

Sure Care (UK) Limited

Derwent Lodge Nursing Home

Inspection report

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15 January 2018

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Ratings

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

Summary of findings

Overall summary

The inspection took place on 10 and 15 January 2018 and was unannounced on the first day. At our last inspection of Derwent Lodge on 29 October 2015 we found that the service was good overall, however improvements were needed to the quality auditing systems and to record keeping in general.

Derwent Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Derwent Lodge accommodates up to 46 people in a purpose-built building and there were 37 people living there when we visited.

The service is required to have 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. The home had a registered manager.

During our inspection we found breaches of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not always received their medication as prescribed; the requirements of the Mental Capacity Act 2005 were not fully met to ensure that people who lacked capacity to make decisions received the protection they required; the provider had not implemented effective systems to monitor the quality of the service provided.

All of the people we spoke with believed the home was safe and said they were happy living at Derwent Lodge. There were enough staff to meet people's needs. Regular checks of services and equipment were carried out by the home's maintenance person and utilities and equipment were checked and serviced as required by external contractors. A log of accidents and incidents was maintained and showed that appropriate action had been taken when accidents occurred. Staff received annual training about safeguarding and the manager had reported safeguarding incidents as required.

People were generally satisfied with their meals and special dietary needs were identified and catered for. People received the support they needed to eat their meal. The care notes we looked at contained malnutrition risk assessments that were updated monthly. We saw evidence that people at risk were referred to a dietician. Staff received regular training and supervision, however the Care Certificate had not

been implemented for new staff. A number of people were being looked after in bed and equipment had been provided to meet their needs. Improvements were needed to some parts of the building, including two shower rooms that were out of use awaiting repair.

People who lived at the home told us that staff treated them with respect and respected their choices and independence. Relatives we spoke with were very happy with the care their loved ones received. They could visit at any time and we observed that they were comfortable to speak with the manager and the nurses.

We looked at the care files for three people. These showed that people's care and support needs were assessed before they went to live at the home to ensure that the service would be able to meet the person's individual needs. The care plans contained basic relevant information including nutritional assessments and eating and drinking care plans, falls risk assessments and moving and handling plans, personal hygiene care plans and sleep care plans. These had been updated monthly. There was a weekly programme of varied social activities. People we spoke with said they would be happy to approach the manager with any complaints. The complaints procedure displayed advised people who they could contact with any complaints. We saw that the manager had kept detailed records of complaints that she had received and the records showed that complaints had been investigated and addressed.

We saw evidence of regular staff meetings which were well attended. The minutes of the staff meetings showed that staff felt able to express their views. There was also a staff questionnaire twice a year. Questionnaires had been sent out to people who lived at the home and their families. We saw some completed satisfaction questionnaires from 2017 and these contained some very positive comments about the care provided.

During 2017 there was no quality audit plan and we found that auditing tools had been implemented irregularly so did not provide a record of progress within 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?

The service was not always safe.

People did not always receive their medication as prescribed.

There were enough staff to meet people's needs.

Regular checks of services and equipment were carried out by the home's maintenance person and utilities and equipment were checked and serviced as required by external contractors.

A log of accidents and incidents was maintained and showed that appropriate action had been taken when accidents occurred.

Staff received annual training about safeguarding and the manager had reported safeguarding incidents as required.

Requires Improvement 

Is the service effective?

The service was not always effective.

The service was not fully compliant with the Mental Capacity Act 2005.

People were generally satisfied with their meals and special dietary needs were identified and catered for. People received the support they needed to eat their meals.

Staff received regular training and supervision, however the Care Certificate had not been implemented for new staff.

Requires Improvement 

Is the service caring?

The service was caring.

People who lived at the home told us that staff treated them with respect and respected their choices and independence.

Relatives we spoke with were very happy with the care their loved ones received. They could visit at any time and we

Good 

observed that they were comfortable to speak with the manager and the nurses.

Is the service responsive?

Good ●

The service was responsive.

Care plans contained basic relevant information about people's care and support needs.

There was a weekly programme of varied social activities.

People we spoke with said they would be happy to approach the manager with any complaints. The complaints procedure displayed advised people who they could contact with any complaints. The manager had kept detailed complaints records.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The provider did not have satisfactory systems for monitoring the quality of the service provided.

The home had a manager who was registered with CQC.

Staff were able to express their views in regular staff meetings and questionnaires.

People who lived at the home and their families were able to express their views through resident committee meetings and questionnaires.

Derwent Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 10 and 15 January and was unannounced on the first day. The inspection was carried out by an adult social care 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.

Before the inspection we looked at any information CQC had received about the service since our last inspection and we contacted the Quality Monitoring team at the local authority.

During the inspection we spoke with four people using the service and three relatives. We spoke with staff who had different job roles in the home and observed the support they provided for people in the communal areas.

We looked at the care records for three people. We also looked at health and safety records, staff records, medication management and records relating to the management of the home.



Our findings

All of the people we spoke with believed the home was safe and said they were happy living at Derwent Lodge. One person said "It is very good. I feel quite safe." Another person said "It's a nice place. I'm as happy as can be." All of the relatives we spoke with felt the home was safe. A relative told us "I feel comfortable leaving my [relative] here. I've never heard a bad word said by anyone here."

One person felt there were not enough staff and another told us that there had been quite a few staff off in recent weeks due to illness and they had to use agency staff. One person said that there could be more staff at night and that the agency staff "don't know anybody's needs".

People considered that the home was kept clean and tidy. One person said "It's always clean and they are forever washing floors."

One person said they had medicines four times a day and received these "on time". Another person told us they sometimes received medicines late at night due to the presence of agency staff.

We looked at the arrangements for people's medication. There was a locked medicines room of adequate size on the first floor which was clean and tidy. There was a cabinet for the safe storage of controlled drugs and appropriate records were kept. Room and fridge temperatures were recorded daily and showed that medicines were stored at safe temperatures. Monthly repeat medicines were checked in and signed for on the medication administration record (MAR) sheets. Any hand-written additions to the MAR sheets were signed by two staff.

Administration records indicated that people always received their medicines as prescribed by their doctor, however we found four doses of medication that had been signed for as given but were still in their packaging. These had all occurred within the previous two weeks and we were concerned that nobody appeared to have noticed or reported that people had not received their medication.

We saw that one person was prescribed a sedative medication to be given "when required". There was no clear instruction or guidelines for the staff as to when this medication should be given. The instruction that was written was "assess visual and verbal actions", which was meaningless. This meant that the medication may not been given consistently.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014: Safe Care and Treatment.

One person was receiving their medication covertly, disguised in food or drink. A pharmacist had provided clear and detailed guidance about how this should be done.

The staff rotas we looked at showed that there were two nurses on duty during the day and one at night. There were eight care staff on duty during the day and three at night. Records we looked at showed that these numbers were maintained with some usage of agency staff.

The manager told us that the home was almost fully staffed with a part-time nurse vacancy at night. The deputy manager had recently left the home and recruitment was taking place. The manager had a file which provided details of the agency staff including their training and registration details for nurses.

In addition to the nurses and care staff, we observed that there were enough domestic, catering, maintenance, administration and activities staff.

We looked at the recruitment records for four new staff. All of the files we looked at contained a Disclosure and Barring Service check. We also saw records that showed new staff had a probationary period and were not offered permanent positions if they did not meet expected standards.

However, for one member of staff there was only one reference on file and for another, the references were not verified with a company stamp, headed notepaper or compliments slip. We also saw that candidates had not always provided a full employment history and the interview notes did not record that this had been explored. The area manager showed us the new application form that the provider had introduced and this required all applicants to provide full details of their previous employment.

An infection control audit by NHS staff in August 2017 found some concerns. The lowest score they awarded was for "staff knowledge". We saw no evidence that staff had received training about infection control since then, however they had been given copies of the home's policies and procedures covering areas such as hand hygiene to read.

There were at least two domestic staff on duty each day and a laundry assistant. We visited the laundry and found it clean, tidy, and well-organised. A new sink unit had been installed in the laundry but there was no separate sink for washing hands. We found the sluices on both floors to be clean and tidy. Disposable gloves and aprons were available for staff to use when providing personal care.

We looked at maintenance records which showed that regular checks of services and equipment were carried out by the home's maintenance person. Records showed that testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors. Door-guards were fitted to bedroom doors so that they would close in the event of fire. However, the fire alarm activated during the inspection and we saw two bedroom doors that did not close. We brought this to the attention of the manager who asked the maintenance person to investigate.

Regular fire drills were held but records indicated that these had all been held during the day and not for night staff. A fire risk assessment had been carried out in 2015 by a suitably qualified person. This had been reviewed in June 2017 and as a result, paving around the perimeter of the building had been re-laid as it was deemed unsafe.

A 'grab file' contained important information including phone numbers and contacts to be used in case of

emergency. Personal emergency evacuation plans were in place for the people who lived at the home and were updated regularly.

We saw two display cabinets with glass panes, one in a communal area and one in a bedroom. These were not attached to a wall and could have been pulled over causing injury. The maintenance person said he would address this immediately and attach them to the wall. This had been done by the second day of the inspection.

A log of accidents and incidents was maintained and audited monthly by the manager. The records showed that appropriate action had been taken when accidents occurred, for example referral to the Falls Prevention team. The manager had informed CQC of serious incidents that occurred during 2017.

Staff received annual training about safeguarding. A member of staff who we spoke with said they "wouldn't be shy" about whistleblowing if they felt anything was wrong. CQC records showed that the manager had reported safeguarding incidents as required. Full records were kept of safeguarding referrals that had been made.



Our findings

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

A brief mental capacity assessment was included in the care files we looked at but there were not always details of what decisions people were able to make for themselves and where they needed support. In one person's care file it was recorded that a family member had Power of Attorney but there was no reference to Power of Attorney in the other files we looked at. This meant that it was unclear whether a relative had the legal authority to consent to care and treatment, for example the use of bed rails.

Some DoLS applications had been made and three people had an authorised DoLS in place. However, in other care files we saw reference to the person having a diagnosis of dementia and being unable to make complex decisions, but no assessment had been undertaken to establish if they would benefit from the protection of a DoLS.

One person was receiving their medication covertly. This person did not have a mental capacity assessment to determine if they had capacity to make the decision of whether or not to take their medication. A DoLS had not been applied for and there was no record of any best interests meeting.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

All of the people we spoke with thought that the food was acceptable, although one person said they had a relative bring in food, drinks and snacks. Another person told us the meals were "generally very good" and that there was a choice available. Another person described the food as "very good" and "well cooked" and

said it was plentiful and there was a variety every day. One of the relatives felt that the meals had improved.

One person said they could always ask for snacks, but another said there was "not really something in between meals". A relative told us that drinks were always available and that the staff knew his relative's preferences. Drinks and biscuits were served at 11am and 3pm.

The expert by experience had lunch with people in the dining room. They reported people were asked what drinks they wanted and were offered protection for their clothing. Staff asked people for their meal choices at the table. Staff seemed very attentive to people's requirements and asked them if they would like their food cut up. People received the support they needed to eat their meal.

The chef was aware of people's dietary requirements and preferences and white-boards in the kitchen recorded these. They told us that people were consulted about the menus via a questionnaire every six months and their opinions were incorporated in future menus.

The care notes we looked at contained malnutrition risk assessments that were updated monthly. We saw evidence that people at risk were referred to a dietician.

The home's training programme comprised a set of ten topics to be completed annually. Staff were split into groups of mixed roles and had a list of topics to complete each month during the year. Training was undertaken by watching a DVD followed by a questionnaire to check learning. The area manager told us that the training DVDs were updated periodically by the training company that supplied them. On the first day of our inspection, two members of staff were attending a training course to become moving and handling trainers for the home.

We saw no evidence that new staff completed a structured comprehensive induction when they started working at the home and the manager was not aware of the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered by staff who are new to care or do not already have a qualification.

There was a monthly rota for staff supervisions which took place three or four times a year. Staff also had an annual performance appraisal.

The home was not divided into separate living units and there were no restrictions on people's movements around the building.

We observed that a number of people were being looked after in bed and equipment had been provided to meet their needs, including adjustable beds and pressure-relieving mattresses. The pressure mattresses we looked at were on the correct setting for the individual. Different types of hoists and slings were available to ensure that people could be moved and transferred safely. Although the weather was cold, all parts of the home were warm and there were thermometers to monitor the temperature in each bedroom.

Two shower rooms, and a bathroom on the first floor, were out of use awaiting repair. There was one bathroom on each floor that could be used. The area manager told us that the problem with the two shower rooms was being addressed, but the second bathroom on the first floor was surplus to requirements and he was considering an alternative use for the room. Some parts of the environment showed signs of wear and tear, for example paintwork on skirting boards was knocked and damaged; the flooring was damaged in some areas; the dining room furniture was shabby.



Our findings

People told us that staff treated them with respect and respected their choices and independence. One person said they enjoyed "a good laugh" with the staff. A relative told us that staff were "absolutely" respectful. We spoke a member of staff whose relative had been looked after at Derwent Lodge. They told us "I couldn't have asked for more. The manager would come and sit and talk to her. I was very satisfied with the care." A visitor said "The place is homely and my [relative] is well looked after. Staff do what is asked and when, and care is A1." Another visitor told us "I have no complaints about the attitude and performance of staff."

A member of the public wrote to CQC in September 2017 and told us:

"My [relative] lived at Derwent Lodge in 2017. He was treated with the utmost kindness and respect. He was looked after in a very professional and supportive way and the care he had was first class. The management, nurses, care assistants, cleaners and others, without exception, did their very best to ensure that he was comfortable and well cared for. The food was always well prepared for the residents, and as it became more difficult for my [relative] to swallow, the staff were extremely patient and took all the time needed to feed him. As he came to the end of his life, the care that he received was amazing. The staff treated him with dignity and compassion."

We spoke with the relative of a person who had respite stays at Derwent Lodge. They told us they were very happy with the care their relative received at the home and their relative was happy to come. They said "I feel comfortable leaving her here. I can't praise the manager and staff highly enough." Visitors reported they could visit at any time and we observed that they were comfortable to speak with the manager and the nurses.

All of the people we spoke with thought the staff were good and described them as "very friendly" and "can't do enough". One person commented "Some staff have better bedside manners than others". One person said that sometimes they had to wait for staff to help them to go outside.

When asked if they felt they could speak to someone if they worried or feeling down, one person said that they would speak with a friend or one of the nurses who are "very helpful". Another said "I would speak with one of the nurses or carers I could trust, you get used to which one."

One bedroom was shared by two people and the manager told us that this was a long-standing

arrangement. There was a privacy curtain between the two beds and people's personal items were kept separately and marked with their names. The manager assured us that no other bedrooms would be shared unless by request from the people involved.

A dignity audit in 2017 identified that net curtains were needed on the ground floor to protect people's privacy and these had been provided. Care staff had laminated notices to hang on people's bedroom doors when personal care was being provided so that nobody would enter the room. We observed that care staff were sitting talking with people in the lounge during the afternoon.

A copy of the home's 'Residents Guide' was displayed on the noticeboards on each floor and gave basic information about the services available. There was also other information on the noticeboards including a summary of the last inspection report and a weekly social activities programme.



Our findings

All of the people we spoke with felt that they could get up and go to bed when they wanted to. One person said "I go to bed earlyish because I want to." Another person said that they generally stayed in bed and that "now and again I have to wait my turn to get washed and dressed".

Three people said they were aware of their care plan. One person said "I don't get involved" and another told us that this was dealt with by their family. The third person said that they had a copy of the care plan in their room. One of the relatives said he was aware of the care plan but was never asked about reviewing the plan. Another relative said he had never been consulted about changes to the care plan but thought he could be if he wanted to.

People we spoke with felt that any concerns they had could be passed on to the nurse in charge or the manager who was "very approachable". One person said she would speak to one of the carers who would "pass it on". One of the relatives said if he had any concerns he would speak to the manager who he knew "very well".

Everyone we spoke with was happy with their access to a GP and told us that the staff called out the doctor when required. They also told us about visits from an optician, a dentist and a chiropodist.

We looked at the care files for three people. These showed that people's care and support needs were assessed before they went to live at the home to ensure that the service would be able to meet the person's individual needs. Most people who lived at the home required nursing care and others required personal care.

The care plans contained basic relevant information including nutritional assessments and eating and drinking care plans, falls risk assessments and moving and handling plans, personal hygiene care plans and sleep care plans. These had been updated monthly.

Some people were being cared for in bed and we saw charts in their bedrooms that recorded two hourly pressure care. We looked at the care plans for a person who had been admitted to the home with a serious pressure sore. We found detailed wound assessments and treatment plans and regular input from a wound care specialist nurse.

Only one of the care files we looked at contained personal biographic information to help staff understand

the individual, their past life, their family, and what was important to them. The manager said that she had asked relatives for information but they were not always keen to provide it. The manager told us that the activities coordinator was also involved in gathering more information about people's social history.

We spoke with the activity coordinator who worked 30 hours per week including some hours at the weekend. She had a weekly activities timetable and took people out. Entertainers also came to the home, which people enjoyed. A second activity organiser worked at the home on a Friday. Activities available included karaoke, PAT dog, church visits, quizzes and cinema visits.

People we spoke with said they would be happy to approach the manager with any complaints. The complaints procedure displayed advised people who they could contact with any complaints and gave contact details. The manager kept detailed records of complaints that she had received and the records showed that complaints had been investigated and addressed.



Our findings

A relative said they would not be afraid to "voice any opinion". A person who lived at the home said that the manager came around regularly and asked her if she was alright. Two people said they were aware of the residents meetings. One said they never went to the meetings. The other person did go and felt "I can say what I want." A third person said they had "never heard of it". One of the relatives we spoke with was aware of the meetings but never went.

Two people who lived at the home said they knew the manager but a third said "She doesn't come around and introduce herself. "All of the relatives we spoke with knew the manager and one told us "She is very approachable and open to conversation about the clients". Another relative said that the manager had been very helpful with filling in forms.

We observed that staff went about their work in a cheerful and relaxed manner. A member of staff we spoke with said "It is a nice home, very friendly, one of the best." We saw evidence of regular staff meetings which were well attended. The minutes of the staff meetings showed that staff felt able to express their views. There was also a staff questionnaire twice a year, however we did not see how the feedback from the staff questionnaires was used in the development of the service.

Questionnaires had been sent out to people who lived at the home and their families. We saw some completed satisfaction questionnaires from 2017 and these contained some very positive comments about the care provided.

Some of the people who lived at the home were active on the 'Residents' Committee'. This was facilitated by the activities coordinator. Any issues arising were passed on to the manager but we did not see any record of how they were addressed.

During 2017 there was no quality audit plan and we found that auditing tools had been implemented irregularly so did not provide a record of progress within the service. For example, a night check had been carried out in June 2017 and found some concerns, but we saw no further night visits recorded. An activities audit had been carried out monthly up to September 2017 but there were no more recent records.

Care plan audits were not effective in showing that quality of people's care records was checked regularly. The auditing records we were given showed only that one care plan had been checked in July 2017, one in August 2017, and one in September 2017.

Kitchen audits were recorded in February and April 2017, but nothing since then.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

We saw a recently introduced weekly return of information to head office, and a new auditing schedule and monitoring tools which were due to commence in January 2018. These need to be implemented consistently and effectively in order to meet the requirements of Regulation 17 of the Health and Social Care Act

The registered provider is required by law to display their current CQC rating in a prominent place within the service. During the inspection we observed that this had been done.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we reviewed those notifications that had been submitted by the registered provider and found that this was being done.

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 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 RA Regulations 2014 Need for consent |
| Diagnostic and screening procedures | People's capacity to consent to care and treatment was not assessed with reference to the Mental Capacity Act and Deprivation of Liberty Safeguards. |
| Treatment of disease, disorder or injury | |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Diagnostic and screening procedures | People who used the service did not always receive their medication as prescribed by their doctor. |
| Treatment of disease, disorder or injury | |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Diagnostic and screening procedures | The provider had not implemented effective systems to monitor the quality of the service provided. |
| Treatment of disease, disorder or injury | |