Derby City Council

Raynesway View

Inspection report

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection visit took place on 15 June 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

Raynesway View provides residential care for up to 35 people. At the time of our inspection there were 26 people using the service. The home specialised in caring and supporting people living with dementia.

At our last inspection on 10 April 2014. We found that there were not always enough staff available to safely support people with their care. This was a breach of regulation 22 of the health and social care act (2008) (Regulated Activities) Regulations 2010. This corresponds with regulation 18(1) of the health and social care act (2008) (Regulated Activities) Regulations 2014. At this inspection we found further improvements were still required.

During this inspection we that staffing levels and deployment of staff were not always sufficient to provide support to people when required.

People received their medicine when they needed. However we found that written instructions for 'as and when required' medicines were not always in place.

The provider had checks in place to ensure that staff they recruited were safe to support people using the service.

People were asked before support was provided and their wishes were respected. We saw people were given choice about day to day decisions. However, there were inconsistencies in assessing people's ability to make their own decisions. Where decisions had been made on people's behalf the records did not always show that these were made in the person's best interest.

People were supported to maintain a healthy diet and staff ensured people's nutritional needs were met.

People were supported by staff that had received appropriate training in supporting people with their care.

People and their relatives told us they were looked after and that staff were kind and caring.

People's care records were not always specific or individualised which described to staff how people wanted to receive their support.

The service had a registered manager in place at the time of our 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. However the registered manager was on leave when we carried out the inspection visit.

We found that audits to monitor, assess and improve the service were not always completed. Where issues had been identified these had not been acted on.

People felt the home was well run and said that the registered manager was approachable and helpful.

People told us that they felt comfortable to raise complaints and we saw that there was an effective complaints process in place. We saw where issues had been raised; these were effectively investigated and responded to.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staffing levels and the deployment of staff were not always sufficient to ensure people received support when they needed it. People said they felt safe living at the home. The provider carried out checks to make sure only suitable staff were recruited. People told us they received their medicine when they needed them.

Is the service effective?

Requires Improvement

This service was not consistently effective.

People's capacity and consent was not always assessed in line with the principles of the mental capacity act. Staff had access to appropriate training in care. People were supported with their food and drink to make sure their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and helpful. People were supported with their dignity and personal appearance.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples care records did not always include important information about their needs which meant they may not the right support. People felt comfortable if they needed to make a complaint and the provider had a process in place.

Is the service well-led?

Requires Improvement

The service was no consistently well-led.

We found that audits that are used to assess, monitor and improve the service were not available. We saw that recommendations from commissioners were not always acted on. There was a registered manager in place which people felt

ran the home well. We saw that that the provider undertook regular surveys to establish people's views and issues were acted on.

Raynesway View

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.

The inspection visit took place on 15 June 2016 and was unannounced. The inspection was carried out by one inspector.

On this occasion we did not ask the provider to complete the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people who used the service and three visiting relatives and two visiting Healthcare Professionals. We spoke with three carers, two assistant [unit] managers and the administration manager. The registered manager was on leave during our inspection. We reviewed three care records, three staff files and the provider's policies and procedures, accidents and incidents, staff training and supervision records. We also contacted the commissioners who fund care for some people to obtain their views.

Some people living at Raynesway View were unable to communicate verbally, so we observed how staff interacted and supported people to help assist us in understanding the quality of care they received.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 10 April 2014, we found that there were not always enough staff available to safely support people with their care. This was a breach of regulation 22 of the health and social care act (2008) (Regulated Activities) Regulations 2010. This corresponds with regulation 18(1) of the health and social care act (2008) (Regulated Activities) Regulations 2014.

People, relatives and staff had mixed views about staffing levels. One person said, "There's someone around if I need help." A relative commented, "They look after [person's name] well and I have no concerns and are around if we need them." Two other relatives told us that they felt there wasn't enough staff and one commented further that there, "Appears to be fewer at weekends."

A staffing tool linked to dependency levels of people who used the service was completed. The purpose of the tool was to identify how many staff were needed to provide care and support to people living at the home. We saw that the staffing rota did not meet the assessed support that people required. We observed during our inspection that some areas of the home were left unsupervised for periods of 15 minutes or more. This meant staff might not be aware when people required support to keep them safe.
On one occasion a person who required support with their mobility was seen to leave the room with their walking aid and returned five minutes later without it. Tthey appeared to be in a state of distress and unsteady on their feet. We brought this to the attention of a member of staff who assisted the person to sit in a chair and provided reassurance. Once the person felt settled, the member of staff then located the walking aid and brought this back to the person. As the person was unsupervised moving about the home this meant there was a risk an accident may happen as the persons care records told us that they were at risk of falling and walking aids were provided to mitigate the risk.

People were supported by staff that had been recruited safely. The provider followed safe recruitment practices and had a policy in place. Staff files we looked at contained application forms, records of interview and appropriate references. Records showed that police checks had been made to make sure staff were suitable to work with people living at the home. One staff member told us, "I had to wait for my police check to come back before I was able to start work."

People felt safe living at the home. One person told us, "I feel safe here and the staff look after me if anything happens." There were safeguarding policies and procedures in place which explained how staff should report concerns to keep people safe. Staff had completed safeguarding training and were knowledgeable about what action they would take if they suspected abuse was taking place. One member of staff said, "I would report concerns to the senior carer or the manager." Staff were also aware they could contact external organisations such as us or the local authority safeguarding team. The assistant unit manager told us that there were no ongoing safeguarding issues. This was confirmed by the local authority contracts officer who told us that there were no concerns regarding the service.

Risk to people's safety had been identified and assessed. A risk assessment is a document used by staff that

highlights potential risk, the level of risk and details of what reasonable steps should be taken to minimise the risk to the person. For example, Personal Emergency Evacuations Plans (PEEPs) provided information and guidance to staff in the event that people needed to be evacuated from the premises in an emergency. For example, one person's PEEP identified that the person were required support of one member of staff and that staff should provide verbal prompts when evacuating and to also ensure that the person has their walking aid and hearing aids. People also had coloured dots on their doors which corresponded to the PEEP so that staff knew what support people needed. We saw where people needed equipment to be able to be evacuated such as slides sheets and walking frames, these were in place. This meant that staff knew how to keep people safe during an emergency situation.

People told us they received their medicines regularly. We saw that staff sat with people and explained what they were being given. One person said, "I get my medicine when I should". We heard staff checking with people to see if they were in discomfort and needed medicine. We heard a member of staff asking a person whether they wanted one or two tablets to manage their pain.

We saw that the arrangements for medicine storage and stock control were managed by staff and recording of medicines was accurate.

Requires Improvement

Is the service effective?

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 so that they can 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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider was not always working in line with the principles of the mental capacity act.

Where people may lack capacity to consent to their care and treatment, the provider had not always undertaken capacity assessments to look at the required support some people may need and that any specific decisions were made in their best interests. For example, we saw in a care plan that one person who had complex health needs required full support from staff with their personal care. We spoke with an assistant unit manager who had told us they felt the person didn't have capacity to provide consent and confirmed that they had not undertaken a capacity assessment. This meant that the person might have received care and treatment against their wishes.

Some people were prevented from going out by themselves when they wanted to. Staff told us that due to levels of people's mobility and health conditions as some people were living with Dementia, they might be at risk of an accident or become disorientated. We saw that no capacity assessments were completed in relation to people living with dementia and other health conditions and that preventing people from going out on their own was in their best interests. This meant that some people's freedom might be restricted

The assistant unit manager told us that they would complete the necessary assessments and if restrictions are identified, decisions would be made in people's best interest and that they would apply for the relevant DoLS authorisations.

At the time of our inspection visit the provider didn't have an appropriate MCA and DoLS policy in place that provided guidance to staff. Following our inspection visit the provider sent us a copy of their most recent policy and confirmed that it was up to date. Records we looked at showed that staff were trained in MCA. Staff we spoke with had a basic understanding of the principles of the MCA and their role in relation to supporting people effectively. For example one member of staff told us, "It's about not taking over and to allow people to do as much as they want and can for themselves."

We saw that the provider had mental capacity assessments in place for people in relation to preventing falls

out of bed. Where a person was at risk of falling and lacked capacity to consent to preventative care such as the use of bed rails or sensor mats, the necessary applications had been submitted to the Supervisory Body (in care homes, providers must apply to the local authority). We saw that where DoLS were in place for people, staff were working in line with any conditions of these requirements.

People were supported by staff that had received the necessary training in care. One staff member told us that they completed training in a variety of areas such as, "Moving and handling, safeguarding and fire safety." Records we looked at confirmed that staff had undertaken suitable training and they had also received training in caring for people living with dementia. Staff felt if they need more training to enhance their skills, the registered manager would support it. This meant that staff had the skills required to provide effective care and support to people.

All new staff received suitable training and induction when they began work. The induction covered number of areas which aimed to provide staff with the knowledge and skills to support people living in the home. One member of staff told us, "The training is good," and that they were supported to obtain an N.V.Q. which is a qualification in health and social care. Staff told us that they receive regularly supervision from the management team. Supervision is a way for providers to ensure that their staff have the relevant skills and competence to support people. Staff told us that if they needed any further training or advice, this would be provided.

The people and relatives we spoke with were complimentary about the quality of meals and the support people received. One person told us, "I really like the food." We saw that a menu was provided for people to choose from and a staff member said, "If they don't want what is on there [the menu], we ask them what they would like instead." We saw that specialised diets were also provided to meet people's individual nutritional needs such as soft diets for people had been assessed at risk of choking or food that had been fortified with additional nutrients to support people to maintain their weight. We also saw that snacks and drinks were available throughout the day.

People were supported with their healthcare needs. Throughout the care records we viewed there was evidence of involvement with other health and social care professionals. These included, for example, involvement from Speech and Language Therapy (SALT) and physiotherapists. We also spoke with two visiting healthcare professionals during the inspection visit. They both commented that any instructions left by them were always followed by staff. One member of staff told us, "We support people to attend appointments if their relatives are unable to." This demonstrated that people had access to effective healthcare support when they needed it

Good

Is the service caring?

Our findings

People told us that staff were caring and met their needs. One person said "Yes, they look after me" and a relative told us, "Mum is well looked after and always well dressed."

We observed caring interactions between staff and people throughout our inspection. Staff would ensure they were at people's level when speaking with them and would keep eye contact when talking to them. We observed manual handling practice at the time of our inspection and we saw that staff reassured people throughout, explaining what they were doing and checking the person's wellbeing. For example, we saw a member of staff assisting a person to sit. Staff provided clear instructions and encouragement. We observed a member of staff saying, "Hold on to your frame [person's name], I've put the chair behind you. Slowly sit. There we go, well done. Are you okay?" To which the person smiled and replied, "Yes," and proceeded to thank the staff member for their assistance. This also showed that staff supported people to maintain their independence.

We spoke with a visiting relative had told us it was their 70th wedding anniversary and staff had given her a card. They also commented that, "They [staff] have also given me a card from my husband [which he can no longer do] which is fantastic." The person and their relatives were seen to be celebrating in a quiet area of the home which they appeared to enjoy. This meant that staff knew and understood what was important to the person and their relative.

People and relatives felt they were kept informed and involved about their care and support. One relative commented, "They always keep me up to date. Before [person's name] came here, they were always falling and didn't walk. They've referred them to a physiotherapist which has made a huge difference and now they're always walking around. [Person's name] is back to how they used to be seven years ago."

There were regular residents' meetings and people were encouraged to make suggestions about what they would like to do and make any comments about the service they received. For example we saw in minutes of recent meeting that people had raised that they were unfamiliar with some staff. This was because when there were staff shortages, cover was sought from an agency. In response to this we saw that the provider had committed to requesting the same member of staff from the agency to promote consistency and familiarity for people.

Staff understood the importance of treating people with dignity and respecting their privacy. One staff member told us that they would ensure that people were appropriately covered and, if two people were needed to support with personal care, "I'd never take over and I'd make sure the person is included." Another staff member told us that they would always encourage participation in personal care but that it is ultimately the person's choice. We also saw that the provider had achieved the Bronze Dignity Award which is part of the 'Dignity in Care' campaign run by the National Dignity Council which providers have to demonstrate how they promote dignity and respect for people using care and support services.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records to check that these reflected people's needs and provided guidance for staff to support people in the right way. The care plans identified people's needs such as mobility, nutrition and personal hygiene. However people's care plans did not include important information about people's specific care needs and others were contradictory. This meant people may receive inconsistent or inappropriate care.

One person's care records contained conflicting information about how to support them to manage their diabetes. For example, it said that the district nurse would visit daily to administer the person's insulin. We asked a member of staff what time the district nurse was due to visit and we were told that they no longer visit as the person no longer received insulin via injections and that they now manage their diabetes by taking tablets. We saw that there was a further entry in the person's care records to confirm this. However it had not been updated on their main risk assessment that staff would check when providing support. This meant staff may not have the most up to date information or that it was difficult to locate when needed to enable them to respond to people's needs.

The care plans that we looked at were not always person-centred and tailored to people's needs or provided specific instruction to staff on how to support the person. For example, one person's mobility assessment said, "If [person's name] was to have a fall and unable to get up, use a hoist. See moving and handling guidelines C6 and F3." Another person's personal care assessment said, "Ensure that [person's name] is sat down when washing and dressing. See M+H [moving and handling] guidelines E4 and E6." As the assessments did not contain specific or individualised guidance to staff on how people preferred to receive their care. This meant that people may have received inconsistencies when staff supported them.

We reported these issues to the assistant unit manager who told us that they will ensure people's care records are updated and contain specific and tailored instructions on how staff were to support people with their care.

Other people's care records were more detailed and included personalised information about how people preferred to be supported. For example, one person's care plan about drinks mentioned that they prefer to drink tea and like it with milk and no sugar. Also that they preferred a hot breakfast but staff were still to provide options which the person could choose from by pointing as they were unable to communicate verbally. Further to this, there was also a communication plan in place for this person which instructed staff how to interact such as by asking 'yes or no' questions and providing visual prompts where possible. This demonstrated that staff were able to respond to the person's individual needs.

People were not always supported to undertake meaningful activities. For example, one person's care records stated that they are religious and they enjoyed attending a place of worship. We saw that their relation when possible supported the person to attend. However there was no instruction on how staff were to support the person. Staff we spoke with told us that they have not supported the person to attend or explored other options of meeting the person's social and religious needs. We saw that there were no

activity schedule in place and staff told us they would spend time with people when they could. Staff confirmed that there is not a dedicated member of staff in place for organising and undertaking activities but told us when a person participates in an activity they document it in the activities log. We reviewed the activities log and found gaps of up to 21 days. The assistant unit manager told us this had not been maintained and that they would remind staff to complete it going forward. This meant that people may not have always been supported to have their social needs met.

A visiting relative told us that their relation enjoyed watching, "Western Films." We saw that the person was sitting the lounge watching a movie that they appeared to enjoy. We also saw that a small group of people were playing dominoes together. There was a lot of laughter between the people and staff which indicated that there were good relations and rapport with each other. We saw that a hairdresser attended the home frequently and people were able to choose whether they wanted to book an appointment or not.

People and relatives said they found the registered manager approachable and would feel comfortable about discussing issues with her. One relative had said, "I have no complaints but if I had a problem, I know [the registered manager] would sort it. There was also a clear complaints policy which provided guidance for staff about how to process and manage a comment or complaint. The policy was also on display which people and visitors had access to. The registered manager kept a log of each complaint and a written report of how these were investigated and any action taken. This meant people, relatives and visitors were encouraged to provide their comments about the service and had the contact details of who to discuss complaints with.

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider did not have an established internal audit system in place to assess, monitor and improve the service for people living at Raynesway View. For example, we requested to see copies of the medication audits. The assistant unit manager told us they there were unsure if these were completed by the registered manager and that they did not have access to them as the registered manager was on leave.

Following our inspection visit we were provided with a medication audit, however the audit had been undertaken by a representative from the commissioners as part of their contract monitoring arrangement. Their audit found that only 62% of their requirements were met. The provider stated in an action plan that the registered manager would undertake monthly audits. During our inspection we found these had not been completed. We also requested to see audits that were completed by the provider. We were told that no auditing is undertaken and that the head of service was newly appointed and yet to do these. As audits were not undertaken effectively this meant that issues were not promptly identified and action was not taken in a timely manner, therefore improvements for people using the service were delayed.

We also found that the provider's quality assurance and audit systems were not effective because people were prescribed medicines on an 'as and when required' basis, such as for pain relief. The providers policy states there should be written protocols in place to instruct staff when people might need their medicine. We found these were not always in place. People's care records directed staff to look at guidance in other policies in order to support the person and this guidance was not contained within the person's care record.

We reviewed the staff training matrix which details what training staff had undertaken and when it is required to be renewed. We found that there were gaps for some staff and renewal dates had passed for others. We discussed this with the administration manager who told us that this will be updated and staff will be booked on to any relevant training required.

People felt the home was well-run. One relative commented, "The registered manager is very approachable and nice to talk to." A visiting healthcare professional told us, "They are very accommodating and all I need to do is ask and they will do it."

People had opportunities to comment on how the home was run at regular meetings and coffee mornings which were held by the management team. However we found that some comments were not always responded to. For example, one relative told us that they had suggested an outing in late 2015 but nothing ever came of it." We saw that most comments that were raised had been actioned. For example, we saw that people discussed converting an unused room in to a café where people could sit with their visitors. We saw the refurbishment was almost complete and the assistant unit manager told us that only minor decorations needed to be done and then it will be ready for the "grand opening".

Staff told us that they had opportunities to give their views about the service at regular staff meetings. Meetings were held with the head of service, registered manager, assistant unit managers and the care staff team to discuss the organisational standards that were expected. However minutes of those meetings were

not available as staff told us it is mostly, "Informal." Therefore it was unclear as to what was discussed at the meetings and any action the management team may have taken.

We saw that the provider undertook quarterly surveys of people's satisfaction with the service at Raynesway View. We saw that the results were analysed and the management team then produced an action plan to address any issues that were identified. For example, there was a comment from one person that raised an issue with evening meals times as they felt it was too late. We saw that the management responded by changing the meal times and staff worked flexibly to accommodate this. We also saw that feedback was given to people and they used it as an opportunity to remind people that food and snacks such as "sandwiches" are always available.