Dee View Court
Care Home Service

Caiesdykes Road
Aberdeen
AB12 5JY

Telephone: 01224 245 920

Type of inspection:
Unannounced

Completed on:
10 October 2023

Service provided by:
Sue Ryder

Service provider number:
SP2007967940

Service no:
CS2003013713

About the service

Dee View Court is a care centre, which is registered to provide a care service for a maximum of 44 adults with physical and sensory impairments, who may require palliative care. The provider is Sue Ryder, which is a registered charity. At the time of this inspection one resident was supported in another service, also provided by Sue Ryder and located adjacent to the care home.

The centre is in Kincorth, which is a residential area, close to some local shops and a bus route. It is a single-storey care centre which is centred around a large spacious café area. There are two wide corridors, laid out as internal streets, leading to the six houses.

The Sue Ryder website says of Dee View Court: 'For people who have life-changing conditions affecting the brain and nervous system, our neurological centres offer specialist care and support. By focusing on health, wellbeing and what each person can do, not what they can't, we support people to live their lives as fully as possible'.

This service has been registered since 2003.

About the inspection

This was a second inspection which took place on 2 and 3 October 2023. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with five people using the service and four of their family;
- spoke with six staff and management;
- observed practice and daily life;
- reviewed documents;
- spoke with visiting professionals.

Key messages

- People had enough to do, with a range of different activities offered daily.
- Some clinical tasks and associated documentation needed to improve.
- Supervision of staff needed to improve.
- Most people were happy with the service provided.
- There is a new management team in the service.
- Senior managers were working to make improvements to the service.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our staff team?	3 - Adequate
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

We evaluated this quality indicator as adequate and applies where there are some strengths but these just outweigh areas for improvement.

People were generally happy with the service that they received, people told us; 'I am happy with where I am, and on the whole the staff are great with me' and 'the staff are very good, couldn't be any happier with my care'. During both days of our inspection we observed that there was a relaxed but busy atmosphere in the service, and that a variety of different activities were available for people.

At our last inspection we saw that Recreational Therapy (RT) staff had commenced a "life story" scrap book project which people were excited to show us. We were disappointed to see that this had not progressed; this project was important to people's wellbeing and supports staff to better understand people's life experiences and should be progressed . We discussed this with managers who provided some assurances that this would be looked into.

We saw that people had adaptations in place to give them more control, independence and supported them to complete meaningful tasks. For example; RT staff had sourced an electric pass to help one person access their room independently, and an arm support to assist with someone else's preferred activity of painting. This is important as it helps people to maintain their independence and take part in activities that are meaningful to them.

Record keeping of topical medication administration records (TMARS) was below a standard that we would expect of a care service. We observed multiple omissions from these records, and it was difficult to establish if people consistently received the applications of these medications as prescribed. We were reassured when we spoke to people, who told us that staff were applying these medications, however, administration records needed to improve. We also observed other recording omissions in relation to 'as required' (PRN) medications and failures of recording the effects of these medications. **(See requirement 1).**

People's care and support plans described their care and support needs and the interventions that staff needed to carry out to keep people safe. However, we observed that in some cases wound care documentation was incomplete, or had not been carried out at the frequencies described in care plans. **(See requirement 1).**

People were benefitting from a tasty, varied and well balanced diet. The chef knew people's likes and dislikes and tried to ensure that there were alternative options available to suit people's preferences. People had regular access to drinks, meals and snacks and we saw that those who required support to eat and drink were receiving these in line with their care plan. Where people had specific nutritional requirements or preferences, we saw that these were provided, and were available for people. The recording of fluid intake documentation needed to improve. We found that this documentation was incomplete and plans were not in place for people who had not achieved the fluid targets that had been set. **(See requirement 1).**

People were encouraged to move regularly and be as active as possible. This was supported by both physio and the RT team - this impacted positively on people's physical and mental wellbeing and supported them to maintain their independence for as long as possible.

Requirements

1.
By 03 January 2024 the provider must ensure that people's overall health and wellbeing needs are accurately documented, assessed, met and communicated between all relevant staff.

To do this, the provider must ensure:
a) accurate and sufficiently detailed records of all care processes are in place to evidence all care and social interventions;
b) all medications, including topical medication must be accurately recorded at the time of administration and records kept up to date;
c) clear information regarding frequency and detail of recording of wound care, and pain assessments is in place; and where changes in frequency have been made, these should be clearly documented and kept up to date;
d) fluid documentation should be maintained over the agreed recording period. Where targets have not been met, plans are put in place and information and guidance is shared with other professional staff as appropriate.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services), Regulations 2011 (SSI 2011/210) - Regulation 4 (1)(Welfare of Users)

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state that:
'My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.' (HSCS 1.23)

How good is our staff team? 3 - Adequate

We evaluated this quality indicator as adequate and applies where there are some strengths but these just outweigh areas for improvement.

Staff created a warm and friendly atmosphere in the service. We saw lots of interaction between residents and especially the Recreational Therapy (RT) staff team; people told us, 'I would say that I am happy most of the time and I have my favourite staff', and 'I have absolutely no concerns, I am very happy with the care and support that my relative receives. The staff are excellent at keeping me up to date, I have no complaints but if I did I would raise it with them'.

Staffing levels were above safe staffing levels, but the high use of agency staff meant that the staff were not always working as effectively as they might with a permanent staff team. The service ensured that agency staff were kept to a minimum, and were consistent. In discussion with a senior manager of the service, and in the findings of this inspection, it was clear that staff did not always work effectively as a team when agency nurses were leading shifts. This had resulted in increased interruptions (often during medication administration rounds), which had resulted in increased medication errors. This was in the process of being addressed by the time of our inspection, and measures put in place to ensure that staff were reminded not to interrupt senior staff carrying out medication administration tasks. Senior managers

were working with the staff team to address other areas of effective team working, to ensure that people's needs were met, and care tasks were arranged effectively.

Core training competencies for staff were at a satisfactory level with most staff having maintained their essential core and update training. We had concerns regarding staff not being provided with the offered training from the dietician regarding enteral feeding, which had not been progressed quickly enough, and had led to poor outcomes for some residents.
See requirement 1 in section five of this report.

Due to on-going difficulties around recruitment of permanent staff, and the lack of clinical leads and senior staff at the service, we observed delays in ensuring that staff had received the appropriate levels of supervision and observations of staff practice at the service stated policy intervals. This had resulted in delays in addressing some practice issues relating to the findings of this inspection, including medication administration, wound care and completion of care documentation. **(See requirement 1).**

Requirements

1. By 03 January 2024 the provider must ensure that staff have the skills, knowledge and professional guidance to enable them to support people.

In order to do this the provider must ensure:
a) that all staff have access to appropriate levels of supervision to support their professional practice;
b) that leaders in the service observe staff practice to assure themselves that staff are competent;
c) use staff supervision and observations of practice to identify any training needs and ensure staff have access to relevant training.

This is to comply with Regulation 15 (a)(b) (Staffing) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes. (HSCS 3.14).

How well is our care and support planned? 3 - Adequate

We evaluated this quality indicator as adequate and applies where there are some strengths but these just outweigh areas for improvement.

Care plans had improved since our last inspection, these were more personalised and written in the first person perspective, better reflecting people and the outcomes they wanted to achieve.

Key care processes were in the main being carried out at the correct intervals with improvements in wound care documentation and administration of some medications.

There were significant lapses in the recording of administration of topical (TMAR) medications. It was not always clear if this was only due to poor recording, or if some of these medications had not been applied.

We had some reassurances that people had in the main received essential topical medications. We spoke to a number of residents and relatives, who told us that staff did ensure that essential creams were applied during personal care. In addition, we looked at these medications in people's rooms, which were in use. The use of (as required) PRN medications was not recorded following best practice guidance. Incorrect or confusing codes were in use, and staff did not record the effectiveness of these medications.
See requirement 1 in section one of this report.

The oversight and management of care documentation needed to improve. Whilst the recording of wound care had improved, recommended intervals between dressing changes was not being followed in all cases. For example in one case, there was no documentary evidence to show why a decision had been made to extend the intervals between dressing changes and the wound in question had shown some deterioration. This meant that we could not be confident that the deterioration in this wound had not been exacerbated by these delays.
See requirement 1 in section one of this report.

Fluid charts were not at the required standard. Whilst it was good that target levels of fluids for individuals had been set; most of those audited showed gaps in recording, were not totalled at end of each day and/or evidenced that in many cases people were not achieving targets set. Where fluid charts evidenced that people had not achieved their stated targets, there was no plan or guidance available to inform staff of action to take, or how this information was escalated to senior staff and what actions were required to ensure that people received enough fluids. **See requirement 1 in section one of this report.**

There was engagement from community healthcare practitioners and we saw involvement from dietetics, speech and language therapists and tissue viability nurses. However, there were some concerns in relation to delays in staff receiving appropriate training for the management of enteral feeding, (where people receive liquid food via a gastric tube directly into their stomach). Despite this training being offered, and possibly as a consequence of this training being delayed, equipment was not as clean as it should be, and some service users had suffered complications with enteral feeding tubes, and required avoidable interventions as a result. We have since received confirmation that this training is now planned in the near future. **(See requirement 1).**

Statutory six monthly reviews of people's care and support were late and needed to be updated. It is important that people receive a review of their care and support every six months. This is to ensure that their support is right for them, and if any changes are required, these are agreed and put in place. These meetings should include people's representatives, such as Power of Attorney's (POA) and Guardians where people lack capacity, and require representation to ensure that their views are upheld. **(See area for improvement 1).**

The use of the term 'Adults with Incapacity' (AWI) needed to be clarified within support plans. This was being used as a blanket phrase to describe inaccurately that protective measures were in place for people who lacked capacity. When we looked at support plans, in some cases this referred to legislation that GPs use to provide medical care, and did not relate to Power of Attorney or Guardianship. We discussed with managers the importance of ensuring that legal powers were clearly described in support plans, and ensuring that staff understood what these meant and who to liaise with when needed. **(See area for improvement 2).**

Requirements

1.
By 03 January 2024 the provider must ensure that people receive care from staff who are confident and competent in key areas of clinical care.

In order to do this the provider must ensure that:
a) staff training for essential care processes is identified and put in place as soon as possible. This should include but is not limited too, enteral feeding regimes and care of feeding tubes and associated equipment;
b) there are sufficient numbers of staff who are proficient in carrying out essential clinical care tasks at the time of need. Where training is required to carry out clinical tasks safely and effectively, this must be completed as soon as possible and measures put in place to ensure that these care tasks are carried out safely;
c) care processes are delegated appropriately at the beginning of every shift and there are no delays in essential clinical care being carried out timeously.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services), Regulations 2011 (SSI 2011/210) - Regulation 4 (1) (Welfare of Users).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisation codes' (HSCS 3:14).

Areas for improvement

1. In order to ensure that people's support is right for them, is up to date and reflects their care and support needs and outcomes, the provider should ensure that statutory reviews of care are carried out at least every six months, or more often if required. Reviews should also include people's chosen representatives if this is requested, and legal representatives when they lack capacity to ensure their views are fully represented.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state:
'I am fully involved in developing and reviewing my personal plan, which is always available to me (HSCS 2.17).

2. In order to ensure that care and support records accurately reflect the protective frameworks that are in place for people who lack capacity, the provider should ensure that care records fully explain who represents people who lack capacity and the powers that they hold.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state:
'My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions (HSCS 2.11).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The service should ensure that care plans are person-centred. These should set out how the service supports people to access preferred activities, and access to gardens and the local community in ways that are meaningful to them.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
"I can maintain and develop my interests, activities, and what matters to me in the way that I like" (HSCS 2.22)

This area for improvement was made on 10 May 2023.

Action taken since then

There were improvements in the support plans, which were personalised and easier to navigate to find essential information. More separation of recreational notes and physiotherapy notes would improve recording of how the service supports people's recreational needs and should be separate from physiotherapy notes.
The garden areas are still not freely accessible to people due to external doors now being locked. Although staff can and do open these on request, they are not routinely unlocked. We have asked the service to consider how external areas can be made more secure to support free access to and from garden areas. More time has been agreed to support this area for improvement.

This area for improvement has not been met and remains in place.

Previous area for improvement 2

To promote the wellbeing of the people living and working in the service the provider should put in place measures that support the reduction of noise in the internal concourse of the care home.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that:
"My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells" (HSCS 5.20).

This area for improvement was made on 10 May 2023.

Action taken since then

The provider had carried out some investigatory work to seek ways in which noise can be reduced in the internal concourse. Work had been completed around "zoning" the nurse call system which had reduced the impact on people from these. Further improvement is necessary.

This area for improvement has not been met and remains in place.

Previous area for improvement 3

To promote the wellbeing of the people living and working in the service the provider should put in place measures to ensure a reasonably comfortable temperature is maintained throughout the premises.

This is to ensure that care and support is consistent with the Health and Social care Standards (HSCS) which states that:
"My environment has plenty of natural light and fresh air, and the lighting, ventilation and heating can be adjusted to meet my needs and wishes" (HSCS 5.21)

This area for improvement was made on 10 May 2023.

Action taken since then

The provider has made some investigations about how temperature regulation could be better managed, however, no work to address this area has taken place. This is further complicated by fact that external doors to the garden areas are no longer able to be left open as the garden area is not entirely secure. We have asked the service to progress this area for improvement and have continued this area for improvement.

This area for improvement has not been met and remains in place.

Previous area for improvement 4

The provider should continue with regular audits of care plans and recordings to ensure information is consistent and recordings are detailed and evaluative.

This should include but is not limited to;
a) accurate and sufficiently detailed daily records to evidence all care and social interventions;
b) clear information regarding frequency and detail of recording of wound care and pain assessments;
c) food and fluid documentation should ensure that targets are set and easily available to those completing these records.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state that:
'My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.' (HSCS 1.23)

This area for improvement was made on 10 May 2023.

Action taken since then

Whilst some improvements within care planning processes were noted, some care processes within support plans were either absent or had not been documented fully. Fluid charts were not at acceptable standards of documentations and some wound care interventions were late.

This area for improvement has not been met and has been re-stated as a requirement.

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Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

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