Diagrama Healthcare Services Limited

Edensor Care Centre (Diagrama Healthcare)

Inspection report

3-9 Orwell Road
Clacton On Sea
Essex
CO15 1PR

Tel: 01255423317
Website: www.diagramafoundation.org.uk/adult-healthcare

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 27 and 29 March, 2017 and was unannounced.

This service is a nursing and residential home for up to 50 people who have nursing, and physical and mental health needs. At the time of inspection 43 people were living at the service which was set out over a number of areas in the building. The flat, downstairs, and the second and third floor.

There was a registered manager in place at the time of inspection. 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 the service was safe. Good recruitment processes were in place with values based interview questions and all necessary pre-employment checks had been carried out on staff.

Medicines were stored and dispensed safely and people's physical needs, including nursing interventions were carried out in a timely and safe way.

People with complex and challenging behaviours were cared for by staff that knew them well and who supported them with compassion. However, documentation that was specific to behaviours that challenged needed improving to evidence what people told us about the care they received.

Staff had received training to recognise signs of abuse and knew how to act upon concerns.

Dementia and sensory impairment training was needed for staff working with people living with these disabilities. The consequence of not having this training was witnessed in some of the interactions with staff which needed improvement in order to support people to live well with these difficulties.

Some peoples opportunity for social interaction and stimulation was limited meaning they were at risk of social isolation. The management team acknowledged that additional work was needed on the provision of activities for these people.

People received a good choice of food and could request alternatives at any time. People with specific dietary needs were catered for well.

Staff understood the Mental Capacity Act and the importance of this within their everyday interactions with people living at the service.

Staff were caring and respected peoples dignity, privacy and confidentiality.

Care plans were person centred and easy to navigate through, although some people said they did not get involved in the planning of their care.

Loved ones of people living at the service felt they were listened to and if they had a complaint the management team and staff would put it right.

The new provider and existing management team kept people and their loved ones up to date with changes at the service. They also acted as positive role models in all interactions with people and relatives.

Robust systems were in place to investigate incidents and accidents and disseminate learning from these to the staff team.

Clinical governance processes were good and we saw that these were being appropriately used to monitor and manage the quality of care and any potential risks at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Staff were recruited safely to the service, having undergone all relevant checks.

Risk assessments for people's needs were through and gave staff the tools to support people.

Behaviours that challenged were managed in a safe and sensitive way by staff who knew the people they cared for.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People living with dementia and sensory impairment were kept safe, but staff did not always have the skills to ensure that their experiences of everyday life were meaningful and enjoyable.

There was good nutritional, dietary and fluid monitoring for people and people had a good choice and selection of foods that met their preferences. However, the dining experience was not always enjoyable.

Staff did receive robust introduction and mandatory training. Nursing staff were able to access additional training to support clinical skills and revalidation.

Staff had a good understanding of the Mental capacity Act, 2005, assessing for capacity, and asking for consent.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and some went the extra mile, visiting in their free time.

Peoples preferences were respected and staff protected people

dignity during personal care.

Confidentially was important to staff and information about people was shared only with relevant people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

It was not always clearly demonstrated how some people had their social needs met.

Care plans were person centred and accessible to staff and people at the service.

People were encouraged to share their views about the service.

Is the service well-led?

Good

The service was well led.

Managers role modelled the behaviour's they expected to see from staff and people and staff held them in high regard.

The new provider supported the management team and had on-going plans to improve the service and its environment.

Good governance systems were in place to monitor the quality of the service.

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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 and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 27 and 29 of March and was unannounced.

The inspection team included one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case the expert by experience specialised in mental health needs and dementia care.

Before we inspected the service we looked at all the information we held about the service, including notifications sent to us by the service.

During the inspection we spoke with nine people using the service, five relatives, three of which over the telephone, interviewed seven members of staff, and pathway tracked six people's care through care plans, daily care entries and other information pertaining to their care. We carried out a variety of observations of staff and people at the service, to assess the quality of interactions and engagement at the service.

We also spoke with two health and social care professionals about their views of the service and contacted the quality improvement team, a department at the local council who carry out their own checks of care homes.

As part of the inspection we reviewed processes for safe recruitment of staff, reviewing six staff files, and other policies and procedures relating to the running of the home.

Good

Is the service safe?

Our findings

The service was safe.

Staff had been recruited to work at the service safely and all appropriate checks had been undertaken to ensure that potential staff were safe to work with vulnerable adults. All staff had to undertake safeguarding vulnerable adult training as part of induction and at two yearly intervals. We saw that the manager had systems in place to identify those members of staff that required a refresher of this course. We spoke to staff who were able to demonstrate a good understanding of what constitutes a safeguarding concern and who to report concerns to.

In a part of the building known as the 'flat,' the service supported people with long term mental health problems who had complex behaviours that at times could be challenging. One member of staff told inspector, "We have to be flexible, not everyone likes to be doing the same thing, or getting up or going to bed at the same time. We have learnt to read people well and fit in with them and what they would like. We also know when people are becoming upset, their trigger's and what to do to minimise their distress." A relative told us, "We are all very happy with it all I can tell the other residents are looked after and are happy. They have some tricky situations at times and deal with it well." This demonstrated that staff knew people well and understood the support they needed if they became distressed.

Although this was evident in the interactions we observed, the support people received was not always effectively documented. Behaviour charts did not always give any detail of what had happened, why, and what staff had done to support the person. Without effective recording of these interactions it was more difficult for staff to establish patterns in peoples behaviours and reflect on what strategies worked well for the person. We reflected this to the manager who informed us that they would review these closely and offer additional training to staff if needed.

Some people at the service were subject to Deprivation of Liberty Safeguards (DoLS). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The Care Quality Commission check that these processes are being followed. We found that the service had good processes in place to ensure that those people who needed to be deprived of their liberty received appropriate assessment and follow up, but were also supported to retain their independence, and make choices whenever possible. Staff had received DoLS training and had a good understanding of what this meant to people in their care.

Risk assessments were comprehensive and helped to inform staff of how to care for people in the least restrictive way. They covered a variety of different risk facts that were informed by relevant assessments of people's needs. For example, if a person was at risk of developing a pressure sore recognised assessment tools were used to calculate the risk and formulate a care intervention, such as how often a person should be moved and what type of preventative equipment they might need, such as a pressure cushion. These were reviewed monthly or earlier if required.

People had personal emergency evacuation plans (PEEPs) in place, an individual plan for the people who used the service who may need to be evacuated in the event of an emergency. To ensure these would be effective, regular fire drills were carried out and fire alarms were regularly tested.

Staff, relatives, and people using the service told us that there was enough staff to support their needs safely. One relative told us, "There always seems to be enough staff here, I don't worry that [name] might be unsafe." Staffing rota's demonstrated that there were appropriate staffing numbers. When staff phoned in sick, the manager, deputy and training coordinator also supported staff on the floor. Staff told us, "If it has taken us longer to get people up the managers come out and help make breakfast or with care. We don't hurry people and everyone helps each other."

Each bedroom had buzzers so that people could call if they needed help. One person said, "I have two buzzers, somebody comes and helps me up. Time I wait depends, they more or less come straight away." Another said, "Sometimes I need some help. I have a bell here, I don't wait too long." However, one person told us that whilst they got a response from staff when ringing the bell, they had had to wait for nearly an hour at times for staff to help them with the need they rang for. We passed this information onto the manager to investigate.

Medicines were managed stored and managed safely. Nursing staff had protected time to administer medicine and there were clear processes for ordering and disposable of medicines. Regular medicines audits were carried out to monitor that systems to ensure safe medicines management were being followed.

Requires Improvement

Is the service effective?

Our findings

On one floor of the home we found that staff working with people who were living with dementia and sensory impairment did not always have the skills to support people to lead meaningful engaged lives. Activities for this group was limited to a small amount of objects. For example, we found people sitting in front of building bricks for very long periods without staff engaging with them. We saw that this was evident on both days of inspection from a number of observations at different times throughout both days.

For one person who was deaf we observed a member of staff raising their voice when offering a choice of sandwich. This is not best practice for supporting someone who has poor hearing as alternative ways of communicating may be more appropriate. Staff, including the nurse in charge did not intervene to role model more positive interaction, and consequently we could not be assured that this was not usual practice. We discussed this with the training manager and manager at the home who informed us they would look to source some dementia and sensory needs training.

We observed that the dining experience was not always enjoyable for those who needed assistance to eat their food. For example, during a lunch time period we witnessed a number of staff approach the same individuals who needed help, stand over the individuals and feed them a spoonful of food, moving onto the next person. This demonstrated a task focussed rather than a person centred approach and meant that people were not given the individual support they needed.

For those people who required a softer diet, food that needed pureeing was presented in separate parts making it look appetising. One relative told us, "The food is normally alright, my [name] has it pureed and it always looks nice." However, we also observed staff stirring pureed food together which showed a lack of understanding about why it was important to have pureed foods presented individually so that people could appreciate each element of their meal. We spoke to the manager about this who told us that this was not normal practice and that staff would normal sit with people who needed assistance.

People at the service received a choice of food at meal times, and snacks, fresh cake, fruit and biscuit's during the day. They were also able to request sandwiches, toast and other things to eat. People had been asked about their meal preferences and menus were organised around this.

If people wanted to provide their own food they were supported to do this. We found that this was out of choice rather than necessity. One person told us, "I don't have any of their food. I buy myself steak, chops etc. and they cook it for me. I buy a long pepper and they do that with my steak."

When people had lost weight, appropriate management plans were in place informed by assessments carried out by relevant professionals, such as dieticians and Speech and Language therapists (SALT). The manager had good links with relevant health and social care services to support people's health needs. Staff received a good induction, shadowing experienced carers, receiving regular observation and supervision and were required to undertake the Care Certificate as part of their induction. The Care Certificate supports the induction of care workers by ensuring that they achieve 12 set competencies to

demonstrate they have the right knowledge to care for people safely.

A training coordinator was in place who spent time working with staff to identify training needs. This person also had the responsibility of researching best practice and potential outside training opportunities. A training matrix was kept to identify if staff needed to be updated on mandatory training.

Nurses told us they could ask for training and training updates that they needed to carry out specific nursing interventions, such as catheterisation for people with continence needs, and PEG feeding. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

Training of staff took place during face to face, one to one and online modules. One relative told us, "Staff are really well trained and know what they are doing." A person told us, "They support me well when they use that hoist on me. They know what they are doing."

As the service supported a number of people with complex mental and physical health needs it was essential that they had good links with GP services and relevant mental health workers. We found that in spite of a number of changes in the locality for GP and Mental health services, the management team and staff at the home had maintained and advocated well for people in their care, to get the treatment and assessments they required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We observed staff giving people time to respond to questions around choices they would like to make. People were not hurried and rushed to make decisions. One member of staff said, "We can't rush people. I wouldn't like to be rushed so I don't rush our residents."

People told us that most staff supported them to make their own decisions about how they wanted to be cared for. One relative told us, "[Person] has choice, they let her stay up late if she wants to." One person told us, "I like sitting watching telly and doing what I want, they try and get me to go into the other room but I prefer my own company."

Good

Is the service caring?

Our findings

Although people told us that staff were kind and caring we observed opportunities were missed to ensure people's dignity and comfort. In the lounge on the second floor we observed some people sloping sideways in their chairs looking very uncomfortable, another person living at the service was falling forward with his head resting on a pile of 'Jenga' bricks. Three people were laying in bed, two with no access to an alarm or fluids.

Despite this we observed staff sitting with people and chatting to them about their lives and what they liked to do. These observations were warm and it was apparent that staff knew people they cared for well and that people knew and liked them. One person told us, "They are so nice to me."

Staff told us that there was a caring ethos at the home and that the management staff were visible, approachable and supported them in a caring way. One member of staff said of the management, "When they look after you well, it helps you look after other people well." One person living at the service told us, "I love it here they are all so lovely, do anything for you."

People's individual preferences, and protected characteristics were respected by staff who made efforts to support people to meet these needs independently and without judgement. Staff would support people of faith to attend church if they wanted to go, and would get to know what a person's preferences related to managing their disabilities. We asked how staff would support people's sexual orientation and staff gave responses that were non judgemental and sensitive. For example, one member of staff said, "What's important is the person and what they need. This is their home it's not our place to make judgements on people. We treat people with respect here."

Regular meetings took place between people, staff, managers and relatives to discuss changes at the service and improvements they would like to make. These were recorded and clear actions identified and whose reasonability it was to carry out that action.
Personal information about people was stored safely and securely, whilst also being assessable to staff should they need some guidance on how to support people's specific needs.

Requires Improvement

Is the service responsive?

Our findings

It was not always clearly demonstrated how people who were cared for, or who spent a lot of time in bed, had their social needs met, were provided with stimulation and/or how risks associated with isolation were being addressed effectively. We observed three people whose rooms were very bare, with little to look at or provide interest. For example there was nothing on the walls (pictures etc) and no television or radio. The management had identified that improvements were needed around activities and the environment. They were working through these plans which would further demonstrate how people using the service were supported and risks mitigated.

Despite these improvements that were needed care plans were comprehensive and separated into segments of need to make them assessable for busy staff looking for information about how to support people with specific tasks. We found care plans to be person centred, identifying people's individual needs and preferences. This was partially relevant for those living with complex mental illness and who required specific support to manage behaviours that challenge. For example, how staff should approach people depending on the way their illness was presenting itself that day. What staff could do to minimise distress to the person and risk to others, whilst also respecting the person's preferences.

People's care plans were reviewed by nursing staff and discussed with people, and where appropriate with their loved ones and other health and social care professionals. Involving people, when they were able, in identifying their needs and how they wished to be supported was important to staff and people. One person said, "They have made changes because of what I like and don't like."
Visiting times were open and we saw a number of visitors coming to the service during the inspection. One relative said, "I come when I want, I like to drop in unannounced to check my [relative] is being looked after well. I am always welcomed." We also saw that the management team regularly contacted relatives when they had concerns about their loved ones at the home. One relative told us, "I never have to worry as I know they will phone me if something happens to [person]."

A clear complaints policy was in place and when complaints were made they were thoroughly investigated by the manager and their deputy. There had not been any active complaints for some time, however people and relatives we spoke to told us they knew how to make a complaint and felt staff and the manager was approachable. One person told us, "I did have a complaint once, it did change."

Good

Is the service well-led?

Our findings

The service had recently gone through a period of change of provider and it had been unsettling for people and staff at the home. There had been little investment in the home prior to the new ownership. However, we found that the existing management team had offered good support to people, relatives and staff during the transition. This support had helped to retain regular staff working at the service. One member of staff told us, "[Manager] and [deputy] are so approachable and supportive. They are always visible and I know their door is always open."

The new provider had also been active in offering support to people and staff and had some creative ideas about improvement's to the service over the coming year. This included increased activities and maintenance and some renovation to the environment.

We observed the management team actively engaging with people at the service, role modelling the behaviour and values they expected from members of staff in their interactions with people and their loved ones. The manager told us, "This isn't just a job for me, this takes up my life. When I go home I am still available. I care about these people." Staff, people and relatives echoed this statement. A relative told us "[Manager] is absolutely brilliant. Always available, helpful and always lets us know what's happening for [person]." People at the service held the management team in high regard. One person said, "Oh she is lovely, so kind and [deputy manager] too."

Accident and incidents were recorded appropriately and when these did occur, such as a person developing a pressure sore, or having a fall, the investigations were carried out in a timely manner and measures put in place to manage, and minimise any potential risks.

Relatives and people told us that the management team were open and transparent with people and their relatives. One relative told us, "Staff update us with how they have been, any problems and they have rung us straight away. We have always been informed in that respect. [Name] is the manager, we would go to her never but have no cause to. Occasionally they send a questionnaire out, the new owners have written to us two to three times with their plans." One said, "My [person] does get chest infections and if there is anything they phone us straight away." and another told us, "I'm always kept in the picture, if I had a problem I would go through the office".

The management team were keen to keep up to date with best practice and had linked into local authority joint initiative "PROSPER" (Promoting safer provision of care for elderly residents.) This initiative focuses on pressure area prevention, fluid and nutritional care and falls prevention. We saw that the managers were using tools provided to monitor these areas.

Good clinical governance systems were in place to monitor the quality of care and any potential risks to this. Each system was filed in a way that was highly accessible and allowed for the management team to quickly respond to any question or need. These systems included audits of the environment, care plans and risk assessments and medication. Staff files were neatly ordered and contained all the relevant information to

demonstrate that staff had received appropriate checks and on going supervision and appraisal to assess their skills and needs.