Durham Care Line Limited

De Bruce Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
De Bruce Court is a residential care home providing personal and nursing care to 21 people at the time of the inspection. Care is provided to younger adults and older people, some of whom have dementia, physical disabilities or mental health needs. The service can support up to 46 people.

People's experience of using this service and what we found
The provider and the management team had taken steps to improve the service and ensured people received safer care. An action plan to address the warning notice issued by CQC had been developed and was being completed. Some of the requirements of the warning notice had been met, but not all.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Decisions made in people's best interests had not always been recorded appropriately.

Quality assurance systems to measure the effectiveness of the service had improved, but further improvements were still needed. The management team had a better oversight of the service and this needed to be sustained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 29 November 2019) when there were five breaches of regulation. Following our previous inspection, we served a warning notice on the provider. We required them to be compliant with Regulation 17 (good governance) of the Health and Social Care Act 2008 Regulations 2014 by 30 November 2019.

Why we inspected
We undertook this targeted inspection to check whether the warning notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on warning notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for De

Bruce Court on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Inspected but not rated**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Inspected but not rated**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Inspected but not rated**

De Bruce Court

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the warning notice in relation to Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
De Bruce Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

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. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke

with six members of staff including the manager, the deputy manager, a nurse, a senior care assistant and two care assistants.

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

Inspected but not rated

Is the service safe?

Our findings

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

At the previous inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice. Some improvements were noted, but further improvements were needed. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At the previous inspection we found risks were not always well managed. The loft space was not secured which put people at risk of harm. When we started the previous inspection on the evening of 13 August 2019, we found all eight staff on duty had not completed training in how to use evacuation equipment.

- Key codes were now in place which meant people could not access the loft space, which reduced the risk of harm.
- Improvements had been made to staff training and all staff had completed training in how to use evacuation equipment.

Staffing and recruitment
At the previous inspection we found recruitment procedures were not always safe which placed people at risk of harm.

- Action had been taken to make improvements and recruitment procedures were more thorough.

Using medicines safely
At the previous inspection we found medicines were not managed safely as medicine records had not been completed correctly and care plans and risk assessments were not always up to date.

- Some improvements had been made, but further improvements were needed. There was still no clear guidance for staff to follow for one person who received medicines 'when required.' The manager said they would rectify this.

Inspected but not rated

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 the previous inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice. Some improvements were noted, but further improvements were needed. We will assess all of the key question at the next comprehensive inspection of the service.

Ensuring consent to care and treatment in line with law and guidance
At the previous inspection we found the provider was not working within the principles of the Mental Capacity Act 2005 (MCA). Mental capacity assessments had not always been carried out when required. Where people were unable to give their consent, decisions had not always been made in their best interests and documented appropriately. At this inspection we found some improvements had been made, but further improvements were needed.

The 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- The provider was still not working within the principles of the MCA. Although there had been some improvements in documenting decisions taken in people's best interest, further improvement was needed. Two people still did not have appropriate best interest decisions documented.

Supporting people to eat and drink enough to maintain a balanced diet
At the previous inspection we found incomplete records meant we could not always be sure people received enough to eat and drink.

- Improvements were noted in people's eating and drinking records.

Inspected but not rated

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 the previous inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice. Some improvements were noted, but further improvements were needed. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the previous inspection we found quality monitoring systems were not effective and care records were not always complete and accurate.

● Improvements had been made to people's care records. People's weight had been checked regularly and their risk of pressure damage was being monitored more closely. Further improvements were needed as we found one person's care records still contained gaps.
● Action had been taken to improve the quality monitoring of the service. Whilst several improvements were noted on this inspection, these need to be sustained and further developments were still needed. The requirements of the warning notice have been partially met.