Lifestyle Care Management Ltd

Derwent Lodge Care Centre

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 17, 18 and 21 October 2016 and the first day was unannounced. We had previously carried out an unannounced comprehensive inspection of this service on 27 and 28 January 2016. After that inspection we received information from the local authority in relation to safeguarding incidents and this raised concerns around the reporting of safeguarding issues, moving and handling processes, risk assessment completion and staffing levels. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Derwent Lodge Care Centre on our website at www.cqc.org.uk

Derwent Lodge Care Centre provides nursing care for up to 62 people. There are three floors and the units offer nursing care for older people including those with dementia care needs and people with physical disability needs. At the time of inspection there were 48 people using the service.

The service is required to have a registered manager and there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider had arrangements in place to safeguard people against the risk of abuse however these were not always being followed and some incidents had not been managed appropriately.

Staff did not always follow correct procedures for moving and handling which placed people at risk.

The staffing levels were not based on dependency levels and there were not always enough staff on duty to meet people's needs. We have made a recommendation about monitoring staffing levels.

Staff received training around how to care for people's needs, however they did not always put the training into practice, which placed people at risk.

Staff did not always find the registered manager was approachable and supportive.

Risk assessments were in place for identified areas of risk with action plans to minimise them.

People's nutritional needs were assessed and monitored.

Systems were in place to monitor the quality of the service, however these had not always been effective in identifying issues.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe. The provider had arrangements in place to safeguard people against the risk of abuse however these were not always being followed.

Staff did not always follow correct procedures for moving and handling which placed people at risk.

The staffing levels were not based on dependency levels and there were not always enough staff on duty to meet people's needs.

Risk assessments were in place for identified areas of risk with action plans to minimise them.

Is the service effective?

Requires Improvement

The service was not always effective. Staff received training around how to care for people's needs, however they did not always put the training into practice, which placed people at risk.

People's nutritional needs were assessed and monitored.

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems for managing safeguarding had not always been followed and had left people at risk.

Staff did not always find the registered manager was approachable and supportive.

Systems were in place to monitor the quality of the service, however these were not always effective in identifying issues.

Derwent Lodge Care Centre

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.

This inspection took place on 17, 18 and 21 October 2016 and the first day was unannounced. Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The first day of inspection was carried out by two inspectors and then one inspector attended for the other two days of inspection.

During the inspection we viewed a variety of records including risk assessments and associated care documents for eight people, daily care records for 10 people and a selection of other records including safeguarding records, incident records, audit and monitoring reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff on all units.

We spoke with five people using the service, five relatives, four other visitors, two clinical and operations directors for the provider, the registered manager, five registered nurses, six permanent care staff and five agency care staff, the activities coordinator, the cook, the maintenance person, the housekeeper and the laundry assistant.

Requires Improvement

Is the service safe?

Our findings

There had been an instance in June 2016 where safeguarding concerns had been raised by staff but the provider's safeguarding procedures had not been followed, thus placing people at risk. Following this incident the provider had taken action to address the shortfalls. There had been training updates for staff and any safeguarding incidents including unexplained injuries and bruises had been reported to the local authority. We had been informed that as part of the action plan to improve safeguarding practices, safeguarding and reporting of incidents was discussed at each handover. On the first day of inspection we attended the morning handover and noted this practice was not followed on either unit we visited. One team leader explained they had regularly discussed this topic previously with the staff on duty.

We viewed the records for two people with unexplained bruises. For one we found some time discrepancies in statements relating to the time a bruise was discovered. The daily records clearly identified the time it was seen by the registered nurse and this tallied with the incident report. We asked the registered manager about the discrepancies in timings on the statements from staff and this had not been followed up. Whilst it was clear the incident had been reported, there had been no follow up to clarify the information provided in staff statements.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Equipment was not always used safely and people were at risk of injury. We saw an instance where staff went to transport a person in a wheelchair without footplates and with their feet dragging on the floor, so we intervened for safety. When we asked staff about this they said the person could 'hold their feet up'. This meant staff did not understand the risk of the person catching their feet on the floor and sustaining an injury. In another instance staff brought a commode chair to transfer a person onto, again with no footplates, instead of using a wheelchair. When we spoke with staff they said they did not know where the wheelchair footplates were and there were not enough wheelchairs available. However, when we spoke with the maintenance man there were additional wheelchairs available for occasional use, for example, to transfer people from one room to another, and they provided one during the inspection. Staff were able to tell us the correct moving and handling procedures to follow but they did not always put this into practice.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On another occasion we saw someone who needed to be assisted onto a chair using a hoist. Staff brought the correct equipment and carried out the manoeuvre safely whilst reassuring the person and explaining what they were doing throughout. One person confirmed staff knew how to use equipment and explained what they were doing. They added, "They talk, they care, you're never neglected." Staff knew people's individual moving and handling needs and the equipment to be used for each person. On the first day of inspection three hoist frames and two wheelchairs were dirty and in need of cleaning, which was addressed. Other items of equipment viewed were clean and ready for use.

Policies and procedures for safeguarding and whistleblowing were in place and we saw copies were available in the staff room and staff confirmed they had read them. We gave staff various safeguarding scenarios and they were clear to report any concerns to the nurse in charge or to the registered manager. Staff knew to follow whistleblowing procedures and to contact the local authority if no action was taken by the provider. The contact telephone number for the local authority was available in the office on each floor and staff knew about this and showed us.

We asked people, relatives and visitors if they felt people were safe and happy at the service. One person told us they felt safe except when the staffing levels on the unit were low and they were happy at the service. Others said, "I wouldn't be in any other place.", "If I need help they come. The least little thing you just ask" and "The care is alright providing they have enough staff." Comments from relatives included, "I found it very good, to be honest, very good. I've found everybody very approachable.", "The staff are brilliant. The girls work hard and you always see them with a smile on their face." "I think [relative] is still surviving because of being here. The nurses are lovely.", "First class, she couldn't have wished for a better place to come to" and "It's really good, no problems at all." Comments from visitors included, "They are always so nice. [Person] gets on well with them. She is very lucky to be here" and "They are very kind, very nice staff here." Some relatives commented about the staffing and felt with more permanent staff there would be the opportunity to provide more activities and continuity of care.

At the time of the inspection we were told the staffing for each floor for the current numbers of people using the service. On the ground floor it was two nurses and three carers or one nurse and four carers during the day and one nurse and two carers overnight for 17 people. On the first floor it was two nurses and four carers in the morning, one nurse and five carers in the afternoon and one nurse and two carers overnight for 23 people. On the second floor it was one nurse and two carers during the day and one nurse and one carer overnight for 8 people. We asked staff on each unit if they felt there were always enough staff on duty to meet people's needs. Comments included, "We are always short staffed.", "If there were more staff things would improve" and "There are never enough carers."

While they were recruiting new staff, the service was using agency staff regularly to cover vacant nurse and care staff shifts and some of these agency staff worked regularly at the service and had got to know people well. We received mixed feedback about the staffing of the service. Permanent care staff told us that there were occasions when once they had finished helping people with personal care on one unit they were asked to then go and help out on another unit where they were short of staff. Although the care records were person-centred, staff told us that due to the workload care was task led and they did not have enough time to spend with people to provide person-centred care. The staff were very caring and put the needs of people first, however some of the permanent staff told us they were tired and morale was low.

We asked about the dependency levels used to calculate the staffing numbers required and this information was not available. The registered manager put together a list of people on each floor who were independent, those who needed one member of staff to provide care and those who needed two members of staff to provide care. The majority of people on each floor needed two staff to assist them and staff were very busy throughout the morning right up until lunchtime providing this care. On the first day of inspection at least one member of staff did not take a morning break in order to ensure people received the care they needed. Staff told us there were days where the units were short of staff and we saw from the rota that there had been days when two care staff had been on duty instead of four, and a carer had been moved from another unit to assist, so leaving that unit one short. The documentation for staffing was not always accurate, for example the daily work allocation sheets had at times been completed prior to the shift commencing and had not then been altered to reflect any changes in staffing for that unit, so it was not always clear which staff had been on duty each day on each unit.

The service had developed handover documents for each floor which provided the details of the day to day care people required including any specialist care, for example, if people had thickened drinks or the moving and handling equipment to be used. Where people required two staff to carry out personal care we saw that agency carers were allocated to work with a permanent care worker to provide care, to provide continuity from staff who worked with people regularly. Two agency carers we spoke with said they had received a handover and had been given the handover sheet to follow, which they showed us. They confirmed they were happy with the handover they had received and could read the care plans for more in depth information about people.

On the first day of inspection an agency carer told us, "I do not know what most of them have got wrong with them." When we asked if they felt safe working in the environment they said 'no' and felt they needed more staff as the unit had several people who displayed behaviour that challenged. They told us they had received a handover from the nurse but had not been provided with the handover document and had been working alongside another agency carer on their particular shift. We also saw an agency carer arrive shortly after the morning handover and they stayed in the lounge area and were not involved with providing personal care to individuals. The unit was short of one nurse and they were waiting for an agency nurse to arrive, so the handover that had been given to the other staff on duty was brief and staff then got on with assisting people with their care.

People required assistance with eating and we saw that at lunchtime on one unit one care worker was overseeing four people, all of whom needed prompting or some assistance with their meals. The carer completed this effectively; however they also served up all the meals for the unit and were left to manage the dining room whilst other staff assisted people who were in their rooms. We observed that if people were assisted in bed with meals the staff made sure they were sitting up and in a good position to eat safely. This was in line with information contained in people's nutritional assessments and care plans to minimise any swallowing risks, for example, the risk of choking.

We acknowledged that the service was engaging agency nursing and care staff to cover predicted gaps and it was when staff were absent at short notice that further gaps occurred, for which agency staff were not always easily available. The service was actively recruiting for nursing and care staff and was waiting for pre-employment checks to come through for several recently recruited staff. Therefore they were taking action to address the shortage of permanent nursing and care staff.

We recommend that staffing levels are regularly assessed and monitored to make sure they are flexible and sufficient to meet people's individual needs and keep them safe.

Several incidents of unexplained bruising and skin tears had been reported both to the local authority and to the Care Quality Commission (CQC) since June 2016. We viewed risk assessments and associated care plans for areas of risk. These included assessments for falls risk, mobility and dexterity, personal safety, skin integrity and risk of pressure sores, nutrition and risk of choking. The associated care plans were person-centred and identified the care required to minimise each risk. The assessments and care plans had been updated monthly and were up to date. Staff were clear to report any incidents of bruising, skin tears or other accidents or injuries and these were recorded.

An incident form was used for recording all incidents and accidents and these included details of the injury and the action taken following discovery of the injury, for example, being seen by the GP or attendance at hospital. The form also included any action taken as a result of the injury to minimise the risk of recurrence. Where people were on daily observation charts we noted some had not always been completed but we saw people were receiving the care, so the records did not reflect all the input people received. The registered

manager took action at the time of inspection and met with staff to reiterate the importance of ensuring all documentation was kept up to date.

Requires Improvement

Is the service effective?

Our findings

We asked staff about the training and support they received. They told us the service provided a good amount of training and topics included safeguarding, food hygiene, dementia awareness, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), moving and handling, COSHH, First Aid and fire awareness. The majority of the training was done online and staff said they found this good and there was a test at the end for which they had to gain 100% in order to pass the training. Practical training sessions also took place for moving and handling so that staff were observed to know how to use equipment safely. When asked, staff were able to describe the procedures to be followed, for example for reporting safeguarding concerns and when moving people around the service. From our observations we identified that staff did not always follow the training they had received, for example, poor moving and handling practices, which needed to be addressed.

Staff said they had regular one to one supervision sessions every one to three months to discuss performance, training and development and any other identified areas of their work. Group supervisions had also taken place to discuss specific topics. We saw records of recent group sessions and these had included safeguarding and reporting of incidents, dementia and challenging behaviours, MCA and DoLS with best interest assessments. Records of supervisions for each unit were maintained to evidence these had taken place.

Staff understood the different types of meals people required to meet their needs, for example, fortified food, pureed or 'fork mashable' foods and thickened fluids. We saw this was provided for people and the cook was clear about people's nutritional needs and food preferences, so these could be met. Staff also ensured people were sitting in the correct position during meals to minimise any risks such as choking, to maintain their safety.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since October 2015 and was registered with the Care Quality Commission. She was experienced in managing care homes for older people and had a recognised qualification in management. The deputy manager had recently left the service and the provider was in the process of recruiting to this post.

We received mixed feedback from staff regarding the management of the home. Comments from staff included, "I really enjoy working here, this is my second home.", "Manager gets stressed and takes it out on the carers." "[Manager] has good knowledge but a short temper" and "I am very dedicated to what I am doing but I have been demoralised. The manager is unpredictable." Some of the long term staff had found the registered manager's style of management difficult to adapt to and felt the atmosphere at the service had changed. One told us, "I've never seen Derwent like this before." Three staff told us the manager took on board any points they raised and took action to get things addressed, for example, obtaining new equipment when required. We spoke with the registered manager about her management style and she did not pass comment.

There was a system for monitoring individuals, for example, monitoring of skin tears, infections, pressure sores and invasive devices such as catheters or feeding tubes so action could be taken if concerns arose. The registered manager was using a spreadsheet to monitor the progress of the safeguarding cases and the incident reports included information on the action to take to minimise the risk of recurrence. The registered manager was aware of the significance of safeguarding procedures having not being followed and was reporting any potential safeguarding concerns to the local authority safeguarding team.

The maintenance person carried out monitoring checks for premises and equipment including emergency lighting, nurse call system, fire equipment, water outlets and temperature checks to ensure these were safe and in working order. The company documentation did not include a section for wheelchair checks and the maintenance man had been recording monthly checks separately. The provider said they would look to include these checks in future documentation. There had been a recent survey about the food provision and the cook said the menus had been reviewed in light of the feedback and new menus were being introduced shortly.

The registered manager had daily flash meetings with the heads of department to discuss any issues or concerns and to ensure everyone knew what was happening in the service that day. Staff told us that following our first day of inspection there had been a meeting to discuss the concerns identified and action had been taken to start addressing them, for example, ensuring the daily care records were being kept up to date.

Notifications were being sent to Care Quality Commission (CQC) for notifiable events, so we were being kept informed of the information we required. For some of the safeguarding concerns raised since June 2016 the incorrect notification had been used. We had discussed this with the provider and this had been addressed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were established but had not always being operated effectively to prevent abuse of service users. Regulation 13(2)