planned for. However, people received differing support at mealtimes. In one area the

Summary of findings

support was good but in another there was only one staff to support several people. This meant that people did not receive individualised care as the member of staff had to support several people at the same time.

Are services caring?

The service was not always caring; people's needs were known by staff.

People did not always receive caring support; staff ignored people, talked over people and were not respectful. They left personal information available in a communal lounge for others to read.

Are services responsive to people's needs?

The service was not always responsive to people's needs. People were provided with some information and consulted about the home. Not everyone had been asked about changes to the environment. There were limited activities taking place and not everyone was happy with these.

People were aware of how to raise a concern. However, people's experiences of the handling of their concerns varied. Not everyone had received good support with this.

Are services well-led?

The service was not well led; the manager was not registered with The Care Quality Commission (CQC), for this home and areas of improvement were found at the visit. These had not been identified by the quality assurance systems in the home.

Staff were not always well deployed. Staff were not always caring and respectful to people. We observed staff ignore people and talk over people. This culture had not been identified by the management of the home.

People completed questionnaires and attended meetings. However, relatives and staff were not always aware of information, for example changes to the management of the home. Systems in the home had not made sure people had an opportunity to comment on these changes to their lives. Yet for some people these had a large impact in their lives.

Staff were supported through supervision sessions. However, not all staff felt able to talk to the manager. The culture of the home was not open and inclusive for staff.

Summary of findings

What people who use the service and those that matter to them say

We spent time talking with people who lived in the home. They told us how they felt about some of the changes to the home. They said, “I am fed up with it and hope to move to another home.” Another person said they were not happy with the language one person used.

However, other people told us “It’s great here I love it,” and “I would prefer to live in my own home but staff here are good.”

Other people told us they felt safe in the home. Their comments included, “I feel safe because staff are about” and “He feels safe here and may now live forever.”

When we asked people about activities they told us “I never see anyone. No-one takes me out” and “ I go to the dining room but spend a lot of time in my room” and “I am alone for a lot of hours in this place but my family visit me”. We observed some staff had a supportive manner but also observed some people who were nursed in bed were left for long periods.

People told us about raising concerns, they said,” I have complained and they said they would let me see the manager but she hasn’t come yet. I thought you were the manager as I’ve never seen her yet.” And a relative commented, “If I had concerns and wanted to complain I would speak to the manager.

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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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited this service on 13 May 2014. The inspection team consisted of a Lead inspector and a second inspector. The second inspector concentrated on spending time chatting with people who lived in the home.

The last inspection of this service was on 18 February 2014 with the service being non compliant in relation to respect and involvement, and care and welfare of people who use services. The provider sent us an action plan. This described the actions they would take in order to become compliant; the final date for the service to achieve this was 20 April 2014.

Before the inspection we reviewed the information we held regarding the service. This included any notifications they had forwarded to us about incidents in the home. We also reviewed any information we had received from other people, including relatives and commissioners of services. We contacted other professionals involved with the service to gain their feedback.

We received a Provider Information Record (PIR) prior to the inspection. The PIR provides CQC with additional information from the service.

During the inspection we spent time in different areas within the home and spoke with people who lived in the home, staff, managers and visitors. This included discussions with the manager and three care staff. We reviewed documentation held. This included three care plans for people who lived in the home, duty rotas, staff training records, menus and policies and procedures.

We spent time with people who lived in the home; observed the support people were receiving and interactions between people who lived in the home and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Are services safe?

Our findings

We looked at staff duty rotas which covered several weeks. We saw that staffing levels varied throughout the week to assist with the varying needs of people. There was routinely a nurse on duty and this was often the deputy manager. The deputy manager had two shifts a week when she was able to complete management tasks and was not the nurse on duty. The manager was responsible for two homes and shared her time between these. People living in the home and staff felt there could be more staff. One person told us, "I never move from here only to go to the toilet and they kept me we waiting half an hour."

We observed one member of staff was responsible for five people, three of whom had dementia needs. The staff member often had to leave people to attend to other tasks. It was clear that one member of staff was not sufficient to meet people's needs. People had to wait for support and this was not personalised to the individual. Other staff were working in other areas of the home. The organisation of staff required addressing to ensure people's needs were met across the service.

One staff member told us how they had been recruited to work in the home. This included the checks that had been completed before they could work here. This included undertaking a Disclosure and Barring check (DBS). These checks helped to ensure that staff were suitable to work with vulnerable people and that they did not hold a criminal conviction which may have prevented them from doing so.

Staff told us they had completed training to help make sure they were skilled. Training included both routine courses and training on specific conditions, for example dementia awareness. There was an online system for checking staff training. Records evidenced that 80% of staff were up to date with their training. This helped to make sure that staff were competent in their roles when meeting people's needs.

People were assessed for any dementia related needs and this was recorded in their care plans. This included any support they required with decision making. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation. This is in place for people who are unable to make decisions. The legislation helps ensure that any decisions are made in people's best interests. There was no evidence that people's assessments had been formalised and covered all of the areas in the Mental Capacity Act (MCA 2005). This had the potential for information to be missed and people to not be fully supported.

The manager told us that no-one who lived in the home had been referred under the Deprivation of Liberty Safeguards. (DoLS), The Deprivation of Liberty Safeguards provides a legal framework to protect people who need to be deprived of their liberty for their own safety.

The MCA (Mental Capacity Act 2005) legislation is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. Best interest meetings are held when a person is no longer able to make a complex decision for themselves. The meeting consists of people involved in the person's life; this may include professionals and the persons representative or relative. They assist the person to make a decision in their best interests. The manager told us best interest meetings had not taken place. However, some people had been identified as requiring support with decision making. There was no evidence of the support they had received with decision making about their lives.

At the last inspection a concern was raised about whether people had given permission for the administration of their medication. The manager told us that everyone received their medication correctly within the appropriate guidelines; giving their permission. This helped to protect people's rights and choices.

People's care plans included a variety of risk assessments. These helped people live their life safely and maintain their health. We saw that they covered a variety of areas and included the risks of choking and the risk of falling. When necessary support equipment was identified for example, bed rails. At the last inspection on 18 February 2014 we asked the provider to take action to make improvements with risk assessments and this action has been completed.

People's files also included assessments of their needs both prior to and on admission to the home. These included whether the person needed support with their behaviour. People had been assessed for this support. However, care plans did not include details of the support they would receive to meet these needs. Consequently

Are services safe?

people were not assured these needs could be met. At the inspection on 18 February 2014 we asked the provider to take action to make improvements with this; this action had not been completed.

We also observed one person with dementia who walked around all day. Staff tried to get the person to sit down and became frustrated when the person didn't want to. This reflected a lack of understanding of people with dementia needs.

We saw there was a policy for staff to report any allegations of abuse. The policy required minor improvement. It included information regarding abuse but was not clear in guidance to staff. No safeguarding concerns had been reported to us since the last inspection visit. Staff told us they had completed training to help protect people and deal with any safeguarding concerns. People living in the home told us "I feel safe here because staff are about. Just to talk to someone puts my mind at rest." A relative told us "He says he feels safe here and says he may now live forever."

Are services effective?

(for example, treatment is effective)

Our findings

The building had not been originally designed for people with a dementia. However, the manager told us that a number of the people living in the home had a dementia related need. There was some outside space but there was no ease of access for people to come and go as they chose. There was very little signage and what there was had not been designed for older people or people with a dementia. The writing was too small, use of fluorescent colours made signs difficult to read, names on doors were not clear because of small type, there were no photographs on people's doors. This did not help people to be comfortable in their home.

At the last inspection on 18 February 2014, we asked the provider to take action to make improvements in the environment regarding hand rails as they were not easy to see. When we looked around the home we saw these were now a different colour and that the appropriate actions had been taken to support people with this. People's access to bathroom areas was now easier.

The manager had combined the two residential units of the home. They told us this was to give people more freedom of movement. This meant that there was no specialist dementia unit. People with a diagnosis of dementia shared accommodation with people with frail and physical illness but without a diagnosis of dementia. This had caused some people to express their concerns. One person who lived at the service said they had found it difficult living with people with dementia. Another person told us about a person coming into their room to straighten their pillows. Although they had managed this situation it has caused some concern for them. One person complained about another's use of poor language they said, "Having dirty language at the table should never be allowed". We were also told about a situation which did not protect a person's dignity. These situations did not promote positive relationships and did not protect the dignity of some of the people who lived at the service.

We saw that on the ground floor there was a lounge for people to sit and chat with others living in the home. Additionally there was a separate seating area where people sat to chat with their relatives in private. This helped people to maintain relationships with people who were important to them.

People were supported to live their lives as they chose. People's care files recorded their choices to help make sure that staff were aware of and able to support these. One example recorded was the time the person wished to retire for the day. Staff gave us examples of how they supported people's choices they said, "I always ask people what they want to wear. If someone had dementia I would still ask them. If they were unable to choose I would only choose something I thought they would be happy to wear."

The manager told us about people's different dietary needs. This included people who had specialist diets. People's nutritional needs were assessed and recorded in their files. This included their personal preferences. When necessary people accessed specialist support for example, a dietician.

We looked at the support people received with their meals. We observed that in one area of the home staff were kind, considerate and clearly knew people's needs and preferences. Staff maintained good eye contact, were polite and supportive. They spent time offering people choices with their lunch, being responsive to their requests and changing food. Staff were patient with people and encouraged them with their dietary intake. They knew when to withdraw if the person was clearly disinterested and did not trouble the person. However, we also observed staff in a second dining area. In this area there was only one member of staff to support people. They had to undertake multiple tasks and were unable to make sure people's needs were met .At a different time we saw staff did not consult with people who lived in the home. Staff were task orientated and mainly did things for people rather than asking, although they were polite to people.

At the last inspection on 18 February 2014 we asked the provider to take action to make improvements to ensure tables were set correctly and this action has been completed. When we observed lunch we saw that tables were set with tablecloths, napkins, flowers, cutlery and condiments. This had been an improvement from the previous inspection when people had not been given teaspoons. People were supported to eat their meals in a pleasant environment.

Are services caring?

Our findings

People who lived in the home told us "It's great here, I love it." And "I would prefer to live in my own home but the staff here are good. They take me to the local shops for my sweets. "A relative said to us "I think it's fabulous. The staff are so welcoming and polite".

When we talked with the manager she described the needs of people and support they received from other professionals. Staff told us they read care plans and were able to describe a person and their needs accurately. Staff gave us an example of people's diagnosis and were able to relate the person's likes and their preferred support.

When we completed a SOFI we saw poor practice in relation to people being engaged by staff and staff responses to people. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We saw that staff sat with people who lived there, chatted amongst themselves and ignored people. When one person tried to talk with staff; they were given one word answers and then ignored. Another person was talked over by staff. When one member of staff spoke with one person they did not give eye contact and continued to write, invalidating the person. Another member of staff spoke with one person, looked at their watch and then continued to talk. They did not continue the discussion with the person and disempowered them. People were not respected.

Staff discussed what some people who lived in the home had eaten and drank in front of other people who lived in the home. People's files were left for others to read in a communal area. This did not protect people's privacy. This is a breach of regulation 17 of The health and Social Care Act 2008. Regulated Activities 2010.

However, we also observed that two staff had received a company "kindness" award following comments from relatives and people who lived in the home. These comments included "She shows extraordinary kindness" and "She delivers excellent care with the utmost kindness." This reflects an inconsistent service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People were offered an information pack before they moved into the home. This provided information on what life was like in the home. It included details of activities and food. This information helped people when deciding if they wished to move into the home.

People were consulted about life in the home through regular meetings. These could include their representatives. People told us they attended these meetings and a relative told us they were kept informed. However, we were also told that not everyone had been consulted about the changes to the environment. Yet for some people this had been a big change in their lives.

People were not currently using advocacy services. However, we observed signs around the home informing people about the advocacy services available should they require them. These services provide support for people to speak up and raise any issues or concerns they may have. This is when they are unable to do so themselves.

People's files included assessments which recorded the details of their likes and dislikes. This included their daily routines. For example, "Usually wakes between 8.00 and 8.30". People told us "If I don't feel like getting up I stay in bed" and I am asked if I want to go bed. I am not sure what would happen if I said I didn't want to get up when the girls come in a morning as I am happy to get up". One person told us, "I fell out of bed so I now have a new bed that can go low and a new mattress".

People's care plans included information in relation to their hobbies. We saw there was an activities programme in the pre admission information provided to people. This information was also on the noticeboard in the home. Activities recorded as available included a church service and an exercise class. Additionally there was a 'What's on in May' notice, which recorded different planned activities.

People told us, "I never see anyone. No-one takes me out" and " I go to the dining room but spend a lot of time in my room" and "I am alone for a lot of hours in this place but my family visit me". We observed some staff had a supportive manner but also observed some people who were nursed in bed were left for long periods.

We observed some people played dominoes and some ladies had their nails polished. They told us they enjoyed this. We also saw families visited and took their relatives outside in wheelchairs. A relative told us, "I'll be coming on Sunday for lunch. I have been twice and the food was lovely".

People's files included only limited life story work. Life story work is a record of the person's life prior to them living in the home. This provides staff with a history of the person, providing a talking point and assists in the development of relationships. However, as this information was limited staff had less knowledge about the person to help them build relationships.

People were provided with information on how to raise a concern and records of this were kept. Information about raising concerns was on display so people were aware how to do this. Staff were also provided with information on handling concerns. However, this required some improvement to make sure they were clear with this. People who lived in the home told us," I have complained and they said they would let me see the manager but she hasn't come yet. I thought you were the manager as I've never seen her yet." And a relative commented, "If I had concerns and wanted to complain I would speak to the manager. I tell the staff if he needs something doing and ask if things have been done and they are happy to tell me".

We observed that not all staff had good communication skills with those people who had a dementia. For example, one member of staff said they would spend some time with a person and then got up to give out teas and left them. This did not empower the person or enable them to share information or raise concerns.

Are services well-led?

Our findings

At the time of the visit the home did not have a registered manager .The manager had worked in the home for a short time since the previous manager had left. This was to help make sure people's needs were met. The manager told us they planned to become the registered manager for this home. However, one relative was concerned that there had been too many changes to the managers of the home.

The manager told us about systems of support within the organisation. This included a computerised system for recording information. Accidents, incidents and falls were analysed to help prevent further incidents occurring. The manager told us how this information was reviewed by the quality assurance manager. This helped to ensure the amount of incidents were reduced within the home. Complaints were also recorded and reviewed. We looked at a recent complaint and saw that this had been responded to appropriately. However, in feedback not everyone had received good support to address their concerns. This had not been identified in the audits undertaken in the home.

There was also a quality assurance system to review different areas of the home. This included the wellbeing of people, the environment, safeguarding and staff training. This helped to make sure managers were aware of any required improvements. A quality assurance manager visited and reviewed the home. The manager told us how the home had specific targets to meet within the organisation. Also those regular meetings were held to review any areas of improvement. During the visit we also found some improvements were required.

The manager told us that staffing levels were based upon the dependency levels of people who lived in the home. These would be reviewed accordingly. However, as noted previously staff deployment was not adequate to make sure people's needs were met. Additionally staff practice required addressing as staff were not always caring.

People completed questionnaires which helped them express their views of the home. The results of these were on display both in text format and in pie charts. This helped make it easier for people to pick out the main points. People and their representatives also attended meetings about the home. Minutes of these meetings were on display in the home. This helped to make sure people were involved in the home and kept up to date. However, one person told us "I'm not happy at the moment but no-one checks if I'm happy" and a relative said "No-one has told us about the changes in the home."

Monthly staff meetings also took place. We spoke with three of the seven care staff on duty. This is over 40% of the available staff. We were told these staff did not feel informed. They told us they had not been informed about the change of manager and were not sure about some of the changes taking place. However, they did feel the culture in the home was acceptable. They said "We get along together." They also confirmed they felt able to support each other to raise concerns. However, they did not feel able to raise concerns with the manager. They told us "The manager doesn't talk to staff much and I don't know her so I wouldn't be able to go to her." Another staff member told us they knew the whistleblowing policy and how to raise a concern, they said "It is a nice little home here". This reflected that there was not a consistent, transparent and open culture between the managers and staff.

Staff received regular supervisions and records of this were kept. The subjects covered included planned work and training. Regular supervision helped to make sure staff were given the correct support from the manager. However, staff comments did not uphold this.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. Services users were not treated with dignity and respect. Their privacy was not protected. Regulation 17 (1) & (2).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. Services users were not treated with dignity and respect. Their privacy was not protected. Regulation 17 (1) & (2).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. Services users were not treated with dignity and respect. Their privacy was not protected. Regulation 17 (1) & (2).