Barchester Healthcare Homes Limited

Derham House

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection was unannounced and took place on 11 and 12 December 2014. The provider was meeting legal requirements at the last inspection in October 2013.

Derham House is registered to provide accommodation for 64 people who require nursing or personal care. The service provides care to people living with dementia, older people who are physically frail and people in need of nursing care. The service also provides an end of life service with support from the local hospice.

At the time of inspection there was a registered manager in place. '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.'

People told us that they felt safe and that they trusted the staff who cared for them. There were arrangements in place to ensure that people were protected from abuse or harm because staff were aware of how to identify, manage and escalate risks. Regular risk assessments in

Summary of findings

relation to the service provision, delivery of care and the environment were completed. Medicines, were stored, handled, administered and disposed of in a safe and consistent manner.

Staff were aware of the emergency procedures to take in the event of a fire or a medical emergency. We reviewed staff rotas and found that staffing levels were in line with what staff and the manager had told us and ensured that there were enough staff on duty to meet the needs of people. Sickness and short term absence were covered by staff or by regular bank staff and agency staff were only used as a last resort.

Care was person centred, planned and reviewed in a timely manner. Staff were supported to deliver effective care because the service ensured that staff attended regular supervision. Training and appraisals of staff also took place. There were systems in place to ensure consent was sought before care was delivered. Staff had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). However care staff when asked demonstrated limited knowledge about DoLs.

We found that people were supported to eat a balanced diet. Specialised diets were catered for and regular nutritional risk assessments were completed in order to detect any malnutrition.

People told us that staff were caring and attentive to their needs. We observed that staff were caring and compassionate and listened to people who used the service. Call bells were answered promptly so that people did not have to wait for prolonged periods of time for care to be delivered.

Care plans included people's personal preferences including cultural and religious beliefs and hobbies. People including those who chose to stay in their rooms were offered activities in order to keep them engaged.

The service had systems to ensure that the quality of care delivered was monitored. There were clear leadership structures and staff were aware of their individual responsibilities. People and their relatives were aware of the complaints process. We saw evidence that people's views were listened to and where required changes were made to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us that they felt safe and trusted the staff who looked after them. There were procedures in place including regular risk assessments to ensure that people were protected from harm and abuse.

Medicines were ordered, administered, stored and handled safely.

There were safe recruitment practices which included appropriate checks to ensure staff were able to work with vulnerable adults.

Is the service effective?

Requires improvement

The service was effective. People told us that they were happy with the staff that looked after them. There were procedures in place which management followed to ensure that staff received regular training, supervision and appraisals.

Most staff were aware of the Mental Capacity Act (2005) and senior staff demonstrated knowledge of how to lawfully deprive a person of their liberty. Capacity assessments were specific and involved relatives and the GP. Although care staff had completed Mental Capacity training they relied on nursing staff knowledge to assist them to apply this in practice.

Is the service caring?

Good

The service was caring. People and their relatives told us that staff were kind and treated people with respect. We observed that staff treated people with dignity and respect by waiting for them whilst supporting them to walk or eat at an appropriate pace.

Staff demonstrated that they knew the people they were caring for including their preferences and personal histories. People were cared for by staff who were compassionate.

Is the service responsive?

Good

The service was responsive. People were involved in planning their own care and told us that staff respected their preferences.

Regular feedback was sought from people during meetings and annually through a satisfaction survey and results were acted on in a specified time frame.

People told us that they were able to make complaints and felt that the manager and staff listened to their complaints and took remedial action.

Summary of findings

Is the service well-led?

Good

The service was well-led, with good leadership from the registered manager and managerial staff. The provider was aware of their obligations in relation to working with the CQC and other agencies.

People and their relatives told us that they could speak to staff or the manager about any concerns they may have and told us that there was an open and honest culture.

There were clear leadership structures and systems to monitor the quality of care provided. Where shortfalls were identified action plans were implemented to remedy these in a timely manner.

Derham House

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 December 2014 and was unannounced.

The inspection team consisted of two inspectors.

Prior to the inspection we gathered and reviewed information we were given by the local authority and the local Healthwatch. We also reviewed the service's website and information we had received from the service relating to deaths and safeguarding notifications.

During the inspection we spoke with12 people using the service, five relatives and friends. We interviewed 12 staff including the manager, care staff, the chef, the activities coordinator and the head of maintenance. We also observed the care and support people received and the interaction of staff with people using the Short Observational Framework For Inspection (SOFI) for 40 minutes. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed care interactions between staff and people as well as between the visiting chiropodist, the hairdresser and people. We reviewed seven people's care records, 10 Medicines administration record charts, and three staff files.

Good

Is the service safe?

Our findings

People told us that they felt safe in the service. Relatives told us they thought the home was secure. Reception was manned by staff during the day to ensure that everyone who entered the home was verified and to stop strangers from gaining access to the service. We saw that entrance to both units was via keypad access system which was made known to relatives and people who used the service. People and their relatives said they were able to raise concerns with any member of staff. One person said, "I feel quite safe and secure here." Another said, "there is always staff on hand to help me when I need help."

We saw that risk assessments were in place so as to minimise harm to people using the service. These included moving and handling, falls, nutrition and swallowing. Staff were aware of how to complete these assessments and could tell us how they mitigated risks once identified. For example for people at risk of developing pressure sore, regular turning regimes were in place. For people with swallowing difficulties they were always assisted to eat whilst sitting up. Staff were aware of the procedure to follow in the event of a fire or a medical emergency. Regular risk assessments on the environment were completed by a maintenance man. Procedures were in place to ensure that premises and equipment were maintained. Staff told us how they followed these daily and could tell us how and where they reported any faulty equipment or any identified health and safety risks. Hoists and lifts were regularly serviced and gas, electricity safety checks were completed.

We found that people using the service and staff were protected from bullying, harassment and harm. There was an open culture that promoted the reporting of incidents and concerns. All care staff had received training that included safeguarding adults, dementia awareness and manual handling. We spoke with staff who told us about training they had received and demonstrated their understanding of the procedures for alerting senior staff and managers of any potential or actual harm or abuse. We saw evidence of this training within their staff files. There was a reporting hotline that all staff were aware of and felt comfortable to use, and all staff told us how they would talk to the nurse or registered manager about any concerns they had.

The service followed a robust recruitment policy to ensure they recruited staff safely. From reviewing three staff files, we saw that they had all completed all their induction training, they had relevant care qualifications and where required nursing accreditation. There were two references, criminal records checks and evidence of identity in each file we reviewed. The manager told us how they followed their disciplinary procedure in order to identify and stop staff from delivering unsafe care. We saw evidence of this process documented in one of the staff files we reviewed where the policy had been used to issue a formal warning.

Staffing levels were reviewed regularly by the manager depending on the needs of the people. People and staff said they thought there were enough staff to support people on both the day and night shifts. We reviewed the rotas from November 2014 till 12 December 2014 and found that staffing was in line with what people and staff told us. Sickness and absence was covered by staff and a pool of regular temporary staff. There was minimum use of agency in order to ensure that people were cared for by consistent staff who knew their needs

We checked ten medicine administration record sheets (MARS) and found no gaps or discrepancies. We observed staff administering medicines in a safe way. They checked that they had the correct medicines and the correct person before administering these and waited to ensure people had taken medicines before signing the MARS. The medicine trolley was kept locked and secure in a separate locked room when not in use. We were told that staff were competency assessed before they administered medicines. We saw three competency records for staff who administered medicines which were completed to ensure staff adhered to safe administration guidelines. Staff we spoke with were able to tell us the procedure to order medicines monthly and the procedure to dispose of medicines after they have been discontinued or after and after a person's death.

Medicines including controlled drugs were stored, handled, prescribed, administered, and disposed of in an appropriate manner. Where medicines were given covertly there were clear procedures for giving medicines, in line with the Mental Capacity Act 2005. These included a mental capacity assessment specifically for medicines and advice sought from the GP and sometimes a pharmacist where the medicine was not always available in liquid format and needed to be crushed.

Requires improvement

Is the service effective?

Our findings

The service was effective in delivering care and support to people living in the home. People told us that they were happy with the staff that looked after them. One person said, "Staff are very good. They seem to know what they are doing." Another said, "I can't fault the staff at all. They call the doctor for me when I get ill." People and relatives had mixed reviews about the food. Most people enjoyed the food whilst two people said the food quality and presentation could be improved.

We observed that consent was always sought for treatment and care, with care workers always offering choices to people using the service and gaining their consent for personal care. Staff we spoke with had an understanding of capacity and consent and the importance of not using physical restraint. All the care staff told us how they involved people in decision making, which was also demonstrated within the care plans and through feedback from relatives that we spoke with. One care staff told us of different methods used to communicate with people who are unable to speak, but were able to make decisions through pointing, nodding and body language. Although care staff had completed training on the Mental Capacity Act (2005) and DoLs they did not have a clear understanding of this and said they would always ask the nurses. We informed the manager of this and they said they would reassess and check their understanding. This did not have a direct impact on people as there was always a nurse on duty to support care staff.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the Mental Capacity (Act 2005) and Deprivation of Liberty Safeguards.

The manager and nursing staff were knowledgeable about the Mental Capacity Act (2005) and how to apply it in practice including when they needed to apply for a DoLS authorisation. We saw a folder with current applications still awaiting authorisation. Mental capacity assessments were in place for processes such as covert medicines administration and Do Not Attempt Resuscitation (DNAR). We reviewed four DNAR forms and four covert medicines risk assessments and found that the decisions had been made with evidence of discussion with the person, the family and a health care professional such as a GP.

We found that staff were supported to deliver effective care by means of an induction when they first started working at the home. We reviewed three staff files, including supervision records, which showed us how issues could be brought up with managers and discussed, with clear actions arising from them. Staff received regular supervision, annual appraisals and training. Staff told us they were happy with the training they received and some were in the process of obtaining their diploma in social care. Support for this was provided by staff within the home and a trainer who came in to assess staff progress. There was also an apprentice programme aimed at introducing young people to care. On the day of our visit we spoke to the trainer and an apprentice who told us about the programme. The programme consisted of a mixture of practical assessments and computer based assignments.

We reviewed training records and found that there was a dedicated trainer within the service and there was a matrix in place to ensure attendance was monitored and training that was due was provided in a timely fashion. Although training and appraisals were not yet fully completed we saw a dated action plan that aimed for most of the training to be completed by January 2015.Training included fire safety, safeguarding and infection control.

We saw staff ensured that people received their food in a timely manner and that those who needed assistance to eat were fed at a pace that was comfortable for them. Menus were planned with two options for lunch and supper. Systems were in place to ensure that catering staff were aware of the dietary requirements and allergies of people at the service. Staff were able to demonstrate knowledge about the nutritional needs of the people they looked after including telling us the needs of people with diabetes and those on a pureed diet. We saw staff asking people what they wanted to eat and their choices were accommodated. We saw that food temperature probe checks were completed to ensure that meals were served hot. Staff carried out assessments to monitor and identify people who were at risk of dehydration, weight loss and malnutrition so appropriate action could be taken to minimise the risks. We saw that referrals to a dietitian had been made for people who had difficulty in eating sufficient amounts. Where the dietitian made recommendations, these were implemented by staff.

People's health including weight and food intake was regularly monitored. A GP visited weekly and was available

Requires improvement

Is the service effective?

when required to review peoples' condition. We saw evidence that people were sent to hospital if their condition deteriorated. Care workers told us they always escalated to the nurse if they noticed any changes in the people they looked after. We saw evidence of this in the notes we reviewed, For example we noted that vital signs observations were completed and a GP was called out to see someone who was unwell. We saw that referrals to other professionals such as speech and language therapists and, dieticians were made when people needed access to theses.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and treated people with respect. They said staff listened to them. One person said, "Staff are very attentive to my needs." Another person said, "So far, I have been treated very well and have freedom to do and say what I want. A relative said, "Mum is looked after here. All the carers seem to know mum very well and they come fairly quickly when she calls."

People were treated with kindness and compassion. On the day of our visit there was a person receiving end of life care. We saw staff respond positively to the relatives by reassuring them and calling other relatives to come and be with their family member. We saw that staff ensured that a member of staff was always on hand to support the family and the person during their last few hours of life offering pain relief, change of position for the person and refreshment and a listening ear for the family.

People were involved in making decisions and planning their own care. People told us they chose what they wore and how and where they spent their day. One person said, "I chose my room, mainly because of the lovely view I have." Documentation in people's files showed people's involvement in decisions about the food and about how their rooms were decorated. We saw that people were treated as individuals, and were able to ask staff for what they wanted and needed, and that the care workers took their time to sit with them and support them as they wanted.

We saw people in the lounge were supported by care workers, who responded to the people with care and empathy, supporting them to eat and drink. People were not rushed and were able to move around and ask for anything they needed. Staff responded to people in a polite manner. We saw staff took the time to explain things to people. For example one person asked if their daughter was still coming to visit and staff told them they would call to confirm.

We observed that people who used the call bell were responded to within two minutes. We saw staff assisted people to go to the toilet or to go to their rooms or other parts of the service as and when requested. Staff sat down with people and spoke with them about their day whilst completing individual care records such as what they ate and drank and whether they had any pain or concerns. We saw staff responding to people who expressed concerns about pain or constipation by informing the nurse who took appropriate action. Staff also ensured people who were confined to their bed were made comfortable by changing their position as required.

Staff demonstrated that they knew the people they were caring for including their preferences and personal histories. For example staff new the names of one person's son and told us that another person was interested in politics as they had previously worked in government. Staff understood people's needs regardless of their gender religion or belief. Staff gave examples of how some people of a particular religion were visited regularly by their spiritual leaders. Peoples preferences related to same gender carers was also respected and achieved. This was addressed in their care records.

People were treated with dignity and respect. Staff took the time to listen to people's requests and spoke to people in a way they could understand. We saw staff getting down to people's level when speaking with them. People who needed support with personal care were assisted regularly and doors were kept shut during personal care and toileting. We saw staff assisting people with limited mobility to get up and gain their balance before observing them from a close distance whilst they independently walked to the dining room for lunch.

Good

Is the service responsive?

Our findings

The service was responsive to the needs of people using it. We saw that care plans were comprehensive and detailed the involvement of the individual and family members within the plan. Care plans were reviewed and updated monthly. One member of staff told us "it's all about what they want and need. We give them a choice whenever we can and help them to tell us what they want." Staff told us how they delivered person-centred care and strived to involve people using the service in decision making. This was noted within care plans we reviewed that highlighted different ways of engaging people who were unable to communicate verbally and how to support them to make their own decisions about their care and support.

People's care plans reflected how they would like to receive their care. We saw that individual preferences relating to personal care, cultural and religious beliefs were recorded in the care plans we reviewed. For example one person's care plan noted they preferred their teeth to be brushed twice a day. Staff were aware of this and told us this was always facilitated during personal care. Staff told us that they encouraged people to choose what they wanted to do but were also flexible if people changed their mind. For example sometimes people would have chosen to go for an activity but sometimes changed their mind by the time the activity was held.

People were encouraged to stay in contact with friends and relatives as well as continue to take part in hobbies of their choice. Relatives were allowed to visit at any time and activities were arranged daily including weekends. People had an interests and activity log which stated all the activities they attended monthly. They told us and we saw in the files we reviewed that they had one to one sessions with the activity coordinator in their room where they could play games or discuss a topic of their choice. We saw that a person had requested to go out for a meal and this request was met. People also went out for trips to the museum and shopping. Flower arrangement sessions, live entertainment was also available regularly.

There were procedures in place to manage and respond to complaints. Staff were aware of the complaints procedure and told us that they always escalated complaints to the manager. We saw that formal complaints were investigated and responded to. Relatives and people who used the service told us that they would speak with the manager if they had any concerns or with the staff on duty and knew that action would be taken to resolve their complaints to their satisfaction. For example we saw that where the registered manager had received complaints about the food, they have tried to resolve the concerns by bringing another chef from another home to work with the current chef on meal presentation and plans.

There were arrangements in place to obtain feedback from relatives and people. This was done by completing an annual satisfaction survey conducted by an external company. There were regular "Residents Meetings" where people could express their views about the care and treatment they received. We saw that action had been taken following feedback from people about how staff responded to complaints and by retaining staff on how to handle complaints.

Good

Is the service well-led?

Our findings

The service was well-led, with good leadership from the registered manager and managerial staff on the two units. The manager ensured that the CQC received notifications that the provider has to send us by law such as safeguarding concerns and people's death. People and their relatives told us that the provider ran the service in an open manner and they could speak with staff or the manager about any concerns they may have. One person said, "the staff are warm and welcoming. I can make an appointment to see the manager when I need to." We spoke with staff members who all told us the manager was regularly in each unit, talking to people using the service and staff and is approachable and always willing to answer any questions.

People and staff were actively involved in developing the service by means of regular resident meetings and staff meetings. There were also weekly head of unit meetings to ensure any changes were cascaded in a timely manner. The manager told us about a new initiative called "Keep calm and carry on nursing" that had recently been introduced to recognise staff who went the extra mile. Staff also told us about this and we saw previous winners mentioned in the staff meeting minutes we reviewed.

The service had a vision and a set of values that included involvement, compassion, dignity, independence, respect, equality and safety. This was clearly written and staff told us they were made aware of the values when they started to work at the service and were reminded of theses during meetings and day to day care.

Staff told us that they were able to follow up if errors occurred during care delivery and were aware of how to record and report incidents. There were procedures in place to feedback to staff in a constructive manner. Staff told us that mangers were very good at giving them both positive feedback and areas for development and told us there was a no blame culture.

There were systems in place to ensure that quality of care delivered was monitored. These systems included, audits and risk assessments and regular checks to ensure that records of care were reviewed and updated as and when people's needs changed and stored securely. Annual customer satisfaction surveys were completed.

The 2014 satisfaction survey was still being completed. However, we reviewed the September to October 2013 survey results where 41 people had responded through an external company. The manager had completed an action plan where areas for improvement were identified. In that case, action plans were in place for the bottom three scores which were about staff availability to talk with people, staff availability when requested for by people and staff's ability to deal with complaints. We found that as a result, support had been provided for staff as well as regular reviews of staffing levels dependent on people's dependency to make the necessary improvements.