Durnford Society Limited (The)

Tor Vale Nursing Home

Inspection report

Tor Vale Nursing Home, Chittleburn Hill
Brixton
Plymouth
Devon
PL8 2BJ

Tel: 01752480950

Date of inspection visit:
03 May 2016

Date of publication:
28 June 2016

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

Summary of findings

Overall summary

Tor Vale is a purpose-built home for five people with profound learning and physical disability that is registered for nursing care. It is owned and managed by The Durnford Society Limited who run a number of care services for people with learning disabilities. At the time of the inspection five people were living at the home.

This inspection was unannounced and took place on 3 May 2016. At our last inspection in July 2014 we did not identify any concerns.

The home had 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.

All those living at Tor Vale had a learning disability and varying communication abilities. Some people were able to say, "yes" and nod their head when we asked if they were happy living at the home, while others were unable to share with us their experiences. As people could not tell us in detail about their care, we observed their interactions with the staff. People were happy for staff to take their hands, they made eye contact and smiled at the staff. This indicated people felt safe and comfortable in the home. Relatives told us they were confident with the care their relations were receiving and they had no concerns.

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. People's capacity had been assessed in relation to a number of decisions about their care and welfare, such as taking prescribed medicines, the use of monitoring equipment and financial expenditure. However some assessments had not been fully completed. One person had not had a capacity assessment or best interest decision recorded for treatment recommended after a routine health check-up. The registered manager confirmed they would review the home's documentation in relation to these assessments.

Some people were at risk of not eating or drinking enough to maintain their health. Healthcare professionals were involved in assessing people's needs and providing guidance to staff. However, one healthcare professional raised a concern with us that staff had not followed their advice about when to record a person's weight to ensure this was recorded as accurately as possible. Also records were not completed in a way that allowed staff to know how much people were drinking.

We recommend the service reviews the way in which people's diet and fluid intake is recorded, monitored and managed.

Staff had received training in safeguarding people and knew what to do if they suspected abuse. Posters with contact details for reporting any issues of concern directly to the local authority's safeguarding team

were on display. A recent safeguarding incident had been appropriately reported to the local authority's safeguarding team and CQC. Staff were confident any concerns regarding people's safety and welfare would be investigated. One staff member said, "nothing would be ignored". Staff looked out for signs people may have concerns or may not be happy, as many of the people living at the home would not be able to express this.

Risks to people's health and safety were assessed and management plans were in place to reduce these risks. Assessments included risks to people from poor mobility, swallowing difficulties and health issues. Staff were provided with clear instructions about how to meet people's needs safely. People had access to healthcare services when they needed them and guidance was sought from specialist health care professionals where necessary. People received their medicines safely and as prescribed. All staff were trained in the safe administration of medicines although only the nurses administered medicines in the home.

People were supported by sufficient numbers of safely recruited and well trained staff. During the inspection we saw staff spending time with people, supporting them with personal care, eating and drinking and with activities. Staff told us the staffing arrangements varied throughout the week dependent on what community activities people attended. Staff said they received the training necessary to carry out their duties safely and to understand people's care needs. Staff were knowledgeable about the people they supported and were able to describe to us their needs and preferences. Each person had a care file that provided clear information about people's care and support needs. People were supported to maintain a healthy diet and staff were knowledgeable about what food they liked and how to support them to eat and drink well.

People had a named nurse and a 'keyworker' care staff who were responsible for ensuring they received the care and support they needed, were supported with meaningful leisure and social activities, and who communicated with their families. People were encouraged to be involved in a variety of activities both in and out of the home and to maintain contact with their families. One relative said their relation's health and well-being had improved significantly since moving to the home. They described the staff as "marvellous".

As Tor Vale provided nursing care, the home was able to support people should their health decline and they require 'end of life' care. The nurses worked closely with the local hospice to ensure their clinical skills remained up to date and they were able to continue to care and support people through ill health.

The home had effective systems in place to assess people's needs, recruit and train staff and to monitor the quality of the support services they provided. Staff told us the home was well managed and they enjoyed working at Tor Vale. One staff member said, "It's a nice place to work, I like it here" and another said, "I really like working here, we're a good team".

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 home was safe.

People received safe care and support from staff employed in sufficient numbers to meet their needs.

Staff could recognise the signs of abuse, and knew the correct procedure to follow if they thought someone was being abused.

Risks to people's health, safety and well-being were assessed and management plans were in place to reduce these risks.

People's medicines were managed safely and they received their medicines as prescribed.

Is the service effective?

Requires Improvement

The home was not always effective.

People's capacity to make decisions about their care and treatment were assessed. Decisions were made in people's best interests where they lacked capacity. However some assessments and decisions had not been fully recorded.

Where people had been assessed as at risk of not eating or drinking enough to maintain their health, records did not support the monitoring of people's diet and fluid intake.

Staff received the training they needed to understand and meet people's care needs.

People had prompt access to, and were supported by a range of health and social care professionals.

Is the service caring?

Good

The home was caring.

People's privacy and dignity were protected.

Staff treated people with respect, friendship and kindness.

Staff knew people well. They had a good knowledge of people's individual needs and preferences.

As the home provided nursing care, staff were able to care for people at the end of their lives.

Is the service responsive?

Good

The home was responsive.

People enjoyed a range of activities in the home and the local community.

Care records and risk assessments were detailed and person centred. They reflected individual needs, wishes and preferences and provided staff with sufficient information to enable them to provide the care and support people required.

Staff looked for changes in people's behaviour that may indicate they had concerns or were unhappy.

Is the service well-led?

Good

The home was well-led.

Staff had confidence in the registered manager. Staff felt supported and enjoyed working at the home.

There were effective systems in place to monitor the quality and safety of the services and support provided. This included feedback from relatives, as well as regular contact and reviews with the provider's senior management and quality teams.

The home kept up to date with current good practice within the learning disability care service.

Tor Vale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 visit took place on 3 May 2016 and was unannounced. One social care inspector carried out this inspection.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

The people living at the home had a learning disability and had limited communication abilities. They were unable to share their experiences with us. During our inspection we met and spent time with all five of the people living in the home. We spent time in the lounge observing staff interactions with people and saw how people spent their time. We used the principles of the Short Observational Framework for Inspection (SOFI) in our observations. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with three care staff, a nurse and the registered manager as well as two relatives on the telephone. We received feedback from a physiotherapist who visited the home at the time of our visit, as well as a healthcare professional who contacted us following the inspection. We looked at two people's care plans, the medicine records, three staff recruitment and training files as well as records of internal audits and those related to the management of the home.

Good

Is the service safe?

Our findings

All those living at Tor Vale had a learning disability and varying communication abilities. Some people were able to say, "yes" and nod their head when we asked if they were happy living at the home, while others were unable to verbalise their views. As people could not tell us in detail about their care, we spent time observing people and spoke with staff to ascertain if people were safe. People appeared to be relaxed and looked happy when staff approached them and spoke with them. People were happy for staff to take their hands, they made eye contact and smiled at the staff. This indicated people felt safe and comfortable in the home. Relatives told us they were confident with the care their relations were receiving and had no concerns.

Staff had received training in safeguarding people and knew what to do if they suspected abuse. The provider had safeguarding policies and procedures in place. Posters with contact details for reporting any issues of concern directly to the local authority's safeguarding team were on display. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns. One staff member said "nothing would be ignored". A recent safeguarding incident had been appropriately reported to the local authority's safeguarding team and CQC. The registered manager had taken action to protect people and minimise the risk of further incidents.

Risk assessments were completed for each person. These included risks associated with activities of daily living such as eating and drinking, bathing and mobility as well as when out of the home. Four of the five people living at the home had restricted mobility, three of them significantly so. They were reliant upon staff and equipment to assist them to move safely from their bed and their custom built chairs. Their risk assessments identified what equipment and how many staff were needed to assist them safely. We observed staff throughout the day assisting people with the use of a hoist and this was managed safely each time.

Some people were at risk of choking due to swallowing difficulties. One person's risk assessment identified guidance had been sought from the specialist Speech and Language Team. They had advised the person to have moist food as this was easier to chew and swallow, as well as thickened liquids to the consistency of syrup. Staff told us the person was able to eat with minimal support from staff if they used a spoon. They said staff stayed with them at all times when eating as they tended to put too much on the spoon which could cause them to choke. There was information in this person's care file about what action to take should they choke while eating. Staff also knew to support the person to stay upright and not to use the hoist for at least half an hour after eating to prevent reflux.

People were supported by sufficient numbers of staff on duty to ensure their needs were met in a timely way. At the time of our inspection there was a nurse on duty with three care workers. Overnight there was one nurse and one care staff on duty. During the inspection we saw staff spending time with people supporting them personal care, eating and drinking and with activities. Staff told us there were enough staff to meet people's needs and that staffing arrangements varied throughout the week dependent on what community activities people attended. Shortly following the inspection, the registered manager confirmed

staffing levels had been reviewed in response to people's changing needs and care staff numbers had been increased to four each day.

People were protected by safe staff recruitment practices. Recruitment files included relevant recruitment checks to confirm the staff member's suitability to work with vulnerable adults, for example, seeking references from previous employers and checking with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people.

People received their medicines safely and as prescribed. Medicines were stored in a locked cupboard in a locked room. Each person had a Medication Administration Record (MAR) and we saw these had been fully completed each day with no gaps in recording administration. There were clear instructions for staff regarding administration of medicines where there were specific prescribing instructions. For example, one person received pain relieving medicine and staff were guided to ensure this was given half an hour before the person was to be assisted with their personal hygiene. Medicines received into the home had been signed for and those no longer in use had been collected by an approved contractor. Daily and weekly stock checks by the nurses ensured the balances of medicines held in the home were what they should be. We sampled a selection of medicines and found the balances to be correct. When in the home the nurses administered people's medicines, however all staff had received training in the safe administration of medicines to support people when they went out. For example, some people required emergency medicine should they have an epileptic seizure and all staff were trained in its administration. The protocol for giving these medicines was very clearly recorded in each person's care plan and with their medicine administration records. Staff were also guided to contact the epilepsy special nurse if these medicines had to be given more than once in a week.

All accidents and incidents were recorded and reviewed by the registered manager. They collated the information to look for any trends that might indicate a change in people's needs. The information was also sent to the registered provider's head office.

Staff used protective clothing such as aprons and gloves to reduce the risk of cross infection when necessary. We looked around the home and at the equipment used to assist people. The home had adapted baths to enable people with restricted mobility to use these safely. The home was clean and tidy. There were systems in place to make sure equipment was maintained and serviced as required. There was a file containing certificates to show gas and electrical safety tests were carried out at the correct intervals. Personal emergency evacuation plans were in place which gave staff clear directions on how to safely evacuate people from the building should the need arise, such as a fire.

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's capacity had been assessed in relation to a number of decisions about their care and welfare, such as taking prescribed medicines, the use of monitoring equipment and financial expenditure. However, some assessments had not been fully completed. For example, the way in which information had been presented to people and how their capacity was assessed had not been documented. One person did not have a capacity assessment or best interest decision recorded for treatment recommended following a routine health check-up it. Staff recognised this person did not have capacity to agree to this treatment and discussions were held with their family. It was agreed the person should have the treatment recommended as not doing so could lead to further complications and pain. However, there was no record of a capacity assessment or a best interest decision outcome recorded for this person. The registered manager told us they would complete the necessary documents to show who was involved and how the decision was reached. Records showed people had access to an advocacy service should they have no family support when decisions were required to be made in their best interests.

Staff were aware of the principles of the MCA legislation and that everyone was assumed to have capacity unless they had been assessed otherwise. Throughout the inspection we heard staff offering people choices. People were asked what they wanted to do and what they would like to eat or drink.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made on behalf of people as it was recognised they were under constant supervision and would be unsafe to leave the home unsupervised and the registered manager confirmed one application had been authorised.

At the time of the inspection the local authority's Intensive Assessment and Treatment Team were working with the staff to review how one person was being supported with eating and drinking. This person had lost weight and there were concerns they were not eating enough to maintain their health. Following this inspection, a healthcare professional raised concerns with us that staff had not been following the guidance provided to them to support and monitor this person's nutritional intake. They also said the staff were not monitoring this persons' weight at the same time each week to ensure the weight recorded was as accurate as possible. We discussed this with the registered manager who confirmed the person had been weighed at different times of the day and staff had not recorded why these were not at the time requested. They said the staff were closely monitoring the person's diet and fluids and had made a referral to the GP and dietician. This person was being provided with calorie enhanced foods and their weight was now being recorded at the same time each week.

Staff told us another person was at risk of not drinking enough. The daily care records referred to how much this person had been drinking each day. One entry dated 29 April 2016 stated, "poor fluid intake today" and another dated, 30 April 2016 stated, "food intake good, however fluid intake very poor". Records were kept of this person's fluid intake, however, it was not possible to ascertain from these how much the person was drinking. For example, some staff recorded a 'tick' when the person had been given a drink rather than the amount. On 29 April 2016 staff had recorded three 'ticks' for cups of tea. On 30 April 2016, staff had recorded, "tea 100mls, lemonade 200mls, tea 200mls and two 'ticks' for cups of tea". It was not possible to ascertain how much the person had been offered in each cup and how much they had been able to drink. This person's care plan did not provide staff with guidance about how much this person should be drinking each day to maintain their health or to record the amount the person drank more accurately. Staff told us this person was drinking less since they needed their drinks to be thickened. They recognised that if the person drank the drink shortly after it was made, they would drink more. However, if the drink was left for a period of time it became too thick and the person didn't enjoy the texture. Throughout the inspection we saw staff prompting this person to drink and when it had become too thick, change it for a freshly made one.

We recommend the service review the way in which people's diet and fluid intake is recorded, monitored and managed.

People's food preferences were known to staff and people were supported to make healthy choices. Care plans described how staff should support people to eat as independently as possible. For example, one person could eat the majority of their meal without support if staff cut their food in to small pieces and supported them hand-over-hand for the first few mouthfuls. Another person used a plate with a raised edge placed on a non-slip mat and a long handled spoon. Hot drinks were given half a cup at a time and at a drinkable temperature to enable people to pick up the cup and drink independently without the risks of spills or scalds.

People had access to healthcare services when they needed them. Records showed people had regular contact with healthcare professionals such as doctors and dentists, as well as specialist support from epilepsy nurses, physiotherapists and occupational therapists. People's care files held records of annual health checks and 'Hospital passports' for those people who required specialist treatment. These provided hospital staff with important information about people's care needs. Where people were diagnosed with specific health conditions their care files held detailed information about this and what precautions staff should take to keep people safe and prevent complications. During the inspection a physiotherapist was visiting a person to review their mobility needs and said they had no concerns about how the staff were supporting this person with their mobility.

There was a comprehensive staff training programme in place and a matrix indicated when updates were needed. Staff told us they received "lots of training" either in group classroom situations or on-line. Training included medicines administration, first aid, safe moving and transferring, food hygiene, safeguarding people, the mental capacity act and infection control. Training also included topics specific to the needs of people, such as epilepsy. Certificates for this training were seen in staff files. The registered manager told us new staff completed the home's induction programme, which included several days of classroom based teaching. For those who were employed with no previous care experience, they would also undertake the care certificate. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support. One member of staff newly employed at the home told us their induction had been "very good" and they felt well supported by the staff team. New staff worked a probationary period for the first 17 weeks of their employment. This was to ensure they were supported to settle well in their role and were able to meet people's needs.

Staff received regular supervision and appraisals of their work performance and training needs. These reviews were shared between the nurses and registered manager. The nurses supervised a small team of care staff each and the registered manager provided clinical supervision for the nurses. Staff told us the nurses worked alongside them and observed their practice to ensure they were effectively meeting people's needs. Staff meetings were used to discuss people's care needs, to plan future events and to identify any concerns staff may have.

Good

Is the service caring?

Our findings

All those living at Tor Vale had limited verbal communication. Some people were able to respond to questions about whether they were happy, while others were not. We spent time observing people in the lounge and saw they were smiling and appeared happy to spend time with staff. Relatives said they found the staff caring, kind and thoughtful. One relative said their relation's health and well-being had improved significantly since moving to the home. They described the staff as "marvellous".

People had a named nurse and a 'keyworker' care staff who were responsible for ensuring they received the care and support they needed, were supported with meaningful leisure and social activities and who communicated with their families.

People looked well cared for and were comfortable in the presence of staff. We saw staff treated people kindly and had regard for their individuality. Staff were friendly, patient, and enthusiastic in their interactions with people and people enjoyed this relaxed environment. The staff told us they enjoyed working at the home and had developed close relationships with the people they cared for. One staff member said, "It's a nice place to work, I like it here" and another said, "I really like working here, we're a good team".

Staff were encouraging and supportive in their communication with people. Throughout the inspection, we saw staff encouraging people to become involved in a variety of activities and assisting them to do so.

Staff said they felt they provided a good level of care to people and gave examples of how they ensured people's privacy and dignity were respected. We saw two staff members assisting a person to the bathroom: they spoke quietly and discreetly to them.

People's relatives were able to visit at any time. Staff recognised the importance of people's relationships with their family and promoted and supported these contacts when appropriate. Records showed people had regular visits from and to their families.

Not everyone was able to be actively involved in planning their care. However, staff knew people well and when planning care, took into account what they knew about the person and their preferences. Relatives were involved in planning care when they wished to be and those we spoke with confirmed they were fully consulted about their relation's care.

As Tor Vale provided nursing care, the home was able to support people should their health decline and they require 'end of life' care. The nurses worked closely with the local hospice to ensure their clinical skills remained up to date and they were able to continue to care and support people through ill health.

Good

Is the service responsive?

Our findings

Each person had a support plan which gave staff important information about their individual needs. We looked at the records for two people with varying needs. These held information about people's physical and mental health care needs and provided staff with step by step guidance about how to support people. Information about whether people could undertake care tasks themselves and when staff needed to prompt or provide physical support was clearly identified. This ensured staff could promote people's independence and maintain their skills. For example, people's care plans included 'how I like to bath', 'how I like to clean my teeth' and 'how I like to dress and undress'. This ensured staff fully understood people's needs and people were supported in a consistent manner. These plans described people's needs in relation to their personal hygiene and skin care; their mobility; their nutrition and food preferences; how to manage any health issues and their medicines, as well as their family, leisure and social interests. The plans were well maintained and reviewed regularly. A one page profile of people's likes, dislikes and preferences as well as essential information about people's care needs and how to keep them safe provided staff with a summary of people's needs. This ensured any staff new to the home, or if agency staff were needed to work at the home, had the important information they needed.

'A perfect day' described people's preferred routine, their favourite foods and how they liked to spend their time. For example, one person's perfect day included having a soak in the bath, having cottage pie for lunch and watching football. Staff were aware of people's preferences and told us they tried to ensure these were included in people's day to day events. Staff told us the routines of the home were flexible dependent upon people's plans for the day and their preferences. For example, one person preferred to lie in bed later in the morning when they weren't going out. Another person liked to go to bed later in the evenings if there was football on the television. Staff spoke confidently about people's individual needs. They knew people and their needs well and the individual ways in which they communicated. People's care plans described how people used verbal and non-verbal communication. Information included, 'How I communicate like/happy/ok', and 'things you need to think about to help me feel happy'. For example, one person did not like to sit next to an open window. We saw staff talking to this person about this before they opened a window in the lounge which had become very warm from the sun.

Records showed people were involved in activities both in the home and the local community. People attended a number of social clubs both during the day and in the evenings. Each person's care file included a list of their known interests as well as suggestions for activities they may find enjoyable. One person's care plan described their anxiety when going out of the home to unfamiliar places and staff were supporting them to increase their experiences in a safe and planned way. People went out to local places of interests either individually with staff or in small groups. Some of the activities people had enjoyed were visiting the local garden centre, going to local shops and cafes, visiting and riding on the steam trains and boats or attending events such as motocross. On the day of our inspection, one person was supported by staff to visit a relative and another to go shopping for clothes. On their return they were clearly pleased with the items they had bought and enjoyed showing them to the other staff.

The registered manager took note of, and investigated any concerns raised. People living at the home were

not able to raise concerns themselves. However, staff told us they would recognise if people were unhappy by their body language and general demeanour and would discuss this with the nurses on duty and registered manager.

Good

Is the service well-led?

Our findings

The values of the service were described on their website, and in the information they provided to people and their families, as 'Choice, Dignity, Fulfilment, Independence, Privacy and Rights'. Their aim was to ensure "the interests of individuals are safeguarded to achieve the best outcome for people supported". When we spoke with staff they demonstrated their understanding of these values in the way they told us about people's support needs and how they worked well as team to promote a good quality of life for people.

There was a registered manager who had been in post for several years and who knew the people living at the home well. They said they were very well supported by the service's senior management team with whom they met monthly. These meetings were used to review people's care and support needs and to keep up to date with current good practice within learning disability care. They also received formal supervision from the service's general manager every three months. Each registered manager within The Durnford Society Limited had another manager as a 'buddy' with whom they could share ideas and receive support.

Staff spoke positively of the registered manager and the nursing team and how much they enjoyed their job. They said the registered manager was approachable and always had time for them. They felt listened to and could contribute ideas or raise concerns if they had any. They said they were encouraged to put forward their opinions and felt they were valued team members. The registered manager worked alongside them to ensure good standards were maintained and were aware of issues that affected the home. One staff member said, "there is good communication between the whole team, nurses, staff and manager". When asked if there was anything that would make the home better for the people who lived there or for themselves, none of the staff could think of anything they wished to see changed. Nursing and care staff meetings were held on a regular basis which gave opportunities for staff to discuss people's progress and to contribute to the running of the home. For day to day communication between the nursing and care staff, a communication book and diary were used to ensure messages were passed on and important events were not overlooked.

The Durnford Society Limited had an internal quality assurance team. This team was responsible for undertaking regular visits to the home to spend time with people, staff and the registered manager. They were also responsible for undertaking audits of medicines to ensure they have been administered as prescribed; of care plans to ensure they provided an up to date description of people's needs, as well as health and safety issues such as equipment testing and servicing. They were involved in reviewing how well people's needs were being met as well as reviewing the feedback gained from people and their relatives. The registered manager was aware of their responsibility regarding duty of candour, that is, their honesty in reporting important events within the home, and their need to keep CQC up to date.