Dignity and Respect Visit Report

Darlington Court

Details of visit: Unannounced visit

Service address: Darlington Court, The Leas off Station Road, Rustington, West Sussex, BN16 3SE

Service Provider: Care UK Community Partnerships Ltd

Date of visit: 8/4/15

Authorised Representatives: Sue Morton, Jenny Robinson

Contact details: gareth.jones@healthwatchwestsussex.co.uk

Acknowledgements

Healthwatch West Sussex would like to thank the residents of the home, management and staff together with visitors for their contribution to our visit alongside our Authorised Representatives who collated the evidence for this report.

Disclaimer

Please note this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users, their supporters and staff, only an account of what was observed and contributed at the time.

Healthwatch West Sussex

Under the Health and Social Care Act 2012, all local authorities in England which provide Adult Social Care services have a duty to establish an effective, efficient and representative Local Healthwatch. Healthwatch West Sussex was therefore established as a consumer champion for users of health and social care services in the county. Its role is to:

- Gather the views and understand the experiences of patients, social care clients and the public;
- Make these views known to commissioners and providers of health and social care;
- Promote and support the involvement of these groups in the commissioning and provision of local care services and how they are scrutinised;
- Provide information, 'signposting' for services and support to make informed choices;
- Recommend the undertaking of investigations or special service reviews to Healthwatch England and the Care Quality Commission (CQC);
- Make the views and experiences of people known to Healthwatch England and provide a steer to help it carry out its role as national champion.

What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement.

The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies.

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Purpose of the visit

To understand and report on the experiences of residents of the home, their relatives, supporters and staff; in relation to dignity within the home.

Strategic drivers

- Respond to intelligence received by Healthwatch West Sussex about the home
- Add a lay perspective to the findings of an inspection by the Care Quality Commission (CQC) in December 2014
- Raise awareness of the role of Healthwatch West Sussex in the care home sector and particularly as an additional and independent route for sharing resident experiences
- Care homes are a current Healthwatch West Sussex Board priority
- Close working collaboration developing with West Sussex County Council Adult Safeguarding Board and post Orchid View (Serious Case Review) follow up work
- Emerging interest in seeking evidence on malnutrition in care homes

Methodology

This project was planned as an unannounced visit in response to feedback which Healthwatch West Sussex had received about alleged deficiencies in care at the home. However the questionnaire expands the enquiry into general issues of dignity. Questions were adapted from the Social Care Institute for Excellence 'Dignity Factors'. These included prompts on choice & control, communication and pain management, personal hygiene, privacy and social inclusion. The intention was not to duplicate the CQC inspection which took place in December 2014 but rather to add value to it by asking open questions on dignity issues from residents, relatives and staff where available. Visits were conducted by trained and accredited volunteers, called Authorised Representatives.

We spoke to a number of staff, covering a broad range of roles and levels of responsibility which included the care home manager and members of the Rehabilitation team. We spoke to five residents and one relative, in several locations across the home. We did not speak to any of the rehabilitation patients as they were in their rooms. In addition we only spoke to residents on the first floor as the manager said the residents in the dementia unit would not be able to give informed consent to participate in the survey.

An initial discussion took place with the manager regarding training issues and relevant paperwork. Explanatory forms were left with staff and residents and we also verbally explained why we were there. It was made clear that participants could choose whether to talk to us, and that they could end the discussion at any time. Both Authorised Representatives have undertaken Adult Safeguarding Basic Awareness training.

Service description

Darlington Court is a nursing home owned by Care UK Community Partnerships Ltd, which currently has 61 residents. It is CQC registered to provide Caring for adults over 65 years, those with Dementia, Learning Disabilities, Mental Health conditions & Physical Disabilities.

Summary of findings

Policies, Procedures and Training

All permanent staff underwent induction training which was documented. This included dignity training which was updated annually, as confirmed by a staff member. There were additional courses available on topics including *care for the dying* and *dementia*. Thirty percent of the nursing staff were supplied by agencies as were three percent of the care assistants. The home relied on the staff profiles (including the record of training) sent to them by the agency. All 200 policies were available for viewing in numbered order at the nurse's station.

The home would not re-engage any agency staff about whom there had been a complaint, and previous serious events had been referred to the Nursing and Midwifery Council. Complaints against permanent members of staff would be dealt with by the manager through extra supervision or a disciplinary procedure. There was an up-to-date complaints book in which all the complaints had been dealt with and actioned swiftly. We are unsure whether there was a complaints procedure notice on the notice boards.

It was later clarified by the manager that Western Sussex Hospitals NHS Foundation Trust employ the rehabilitation team who work at the care home; they have a separate line management to which they respond. The Trust is therefore responsible for their mandatory training. However the manager stated the team undertook falls and fire training with the rest of the staff team. The rehabilitation team itself pointed to the lack of training of the care staff which they thought was due to a "*lack of skills and drive by the Unit Manager and also due to lack of funding by the CCG*". They felt that most carers were very caring in the care home setting but not so good with the rehabilitation patients. There were individual treatment plans but we were told that they were not implemented by most carers at weekends. The rehabilitation team was of the opinion that "*the home would function much better without the rehabilitation beds*".

The Rehabilitation Team did comment that under the NICE guidelines that the ratio of staff to patients was higher for rehabilitation patients and they did not think that the Clinical Commissioning Group were funding any extra staffing for the Rehabilitation beds.

However one visitor we spoke to thought that inclusion of rehabilitation beds in a care home had a beneficial aspect in that it allowed residents to see that some patients were discharged home.

If a resident refuses treatment the Manager would call an Independent Mental Capacity Advocate to advise and talk to the family and GP.

There are monthly meetings with residents and relatives with minutes taken. There are also weekly meetings with medical staff, social workers and the rehabilitation team for the patients in the rehabilitation beds.

We felt the manager should have greeted us in a more professional manner as she was chewing gum which did not give a good first impression.

Choice & control

The residents interviewed stated that they had adequate choice regarding activities and daily procedures such as washing and dressing. The Rehabilitation Team would like breakfast for their patients earlier to enable them to carry out their therapy. However the care residents had requested a later breakfast. One resident who needs to use a hoist can only get up and dressed when staffing levels allow.

Communications

The residents to whom we spoke stated that the staff always listened to them. However one resident said they didn't always understand the night staff. They did not feel that there was enough time for the staff to talk to them at meal times. One resident reported that, at night, the staff "*run round like scalded cockerels*". They also said "*when beds closed the management decide they need less staff*" which they thought was dangerous. The communication we saw on the day between various staff members and the residents appeared very good. We did not see any signs on notice boards for the visually impaired. The manager told us that they would be in place if required.

Pain management

Relevant residents felt they were able to receive pain medication when needed, and knew whom to ask for it. The staff would call a Doctor if this was required.

Personal hygiene

Residents appeared clean and well dressed (they had choice as to whether to dress or to stay in pyjamas, unless they had to use a hoist). None of the residents had any complaints concerning personal hygiene. One member of staff said that the bells were answered much quicker due to the new bell system. However another felt that patients were kept waiting too long, particularly on commodes, which caused distress.

Privacy

All residents felt privacy was given when needed. At bath and toileting times all curtains were pulled and doors shut. Staff always knocked on doors before entering. Residents who needed personal space said they always managed to find this. Everyone thought that their personal information was kept private.

Social inclusion

The Activities Co-ordinator tries to personalise the activities to individual residents to make them more meaningful, in addition to having group activities. There were visits to local shops when staff were available. Visitors were encouraged to drop in at any time and could bring in dogs as we witnessed on the day.

A relative whose parent had been in the home for several years was very impressed with the care they received. They told us that there was now a system in place to bring the phone to residents when their relatives phoned. One resident owned a tablet computer, and wanted to be able to access emails and to use Skype. They mentioned that they were restricted in doing this, because Wi-Fi was only available in the office.

Final observations of good or poor practice in care

There appeared to be a difference between the standards of care in the care home beds and the rehabilitation beds. We spoke to one care home resident who at first said the nurses were good but who became upset when we asked them whether they had any family visiting. They said "*I just want to go home as they pull me about*" and gestured to their arm, but no mark was apparent. We had been told by the manager that all residents we were speaking with were able to give informed consent. However after we had spoken to the resident, a member of staff told us that a lot of the residents in the TV lounge had dementia "*and to be careful about what they said*"- implying that we would gain a false impression.

One staff member stated "*it's a caring beautiful place and I can't fault it*". This view was repeated by the relative we spoke to and a visiting professional. All the staff we observed treated the residents with compassion.

However the rehabilitation team gave us an example of how a resident had not had sufficient help with feeding at lunchtime and had spilt soup down themselves, following which they observed that the resident had not been changed at 4pm.

When asked if the rehabilitation team would like their own parents in the home they all instantly and categorically said "*no*".

We were also told that the only lift in the care home could not take a stretcher so when a resident died the body had to be held upright in the lift. They also reported that when a resident who was immobile needed transfer to hospital they had to be put in the hoist in the lift. They felt that, on the occasion mentioned, the procedure was undignified.

Recommendations

Policies, Procedures and Training

- Consideration should be given to closure of the rehabilitation beds.
- Ensure that all care home staff who cover rehabilitation wards at weekends have received training appropriate to this specific area.
- Coordination between care home staff and the rehabilitation team members should be improved to ensure that patient needs identified in individual rehabilitation plans are followed. Specific training should be offered in this regard.
- The rehabilitation team would benefit from improved facilities such as provision of a kitchen which would allow more privacy.

Choice & control

- Consider whether rehabilitation patients could have breakfast earlier whilst still letting the care home residents keep their current breakfast time.

Communications

- Ensure staff have a little more time at meal times to communicate with the residents.
- Ensure there are sufficient night staff and staffing is adequate when beds are closed.
- Signs for the visually impaired should be included on notice boards.

Personal hygiene

- Introduce a checking system for patients left on commodes.

Social inclusion

- Consider introducing Wi-Fi in resident's bedrooms or other parts of the home.

Improved practice in care

- Provide a more dignified method for transporting the deceased and residents who are unwell between floors within the home.

Service Provider Response

Sue Polden (Regional Director, Care UK)

There are areas of this report that we wish to comment on as we feel that information has been provided to the Healthwatch team that was either factually incorrect, historical and therefore already addressed and remedied or possibly historical and which had never been brought to the attention of the home.

Choice & Control

The issue regarding breakfast times is an historical one which has been raised several times by the therapy team. The view of the rehab team is that residents should be woken, given breakfast early and therefore be available for therapy at times which suit the therapy team. The team have been advised that it is resident choice as to their rising and breakfast times and that therefore the therapy should be provided at times to suit the resident, rather than the therapy team.

Communication

We accept that resident perception may be different to the actual position regarding staffing numbers however we are confident that our staffing numbers are always to the required level and take into account dependency of residents.

Personal Hygiene

We are disappointed that the alleged issue of residents being left on commodes was not relayed to us on the day of the visit to enable us to investigate. It is not our practice to leave people on commodes. It would also be useful to know whether it was Care UK staff or Therapy staff who raised this so that we could ensure any training required in this regard is delivered. Furthermore this could be construed as abuse and as such notifications should have been made.

Final Observations of good or poor practice in care

We would request clarification of the meaning of the first sentence so that we can investigate and resolve any disparity. We also would appreciate comments as to how this conclusion was reached during such a short visit please.

The comment, “I just want to go home, they pull me about” does not indicate clearly whether it is aimed at Care UK staff or therapists. In any event any such allegation made to anybody should have been reported back to the Home Manager on the day of the visit as this could constitute an allegation of reportable abuse, irrespective of whether or not there were any visible marks.

The comments in the paragraph in relation to comments made by staff after your speaking to a resident clearly makes a subjective remark in respect of the possible implication. We feel that this should have been clarified on the day rather than making assumptions as to the meaning of such a statement.

The example given by the rehab team in relation to a resident not changed after spilling soup down themselves must have been historical as the Carewatch [Healthwatch West Sussex] team had left the home before 4pm. Without more specific details re dates, times and name of resident we cannot clarify whether the care staff had been made aware and did not act, whether the resident had refused to change etc.

We are disappointed with the comment made by the rehab team in respect of the question asked about whether they would like their parents in the home as the rehab team itself forms part of the care that residents receive. We feel it would have been helpful if the rehab team had shared any such sweeping views of this nature with the management team.

The comments about the lift are correct but we would reply that this is not in fact uncommon in registered homes regardless of the age of the building.

Recommendations

Policies etc

We do not see how Healthwatch can make such a radical statement re the future of the rehab beds after a 4 hour visit. However we can advise that the rehab contract is now coming to an end and therefore the other items in this category are now irrelevant in respect of my response.

Choice and Control

This has been discussed fully on several occasions as stated above and it is our view that resident choice is the most important.

Communications

Staffing rotas are continually assessed to ensure there are sufficient staff in the right place as required. However it is accepted that there is always the possibility that there may still be occasions when this does not appear to be adequate dependent on the levels of assistance being provided to other residents.

As stated before our rotas clearly identify that we operate the home with sufficient and often higher levels, of staffing, including night cover.

Signs for visually impaired, as stated by the manager would be available if required as would any other aid that was required for a resident. The home was also asked whether we train our staff in Makaton to which we gave the same response in relation to providing it as and when it is required.

Personal Hygiene

As we have no background information in relation to this comment it is difficult to say whether a checking system would be suitable. Obviously if, after we are provided with further details on this matter, we find that this is an issue in the home we will take stringent steps and checks to prevent such a lack of dignity and respect occurring. Similarly, this is another issue which could constitute abuse and we feel that these details should have been handed to us on the say to enable us to report and ensure a thorough investigation was held.