Minster Care Management Limited

Duncote Hall Nursing Home

Inspection report

Duncote Hall
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Date of inspection visit:
04 March 2020

Date of publication:
04 May 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Duncote Hall is a residential care home that can provide long and short-term residential nursing care for up to 40 older people, including people living with dementia. At the time of inspection 23 people were using the service.

People's experience of using this service and what we found
Quality systems were not effective in identifying the concerns raised on inspection.

Risks to people had not always been assessed and managed appropriately. Equipment had not always been used in line with the needs of the people using it.

Systems and processes were not effective in ensuring the safety of people or the environment.

The environment had areas that were unclean and some areas that were accessible, were unsafe for people.

Medicine management system needed to be improved. Medicines had not been stored, disposed of or recorded in line with best practice.

We found that staff had not been appropriately deployed to ensure people had their needs met in a timely manner. People told us there were not enough staff on shift and that they were made to wait for their needs to be met.

People's dignity was not always maintained or respected. Personal information was not always stored securely.

Not all care plans held the correct information. Care plans did include people's choices, and preferences as well as any cultural or religious needs.

People who were at risk of dehydration did not always have their fluid intake recorded. People told us the food was good and the kitchen staff were aware of people's preferences and dietary requirements.

People told us staff were kind, we saw interactions between staff and people varied. Some staff interacted well with people, taking time to talk to them and explain things, whilst other staff had very limited interactions with people.

People were referred to healthcare professionals as required. Staff supported people to access doctors, dentists and opticians as required. People who had a preferred gender of staff to complete care tasks, had this need met.

Complaints had been dealt with appropriately and within the provider's timeframes. The manager had acted on and completed their responsibilities under the duty of candour.

Staff had been safety recruited and completed an induction. Staff understood their role in relation to safeguarding adults.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 8 October 2019) and there were breaches of regulations in relation to food and fluid, infection control, safe care and treatment, staffing levels, governance, person centred care, respect and dignity, staff recruitment and environmental concerns.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made, however the provider continued to be in breach of four regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have found breaches in relation to keeping people safe, medicines, infection control, staffing, dignity and respect and oversight of the service at this inspection.

We will update the end section of this report to provide information about CQC's regulatory response to the breaches found. We will do this once any action has concluded.

The overall rating for this service is inadequate and the service remains in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Duncote Hall Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors, an assistant inspector and a specialist nurse advisor.

Service and service type
Duncote Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager. The provider had employed a manager who was in the process of registering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

We contacted health and social care commissioners who have a responsibility to monitor the care of people at Duncote Hall Nursing Home. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in

England. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the manager, nurses and care staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The provider continued to provide updates to their action plan showing the improvements they were putting into place.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained the same. This meant people were not safe and were at risk of avoidable harm

Assessing and managing risks; Ensuring equipment and premises are safe. Learning lessons when things go wrong
At our last inspection the provider had failed to ensure the environment was safe by not locating and maintaining equipment correctly. This is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was no longer in breach of regulation 15.

At our last inspection the provider had failed to ensure people's risks were being assessed and managed appropriately and incidents affecting people had not been reviewed, investigated or monitored. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

- People continued to be at risk of not receiving their care as planned or in a safe way due to inconsistent recording. For example, bedrail, repositioning and safety checks had not always been recorded as completed. A safety check was to protect people who were cared for in bed.
- The provider did not ensure people's risk assessments and care plans always reflected their current needs as care plans and handover documents contained conflicting information. For example, one person's care plan had the wrong specification of a health condition recorded. Another person's care plan had conflicting information regarding their food consistency needs.
- People were at risk of choking. During the inspection we saw a person being fed whilst lying down. Another person's risk assessment had not been updated after an incident of choking.
- People continued to be at risk of skin damage. Four people's specialist mattresses to reduce the risk of skin damage were found to be on the wrong setting for their weight.
- People were still at risk from the environment. We found unlocked rooms which held items that could be a risk to people. For example, exposed wires, substances that could be hazardous to health and medicine.
- People and staff were at risk from fire. The environment had not been made safe in relation to fire. For example, during the inspection we found the cellar and some rooms did not comply with fire safety regulations. The fire register also held incorrect information regarding who lived at the service and their room numbers.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

After the inspection the provider arranged for work to be completed to ensure the property was safe from

fire hazards and risks associated with fire.

Using medicines safely
At our last inspection the provider had failed to ensure that proper and safe management of medicines were completed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● The provider failed to store, dispose and record medicines in line with best practice.
● People were at risk of overuse of medicines. We found two people's records who were prescribed 'as required' medicines, did not identify the reasons staff gave the medicines. Therefore, there was no evidence staff were assessing the need for these medicines to be administered and measuring the effect of each 'as required' medicine.
● People were at risk of being given medicines which had past the use by date. For example, we found a prescribed cream in three people's bedrooms which had been opened over three months ago. The creams instructions stated the cream must be used or destroyed within three months of opening.
● People were not given individual prescribed thickener. We saw that several people were given a prescribed thickener from the same tin.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing; Recruitment
At our last inspection the provider had failed to ensure all staff had undergone the relevant recruitment checks and had the skills and competencies to provide safe care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.

At our last inspection the provider had failed to ensure there were sufficient numbers of care staff deployed to meet peoples assessed care and support needs. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● People were at risk of unsafe care due to not enough staff being deployed on particular shifts. For example, we found staffing varied from two to six staff per shift. There were 23 people requiring support, four people needed one to one support, three people needed two to one support and 11 people were cared for in bed.
● People and relatives told us that there were not enough staff at times. One person said, "I like to get up at 8.00, I rang my bell at 8.30 but it was 9.00 before I was got up." A relative told us, "It happens frequently that [person] has to wait for a long time before being helped to move or go to the lavatory."

This was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

● People were protected against the employment of unsuitable staff. The provider followed safe staff recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. These are checks to make sure that potential employees are suitable to be working in care.

Preventing and controlling infection including the cleanliness of premises
At our last inspection the provider had failed to ensure that procedures relating to infection control had not been followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations

● We found the cleaning schedules had not always ensured a clean hygienic environment for people. For example, some rooms had an unpleasant odour, a mattress was heavily soiled, the sluice room was dirty, chairs within the communal areas were stained and a freezer in an unlocked room had mould within it.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● Staff received infection control training and had access to personal protective equipment (PPE) such as gloves and aprons, to enable them to reduce the risks of cross infection. These were readily available in all areas of the home.

Safeguarding people from the risk from abuse
At our last inspection the provider had failed to have suitable systems in place to protect people from potential abuse or improper treatment This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

● Staff received training in safeguarding vulnerable adults. They were knowledgeable about the types of abuse and the actions they should take if they had any concerns that people were at risk. People told us they felt safe at Duncote Hall Nursing Home.
● The provider had safeguarding and whistleblowing systems and policies in place.
● Safeguarding alerts had been raised appropriately and records were maintained, including sharing information with the local authority safeguarding and putting measures in place to reduce the chance of reoccurrence.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection we have rated this key question requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection the provider had failed to assess and plan for the delivery of care to keep people safe. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made at this inspection and the provider was no longer in breach of failing to assess and plan for the delivery of care to keep people safe.

- The provider has a condition on their registration which requires them to seek permission from CQC before admitting or re-admitting anyone to the home.
- People had assessments completed before being readmitted into the home. These were in place to ensure staff could meet their needs.
- People and their relatives told us they had been involved in their care planning. One relative told us "[Person] has a brand-new care plan, it's really good."
- Staff told us a person's needs changed their care plan was updated by a senior staff.

Supporting people to live healthier lives and access healthcare services and support. Working together and with other organisations to provide effective and coordinated care.
At our last inspection the provider had failed to ensure all the necessary information was recorded to meet people's needs. This was a breach of Regulation 9 (Person centred care.) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

- People were referred to appropriate healthcare professionals as required. For example, Speech and language therapists, dieticians and doctors.
- When healthcare professionals were involved with people's care, this information had been documented within people care notes.
- Staff supported people to access dentists, opticians and hospital appointments as required.

Meeting people's needs and preferences in relation to eating and drinking
At our last inspection the provider had failed to ensure that people were in receipt of suitable food and hydration to sustain good health This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 14.

● People who were identified as at risk of dehydration did not always have their fluid intake recorded. This meant people were at risk of not having enough to drink.
● People told us the food was good. One person said, "the food is very nice, I enjoy it."
● Staff who worked in the kitchen preparing food, knew people's preferences and dietary requirements.
● We saw staff supporting people to eat and drink appropriately.

Consent to care and treatment
● The service was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law designed to protect people who are unable to make decisions about their own care and support. For example, the provider had documented that relatives had made decisions for people without the relevant legal agreement such as a power of attorney.
● The service was providing care that could deprive people of their liberty. They had followed the correct processes to ensure people were only deprived of their liberty when this was in their best interests and authorised under the Deprivation of Liberty Safeguards (DoLS). DoLS provides legal protection for people in hospitals or care homes who are unable to make decisions about their own care and support and who need to be deprived of their liberty in their best interests.
● Staff understood the MCA and knew which people had a DoLS in place.

Staff support, training, skills and experience
● Staff completed an induction and training before starting work at Duncote Hall Nursing Home. Staff told us they read peoples care plans and spent time with people during their induction period.
● Inductions had not always been recorded for agency staff.
● Training records showed that staff were trained in line with the providers policies. However, the manager could not evidence specific training in relation for a specific emergency medicine.

Adapting the design and decoration of the premises to meet people's needs
● The service provided equipment to support people's independence and the meeting of people's personal care needs, such as shower chairs, hoists and lowered beds to meet individual's needs.
● There were different areas within the service for people to use for their preferred activities, and private space to spend time with their families or visitors, or to have time alone.
● People's rooms were personalised for them.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained the same.
This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
At our last inspection the provider had failed to ensure People were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

- People's privacy and dignity was not maintained. For example, during the inspection we heard staff talk loudly to each other about people's bowel movements on three separate occasions. This did not respect people's privacy.
- We found that people's archived notes which contained personal information about them had been stored in an unlocked bathroom. This was a breach of people's data protection rights as their information was not kept securely.
- At times staff did not respond appropriately to people. For example, on two occasions people became agitated with staff completing a task. On both occasions staff did not respond to what the person was asking them.

This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Treating people with kindness, respect and compassion
At our last inspection the provider had failed to ensure people received person centred care to meet their needs and reflect their personal preferences. This was a breach of regulation 9 (Person Centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.
- People told us that staff treated them with kindness. One person told us, "The carers are lovely." Another person said, "I'm happy here, the care is good."
- We saw some staff interacting with people in a compassionate way and taking their time with each person. For example, during lunch we witnessed staff explaining to people what they had chosen, checking people were happy with their choice and offering support as needed.
- Staff told us they knew people well. Staff had information regarding people's history, background and significant people in their lives. This supported staff to interact with people in way they liked and could talk about things that interested them.

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

● Most people had their communicate needs documented within their care plans, however, one person had conflicting information recorded regarding how they communicated.

● People and relatives, when appropriate were involved in documenting information within their care plans. A person said, "I had a review about a month ago." Another person told us, "I've just finished going through my care plan, I had an opportunity to speak to [staff] on a one to one basis."

● People were asked how they wanted their care to be completed. People could choose to have a specific gender of staff to complete personal tasks.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained the same. This meant people's needs were not always met.

Planning personalised care
At our last inspection the provider had failed to have the information and time required to achieve people's preferences and ensure their needs were met. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

- Care plans had been completed with people's needs and choices, including information on their culture, region and faith. One person told us, "Staff know my likes and dislikes."
- The manager told us, that due to the staff supporting two people who previously spent all their time in bed, they both now spent time, either in communal areas or in their bedrooms.
- Staff told us they had read people's care plans and knew people well.

Meeting people's communication needs
- The service was meeting the requirements of the Accessible Information Standard (AIS). The AIS tells organisations what they have to do to help ensure people with a disability or sensory loss get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
- Two people used a white board to communicate with staff. This allowed them to communicate their needs to staff.
- The manager told us that any information could be adapted into another format, such as easy read, large print or another language. Some people had their care plans read to them, to ensure they understood what had been written about them.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant
- Although there were activity co-ordinators who interacted with people and arranged activities, people still told us that there were limited things to do at the service. One person told us, "I'm fed up, there is no one here." A relative said "Not much", when we were discussing activities.
- Relatives and friends of the people who lived at Duncote Hall Nursing Home, told us they were made to feel welcome when they came and stated that staff were friendly towards them.
- The provider arranged services for people's faiths. A minister came to the service every two weeks to hold a service to met people's religious needs.

Improving the quality of care in response to complaints or concerns
- People and their relatives knew how to make a complaint. One person told us, "I would speak to [the

manager] or [the deputy manager], I find them both very helpful."
● Staff we spoke to told us they hadn't needed to complain but would tell the management team if they had any issues.
● There were procedures in place for making compliments and complaints about the service. All complaints we saw had been investigated and responded to within the providers specified timeframe.

End of life care and support
● Staff supported people with end of life care and support.
● Not all end of life care plans recorded the wishes of the person regarding any care leading up to their death. For example, if they wanted a priest or minister to deliver their last rights or if there were any objects or sounds that they wanted played or in their room.
● People had it recorded within their care files, if they had a 'do not attempt cardiopulmonary resuscitation order'.
● Staff received end of life training.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Leadership vision, values and culture. Managing the quality of the service, meeting legal requirements and staff and managers being clear about their responsibilities
At our last inspection the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. The provider also failed to keep people's confidential data secure. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

●The service did not have a registered manager in post, however the manager was in the process of registering. Although the provider, area manager and home manager had made many improvements to the service, there were still areas of risk. The provider had failed to have systems to assess and monitor the safety of the home, placing people at risk of injury, infection and harm.
●People were at risk of not receiving safe care. The provider failed to have suitable systems in place to ensure all risks had been identified, assessed, monitored and actions put into place to mitigate them. For example, risk assessments had not been updated after an incident and fire control measures had not been implemented to keep people safe.
●The provider could not ensure the correct deployment of skilled staff due to not having a dependency tool in place, incorrect information being held about staff qualifications and spot checks not being completed.
●The provider did not have an effective system in place to ensure the safety of the environment and equipment. People living at the home were at risk of accessing areas that were unsafe. For example, unlocked rooms with exposed wires or substances accessible such as thickener which could cause them harm. People were at risk due to incorrect settings on pressure relieving mattresses.
● Four of the care plans we looked at had incorrect or missing information within them. For example, one person's care plan did not identify, they often refused their main meal. Another person's care file contained the wrong type of food constancy. This meant that staff did not have the information required to care for people safely or meet their assessed needs.
● Audits had not identified issues relating to medicine recording, staff training and gaps in recording for fluid intake, repositioning checks and safety checks. This meant the provider did not identify where care standards had failed and had not put actions in place to reduce risks to people.
● Information was not kept securely. We found unlocked rooms and cupboards which contained people's personal and private information. This meant people's privacy was not respected and that the service was not complaint with General Data Protection Regulation.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Acting with honesty and transparency if something goes wrong
● The provider was meeting the requirements of the duty of candour. The duty of candour is a legal duty for providers to act openly and honestly, and to provide an apology if something goes wrong.
● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

Engaging and involving people using the service, the public and staff
● People, relatives and staff had been sent surveys asking for their views about key aspects of the service. However, the provider was still waiting for surveys to be returned before putting actions into place.
●People, relatives and staff told us the manager was visible within the service and they could access them if needed.
● Staff told us they worked as a team and were supported by the management team as required.

Continuous learning, innovation and improving the quality of care. Working in partnership with others
● The manager had been working closely with partner agencies to improve the service.
● The staff had handovers and meetings to discuss people and processes to support learning and improvement to care.