365 Care Homes Limited

Delph House

Inspection report

Wisbech Road
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Tel: 01354610300

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08 May 2019

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Delph House is a residential care home that was providing personal care without nursing to up to 22 people aged 65 and over. At the time of our inspection there were 19 people using the service.

People's experience of using this service:
People experienced mostly good outcomes of care. The service had recently appointed a new manager who was working alongside the existing registered manager who was on leave at the time of our inspection. Once registered the existing manager was going back to the service they originally came from which is owned by the same provider. The service provided safe care to people because it had adequate systems and processes in place to ensure risks were identified and well managed. There were enough staff who were familiar with people's needs.

People lived in a clean environment and there were plans in place to continue to refurbish and redecorate the home and improve signage which would help people navigate their way around.

People received support to stay healthy and access other services as needed. Staff were sufficiently trained to meet people's needs and the manager had identified a range of additional staff training to help enhance staffs existing skills. They had also established regular staff supervision and observation of practice.

People were given medicines as needed and staff received the necessary training and assessed as competent before it was prescribed.

Most people were happy with the service provided and there were a range of social activities to support people's individual needs. Several people said activities were restricted in terms of staff's availability and there was less to do in the afternoon and evening. Staff were allocated to oversee and provide activities each day but usually in the morning.
Staff were kind and caring and upheld people's dignity. We were confident that the service was moving forward and there was a clear plan of action and enough management oversight. Some improvements had only recently been implemented and were not yet firmly embedded.

Rating at last inspection: The service was rated Good at the last inspection on 01/11/2016.

Why we inspected: This was a planned inspection to assess if the service was still providing a good service.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 safe

Details are in our Safe findings below

Good

Is the service effective?

The service was effective

Details are in our Safe findings below

Good

Is the service caring?

The service was caring

Details are in our Safe findings below

Good

Is the service responsive?

The service was responsive.

Details are in our responsive findings below

Good

Is the service well-led?

The service was well- led

Details are in our well-led findings below

Good

Delph House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was undertaken by 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.

Service and service type: The service is a residential care service for people who are predominantly over 65. It does not provide nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced. We started the inspection visit on 8 May 2019 and finished the inspection in one day.

What we did:
As part of the inspection we reviewed the information we already held about this service. This included previous inspection reports, notifications which are important events the service are required to tell us about. A provider information return was sent by the service but not used as part of planning this inspection. A PIR provides us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

On the day of our inspection we spoke with eight people, we viewed records including three care plans, staff records and other records relating to the management of the business. We carried out observations and checked the environment to ensure it was safe for people. We spoke with the provider, the manager, the

domestic, the cook and three care staff.

Good

Is the service safe?

Our findings

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse

● Staff spoken with had a good understanding of what might constitute a safeguarding concern. They knew when and how to report concerns. Staff were confident that the manager would act on their concerns and felt people were sufficiently protected from avoidable harm and abuse.

● There was clear guidance for staff to follow and operating procedures staff should follow when a person had been placed at risk in some way or had occurred an injury or bruising.

Assessing risk, safety monitoring and management.

●The service was designed with people's safety in mind. We did however notice the kitchen door was left unattended and unlocked once which could have placed people at risk.

● Equipment was regularly checked to ensure it remained safe to use. Staff were trained to use the equipment and there were emergency contingency plans to support staff with actions they must take in an emergency.

● Regular testing of the fire safety systems and extinguishers took place and there were individual fire risk assessments illustrating what support people might need in the event of a fire. Fire risk assessments were up to date and fire drills helped to ensure staff knew how to evacuate safely.

● Radiators were covered, and water tested to ensure it did not exceed recommended temperatures. This helped to reduce the risk of injury from scalding. Windows were restricted and there were regular checks on restrictors.

●We were assured the grounds around the property were secured but there was no additional security such as CCTV. We noted there had been an incident in the service where a person had left the service unknown to staff and had ended up in the dyke. The staff were praised by the lead safeguarding investigators for their swift and decisive action which meant the person was not harmed. The safeguarding concern was not upheld. Following the incident, the provider took necessary steps to review the safety procedures to reduce the likelihood of further incidents.

Staffing and recruitment.

●People generally felt there were enough staff to meet their needs and keep them safe. One person said, "Yes (I feel safe). It's the staff. They could always do with more (but) they come quickly if I buzz." Another said, "Yes, (I feel safe). I don't see much of the staff, only when we come in and go out. Staff do what I want

them to do."

●The service had enough staff to deliver safe, effective care. Staff typically told us there were enough staff. One staff said, "staffing levels are okay all staff pull together, we give continuity to our residents."

●We reviewed staffing rotas and spoke with people and staff using the service. Arrangements for staffing included at least a senior and the manager available during the day. At the weekend a senior was always on duty and had the back up of a manager on call. There were additional staff responsible for cleaning and cooking.

●The manager assessed staffing levels to ensure they were adequate by walking round the service daily. They told us they had identified a dependency tool which they were going to implement to help evidence how staffing hours matched the needs of people using the service. People's needs were known, and this was taken into account when planning staffing.

● The manager was aware recruitment processes needed to improve. Staff files included pre- employment checks which established a person's work history, references, address, health and any history of offences which might make them unsuitable for employment. Disclosure and barring checks would confirm this and were requested by the service. Staff records we looked at did not include evidence that new staff had a robust interview. Notes were not kept showing how the candidate had been recruited in line with the personal specification and up to date job description. The manager said in future they would be adhering to best practice and have two senior staff interviewing and would like to involve residents in the recruitment process.

Using medicines safely.

People told us they received their medicines as required. One person said, "Tablets are on time and always available. (Staff member) stays with me until I take them." Another person said, "I don't have any tablets; I just ask if I need painkillers and they bring them."

●Additional staff were being trained and assessed as competent to give medicines to ensure there was always a member of staff on duty able to give medicines.

●We observed medicine administration, and this was done appropriately. The senior was very personable ensuring people took their medicines as prescribed and checking whether people needed medicines that was prescribed when necessary.

●Systems for medicines were robust. Staff were trained and assessed as competent before being asked to administer medicines. Staff training was kept up to date to help ensure it was in line with best practice.

●Medicines were supplied in blister packs, (bio dose system,) and there were robust procedures in place for ordering and accounting for tablets, including a return policy.

●Two people were insulin dependent and some staff had been signed off as competent to administer insulin with accountability to the district nurse. Staff confirmed that a diabetic care plan was in place and guidance viewed was sufficient. An insulin grab bag was in place and staff were aware of it. Two people were prescribed warfarin and the district nurses visited and monitored people's bloods. There was a first aid station upstairs which was accessible should staff need it.

●No one administered their own medicines, but the manager assured us there was a clear process should anyone wish to do so. One person who could be acutely unwell sometimes refused their medicines but there were clear processes in place to account for the medicine, return it and refer them to the GP for advice.

● Each person had individual medicines guidance including an up to date photograph. Daily audits were in place for occasional use medicines.

Preventing and controlling infection

●The service was clean. We noted there was a domestic vacancy which put a strain on the existing domestic arrangements. The domestic staff told us they deep cleaned at least two rooms a day and could keep on top of the cleaning, but it was hard work.

● They had a good understanding of infection control and the procedures they should follow to minimise the spread of infection. We observed staff wearing the correct personal protective clothing.

Learning lessons when things go wrong.

● The service had very few incidents or safeguarding concerns but there were appropriate records. We asked about lessons learn as we could not see a clear record or processes to learn from adverse events. For example, for the man who left the service, although this incident was well managed, we noted that people did not have a missing person form in their care plan and there was poor lighting/ security which could have been a learning outcome from this incident. The manager immediately agreed to review their procedures to ensure continuous learning. The provider has since confirmed that there are emergency contingency plans in place which they said were in place at the time of our inspection. They also said they had adequate internal and external lighting.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

● Prior to admission to the service, people's needs were assessed in line with the homes statement of purpose to assess if the persons need could be met within the service. Staff considered the views and wishes of people using the service and their family, as well as requesting professional assessments as required.

● People confirmed that they were asked about their needs. One person said, "Yes, I was asked about my history and preferences when I came into the home, not since then."

● People's needs were kept under review and staff took into account changing or unmet need through regular monitoring.

Staff support: induction, training, skills and experience.

●Staff received training in line with their job role and their training was mostly up to date. Both e-learning and face to face training was provided to staff and staff's competencies assessed. The manager had established regular supervisions for staff.

●The manager had reviewed staff training to bring it up to date and to ensure all staff completed client specific training, so they could adequately meet their needs. For example, they were currently ensuring more staff were trained to administer medicines to take pressure of existing staff. Some staff told us they had not done end of life care although some had completed an e-learning module. The manager had arranged for staff to visit the funeral directors to look at the end process and have a greater understanding of their role.

●Senior staff either had or were working towards an enhanced qualification in care up to level three. One staff had requested to do their level five. The manager was developing staff champions which meant staff would have oversight for an area of practice such as health and safety and infection control. They would take the lead and have more enhanced training, so they could be a frame of reference for other staff.

●The manager told us that no staff were currently doing the care certificate a standard, national induction which covered all the modules considered essential to work in care. They said this was because staff either had or were working towards a qualification in care. There was an in-house induction staff completed, and new staff were initially supervised.

● One person we reviewed had very complex needs which the staff were managing well but felt the training was not sufficiently in-depth which could make it difficult for less experienced staff to meet their needs. Supporting people to eat and drink enough to maintain a balanced diet.

●People were mostly complimentary about the food they received, and the cook was experienced and knew people's dietary needs well. One person said, "The food is good." Another said they liked a late breakfast, and this is what staff gave them. One person told us, "The food is good, there's plenty of it and the sweet is always nice. We have an evening meal about 5pm, it's always nice. Things on toast, cake afterwards, a cup of tea."

● Catering staff were employed to prepare breakfast, a lunch time main meal and an evening light snack. There was seven day a week cover. The cook was able to tell us about people's preferences and any allergies or food tolerances. There was a four- week menu plan which took into account peoples wishes.

● The cook said they were not aware of anyone one with recent unplanned weight loss. The provider told us the cook was part of the staff handover, so any risks associated with weight loss would be passed on. The cook said they fortified food as required and prepared milkshakes, snacks and finger foods. For those identified at risk of unplanned weight loss. We viewed people's weights but had to go into each individual record to see them. There was no overarching system to review people's weights over a longer period to assess any regular or high weight loss or gain. Everyone was weighed monthly which did not assure us on a sufficiently individualised approach. The provider however assured us there were no current concerns with anyone's weight.

●The kitchen had been awarded three out of a possible five stars from environmental health services and some remedial works were required and were almost complete.

● Guidance was in place for people on specialist diets, or fluid thickeners. Assessment were in place for people who were at risk of choking due to swallowing difficulties. This helped ensure people were not placed at unnecessary risk and staff had clear guidance to follow. Although food and fluid charts were kept when necessary these did not include individual fluid targets which would help to evaluate if the person was drinking enough according to their average intake.

Staff working with other agencies to provide consistent, effective, timely care.

● Evidence from records was provided of holistic care with the service contacting other agencies when appropriate for support, guidance or follow up visit to ensure people's needs were being met. Guidance was in place in people's records.

Adapting service, design, decoration to meet people's needs.

● The premises had been adapted so it was fit for purpose and safe for people. A few environmental issues had been identified. The home was large, and a number of people had cognitive impairment. There was poor signage around the service which if improved would help people find their way around the service more easily. The manager told us they planned to personalise people's bedroom doors to help them recognise their rooms.

● Some renewal and refurbishment were being undertaken. There were plans to extend the laundry and the kitchen and improve these areas in line with recommendations from the environmental health department.

There were plans to redecorate throughout. A new lift had been installed at considerable cost and there was also a chair lift for people to use.

●Bedrooms were personalised, and people told us they were comfortable in the home.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to access health services where appropriate in line with their specific needs. Staff kept records demonstrating how they monitored people's health and identified potential risks to people's safety, such as a risk attributed to not eating or drinking enough. Most people were on fluid records and these were checked daily. Some people were regularly turned when in bed to ensure their skin remained intact and people had the equipment they needed. Turn charts were in place and checked regularly.

● People had access to a GP and a range of other services and there was guidance for staff to follow to ensure people's needs were met.

Ensuring consent to care and treatment in line with law and guidance.

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●The Local Authority had granted a number of deprivations of liberty safeguards. The manager said they were currently reviewing who had a DoLs in place, and who was still waiting for theirs to be authorised. They had a tracker with all the relevant information and understood the requirements in relation to the legislation.

●Staff clearly respected people's choices and decisions and felt they knew people well so could anticipate their needs.

●People's capacity to make decisions had been assessed and care records viewed gave some guidance about whether people had capacity and who should be involved in making decisions in a person's best interest where they lacked capacity. Mental capacity assessments were not task and time specific as we would expect.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity.

● People told us staff were caring and no one had concerns about how they were treated. One person told us, "I can't complain myself and I've never heard anybody (be unkind)." Another said "Yes, yes (staff are kind and caring). One person said, "There's a lot of happiness here. We laugh and chatter.

●We observed positive staff interaction and good engagement.

Supporting people to express their views and be involved in making decisions about their care.

● People told us staff asked them about their daily routines and resident meetings and surveys were used as more formal ways of gaining feedback about the service. We saw minutes from resident meetings which were well attended but had not been regularly established in the past.

●Peoples choices could be promoted more within the service if literature was up to date and staff offered choices in a more robust, person centred way. An example of this would be menus readily available and food plated up to give people a visual choice.

Respecting and promoting people's privacy, dignity and independence.

● People told us staff upheld their privacy and dignity. One person said, I haven't had a bad carer yet. Yes, wonderful little carers. Always very gentle." Another said, "Yes, the staff are very good. I don't know about training but they're alright with me."

●We observed staff respectfully addressing people and speaking with them in a way that was appropriate. People told us staff upheld their privacy and dignity. One person said, "They shut the door and curtains, yes, yes." Another person said, "Yes, staff knock on the door and wait, they close the curtains etc."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good :This meant people's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

●Staff were mostly responsive to people's individual needs although we did receive some mixed feedback about the range and scope of activities provided. The provider told us activities were provided daily and a staff member was designated to provide activities in the morning and in the afternoon, staff supported people with their individual needs and hobbies. The provider confirmed trips took place and the service had a mini bus. They told us it was not possible to take everyone out and trips were weather dependent. They gave us example of trips that had taken place and said these were evidenced through photographs and pictures on the closed social media site. There was an extensive range of books, but one person said there were not enough reading books and they loved to read. We discussed this with the provider to help ensure staff were promoting people choice and making books accessible.
●Some people suggested there was not always much to do particularly in the afternoon and evening and was dependent on how busy the staff were. Staff and people using the service told us the home could be very busy which could impact on people's experiences and time they were able to receive from staff, although in the main people felt there were enough staff. An activity list was in the staff room and all staff promoted activity as much as they could within their hours.
●Staff told us there were links with the women's institute and had school children to sing at Christmas and singers once a month. Physical exercises were a regular feature at the home to help promote people's mobility. Staff said activities took place and they had recently celebrated Easter, having a special tea, Easter eggs and making Easter bonnets. People confirmed there were some planned activities particularly around significant dates.

●Care plans included people's background and social history which helped staff understand people's needs better. Care plans were put in place following an assessment of their needs and any risks to the persons safety. A plan of care was in place for each established need and risk and these were kept under review. Staff consulted with residents and families about their needs and wishes.

Improving care quality in response to complaints or concerns.

●People were confident that they could complain. One person said, "If I had a problem I'm sure someone would help. I would tell them, I wouldn't feel nervous." Another said, "I would talk to any of the staff if I had a problem or complaint." They confirmed there were resident/relative meetings which their family member attended.

● There was a clear complaints procedure which was accessible, and people and their families received a copy of the service user guide telling them what they could do if the service fell short of their expectations.

● There was information at reception including how to give feedback which visitors were encouraged to do to help the manager know what improvements could be made.

●The complaints log only included one recorded complaint which was not sufficiently dated and did not include a clear outcome. We discussed this with the manager and they explained to us how recording would be improved.

End of life care and support.

● At the time of our inspection there was no one approaching the end of their life, but the manager told us how they worked in conjunction with other health care professionals to provide as holistic care as possible.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

Good: This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

● The service had undergone a number of recent changes to the service with several different managers. There was a registered manager in situ who was overseeing two homes owned and managed by the same provider. In the future they were going to oversee and manage one home and a new manager had been appointed to Delph House. They were going through the process of registering with CQC as the registered manager. They were well supported by both the registered manager and the registered provider who was there most days. The provider had acquired a third home which both managers had been supporting to 'start up.'

●The new manager had suitable and relevant experience. On their arrival they had completed a series of audits to determine what their priorities should be in terms of improving the safety and effectiveness of the service. A detailed action plan was in place and being worked through. This had not been updated since the 22 March 2019 and we had requested an up to date copy to assure us the manager was addressing all areas identified. We had not received a copy at the time of writing the report but have not followed this up with the provider.

●Service improvements were being driven by the manager rather than the provider but there was regular consultation about improvements needed and the manager told us the provider was supportive of them and they had autonomy to make any changes necessary.

●During our inspection the provider arrived and clearly knew people and staff well. They engaged with people easily and were responsive to people's requests.

●The feedback we received from people was mainly positive, although some people were not clear about the management arrangements in the service or how they could influence decisions within the service. For example, three people told us they had not been asked what they wanted. One person said, "No, staff don't ask for opinions." Another said, "No-one comes to ask (if I would like any changes or improvements.) Another said, "I'm not asked if anything different is wanted, such as menus." The provider was able to reassure us and tell us how people were involved through individual reviews of their care, residents' meetings, daily contact with the manager and annual surveys to ascertain how the service was provided in line with people's needs.

●The manager had developed a monthly monitoring report to assess the effectiveness of the service. Residents' meetings were being firmly established and there a quality assurance programme of audits and reviews which included feedback from people.

●People told us they would not necessarily ask for things, for example one person said they would like a better chair. Other people told us they were happy for example one person said. "You can't better it; the people are lovely, they treat you properly. I wouldn't want anything changed."

●In the entrance lobby we observed various documents and information. The Service User Guide required updating. It referred to a previous manager. It also stated there were three touch screen computers for residents (the manager told us that tablets provided were not able to be used due to poor WIFI signal and that there was one desktop computer available for residents). The guide also referred to a hairdressing facility; We saw a hood hairdryer in a bathroom but no salon or dedicated room. The safety of the service was paramount, and the manager had replaced equipment and was looking to refurbish the service as appropriate.

●The manager told us they provided an out of hours on call but there was no written procedure for this and not all staff were aware of who was on call. This could lead to delays in them seeking out of hours support.

●We did not meet the registered manager as they were on leave but received good feedback from staff and people using the service about the management of the service. Staff told us how engaging the new manager was and worked alongside staff supporting and mentoring them which had a positive effect on their motivation.

●Staff told us there had been lots of positive change in the service of late and things were more organised. Examples included ensuring people had the equipment they needed, individualised walking frames and wheelchairs and the return of unused equipment. Staff said the manager was looking at staff roles and responsibilities and supporting staff to take a more active role in the home.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

●There were planned and regular audits to help ensure the service was safe and equipment used was in good repair. People were assessed for bespoke equipment and each person where required had their own manual handling sling. We looked at a sample of audits including medication audits, health and safety and cleanliness audits. These included an action plan to show how deficits would be addressed.

●There was a written handover between each shift to help ensure staff were aware of any immediate risks or plans for the day. The provider told us that he carried out night checks, but this was not recorded, and we suggested it would be helpful if they could evidence how they monitored care delivery over a 24-hour period.

●The manager had developed a checklist which was completed regularly and helped to show how she monitored the safety of the premises and how they were meeting the regulated activity.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

● The manager had sent out surveys to ascertain people's feedback but had not yet got them all back or completed an analysis of the finding. The last survey was in 2018 but results were based on very little feedback, so it was difficult to draw conclusions which were representative.

● The new manager had set up meetings for staff, residents and family and going forward planned to have them more frequently. We could not see anything around the service about when the next meeting was planned, and people did not have access to minutes or evidence of how the manager had acted on people's feedback. They assured us any issues were responded to immediately and they planned to have a 'you said we did' board to help show actions taken.

Continuous learning and improving care.

● Systems had been put in place to capture data and provide an overview of where the service was in terms of compliance. We had every confidence in the management arrangements and their ability to address the shortfalls within the service. When addressed this would enhance people's experiences, but to do this they needed to clearly establish priorities based on people's needs and wishes.

● Learning lessons from adverse incidents and accidents needed to be more robust and shared with staff as part of their learning.

Working in partnership with others

● Staff had established links with the local community which could be strengthened by regular participation and engagement. Family members and visitors were made welcome and consulted as appropriate.

●The service regularly engaged with other health care professionals in line with people's assessed needs.