Qualia Care Limited

Duchess Gardens Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Duchess Gardens Care Centre is a residential and nursing care home providing personal and nursing care to 45 people at the time of our inspection. The service can support up to 131 people. At the time of our inspection, some units in the home were not in use.

People's experience of using this service and what we found
Some of the concerns we found at this inspection related to issues found at our previous inspection, meaning action needed to achieve the necessary improvements had not been taken.

The provider was unable to demonstrate robust governance arrangements and learning had not taken place. Systems and processes designed to identify shortfalls and drive improvement were not effective and had not identified the concerns we found.

Care plans and good governance were areas of concern identified in our inspection of July 2021 when we took enforcement action. These concerns remained at this inspection.

The provider had not assessed and mitigated risks to people, and people did not have accurate and complete care records. This included hazards in the home's living environment as well as risks associated with people's health, safety and wellbeing. Procedures failed to safeguard people from the risk of abuse.

People did not always receive their medicines in a safe way. The systems in place and management oversight had failed to identify shortfalls.

Staff were non-compliant in following government guidance on wearing personal protective equipment correctly.

Privacy and dignity were not always promoted. Staff were not always observed to be being respectful and caring and at times we observed a lack of interaction between staff and people.

Safe recruitment practises were not followed as the required background checks had not been undertaken before staff started work at the home.

Most people and relatives told us they felt safe, and most of the feedback from people was positive for the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 16 September 2021), when there were breaches of

regulation. 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 the provider remained in breach of regulations. This service has been rated requires improvement for three consecutive inspections and inadequate for the last consecutive three inspections, including this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Duchess Gardens Care Centre on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well led sections of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches of relation to, safe care and treatment, safeguarding, medicines, ensuring the premises are safe, infection prevention and control, staffing, dignity and respect and good governance.

Please see the action we have told the provider to take at the end of this full report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 return sooner.

Special Measures:
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, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as 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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Duchess Gardens Care Centre

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first day of inspection was carried out by three inspectors. An expert by experience worked remotely. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by four inspectors, a medicines inspector and an Expert by Experience onsite. The third day of inspection was carried out by two inspectors.

Service and service type
Duchess Gardens Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Duchess Gardens Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the first two days and announced on the third day.

What we did before 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 (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and nine relatives about their experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with 10 staff members including the registered manager, clinical lead, nurses, care workers, agency staff and receptionist.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Where we had concerns about people, we made referrals to the local safeguarding authority. We also met with the provider and local authority to discuss the most urgent concerns and were assured immediate action had taken 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. At this inspection the rating for this key question has remained inadequate.
This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and we found new concerns which means the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management, learning lessons when things go wrong.
● People were at risk of harm because risks had not been adequately assessed and monitored. Some of the issues we raised had been identified at previous inspections. Lessons had not been learned and action had not been taken.
● At the last inspection we found there was no accurate documentation or monitoring of the amount of food or fluid people were receiving. This had not been rectified at this inspection and we found daily records that had not been updated throughout the day. We found gaps, lack of information, and no daily target for fluids. They were not always being completed in a timely way. We were not assured people were receiving enough food and fluid due to the shortfalls in the documentation.
● We reviewed daily progress notes for moving and positioning changes and 20-minute safety checks. We reviewed in detail across two inspections days six people's records. These records showed documentation was not completed after each activity. We reviewed records of a person at 4pm on the first day of inspection, and there had been no documentation for any safety checks or positional turns from 7.40am that morning. We were not assured the care activities were being done as per care plan or that the documents were an accurate reflection of care activities provided, which placed people at risk.
●We reviewed 12 peoples care plans and risk assessments and found shortfalls in them all. Risks relating to people's skin integrity, wound management, mobility, nutrition and hydration, choking risks and catheter care were not assessed or monitored effectively. One person had sustained a skin tear on their leg and despite care workers reporting this to clinical staff, no medical review or treatment was provided for up to two weeks following the injury. Therefore, the person was at increased risk of infection and potential further injury as no short-term care plan had been implemented to guide staff on how to provide safe care.
● Peoples weights were not being adequately monitored. We found some people who had been identified as being high nutritional risk and required weighing weekly. On reviewing these people's records, we found evidence that these weekly weights were not being done consistently.
● We found many people's care plans for skin integrity referred to them being on air flow mattresses however, care plans did not contain guidance for staff on what the mattress settings for people should be. We found some peoples air flow mattresses were set incorrectly. For example, one person weighed 50kg, but

their mattress was set to 130kg. This put people at higher risk of pressure damage when in bed.
● We observed multiple occasions when call bells were out of reach for people to use when in their bedrooms, and also observed some rooms where no call bells were available. This meant these people were unable to summon help should they need it and had no access to call staff in an emergency.
●The environment was not always clean and free from hazards. Many areas of the home appeared unclean, with stains on walls in bedrooms and dirty floors. Multiple bedrooms had broken furniture We observed there were free standing heaters in some bedrooms as well as in communal areas which were hot to touch. On day one and two there were no risk assessments in place for these heaters. On day three the provider had implemented risk assessments for the heaters and they continued to be in use. Some storage cupboards were not locked containing potentially hazardous substances. This meant vulnerable people were at risk of harm.
● Some Personal Emergency Evacuation plans (PEEPs) were not always accurate or reflective of the person's room number, floor or mobility. We sought assurances from the provider that these would be addressed.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
●Medicines were not always managed safely.
● Emergency medication that should be available in the event of a seizure for one person was out of date and there was no replacement stock within the home. This medication had expired in February 2022 meaning it was unavailable from 28 February 2022, a total of 21 days. This meant the person was at risk of harm should they have needed the medication.
● One person was prescribed medication to take 1-2 at night. We found staff were always administering two tablets. Staff we spoke to were unable to advise when the variable dose should be given as one or two. There was no guidance to support staff decision in the persons care plan or on the medication administration records (MAR).
● Two people were prescribed thickener resource to thicken their drinks to aid safe swallowing. This was not being recorded when being used, therefore we were not assured this was being used safely. Multiple documents contained conflicting information and guidance on how to use this. We observed thick and easy was stored in their bedrooms, not in a locked cupboard.
● People who required as and when (PRN) medication did not always have a protocol in place for staff to follow to ensure the safe administration of these medications. Details in the protocols were not always person-centred meaning that staff who did not know residents well might not know what signs to look for to indicate someone was in pain and required pain relief.
● Guidance and records were not in place to support the safe administration of topical medicines including creams. We were not assured people were having their creams applied as frequently as the prescriber's instructions stated.

We found no evidence that people had been harmed. However, medicines management was not safe which put people at risk of harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Government guidance on the prevention and control of infections was not always followed. Personal Protective Equipment (PPE) was not consistently worn by staff. We observed multiple occasions when staff

were not wearing face masks properly. This meant risks to vulnerable people were increased and they were at a heightened risk of infection.
● Not all staff were bare below the elbows, some staff were wearing watches and bracelets, which increases risk of cross infection.
● We inspected the cleanliness of high touch points and found that these areas were not clean which increased infection transmission risks to people.
● On reviewing the infection prevention and control audits we found staff had not received updated hand hygiene procedures and we did not observe staff using hand gels on the day of inspection. The audit failed to identify cleanliness issues which we observed during the inspection. For example, the switches in the ground floor dining room were stained with food, as was the handrail. This was evident on day one of inspection and the audit was completed two days later and failed to identify this. On day two of the inspection, after the audit, the switches and hand rail were still stained.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection prevention and control measures were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was supporting relatives and friends to visit people safely. Relatives confirmed they were offered PPE and arrangements were in place for them to complete a lateral flow test before coming into the service.

Systems and processes to safeguard people from the risk of abuse
● We identified reports of people having injuries when the cause was unknown. There was no evidence of a follow up investigation or a referral to the relevant safeguarding authority. Unexplained injuries were not investigated to establish if there were signs of abuse. This meant we were not assured people were protected from the risk of injury or harm from abuse.
● We found evidence staff were not recognising or reporting safeguarding incidents. We observed one person who had a large bruise on the palm of their hand and was wincing in pain. Staff had not noticed this and therefore failed to document and report this injury. This meant there was a delay in investigating how the injury occurred and managing the person's pain and discomfort.
● We found examples of accidents and incidents that had either not been reported to CQC or the local safeguarding authority despite accident forms being completed. This meant there was no monitoring or oversight from external bodies. We have made referrals to the local safeguarding authority.

Systems were either not in place or robust enough to demonstrate people were safeguarded from abuse and neglect. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Overall people told us they felt safe. One person said, "I am safe and comfortable here, we all have our own rooms." Relatives also told us they felt people were safe and had no concerns.

Staffing and recruitment
● Safe recruitment practices were not followed. We found systems were not in place to ensure the required checks were in place. This meant people were at risk of being cared for by staff who were not suitable to work in a caring role.
● We found staff were not deployed effectively within the service to ensure people's needs were met and

people were kept safe. The first floor on all three days of inspection had people staying in their bedrooms, however, on multiple occasions for varying time frames we observed no staff members on this floor.
● On the lower ground floor there were only two care staff to support 11 people, five of which required two staff to provide personal cares. During the inspection we observed people being left with no staff presence when they attended to others personal care needs. This left people at risk of potential harm or injury.
● We observed agency care workers being deployed to the most vulnerable people in the service to provide support with activities such as food and fluids, despite not being given any background information on the person's needs or choking risks.

We found no evidence that people had been harmed. However, systems were not in place to ensure that staff were recruited safely. This put people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Inadequate

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. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence, ensuring people are well treated and supported; respecting equality and diversity

- Privacy and dignity were not always respected, and caring interactions were not always observed.
- We observed occasions where staff members were providing food and drink to people and not interacting with them throughout the meal. There was no description of the meal for the person, no conversations, no checking if the person was ok or enjoying the food.
- We observed food being put near people on tables, but no effort to ensure they could reach these meals comfortably. One person was sat in a chair and their meal was placed on an overbed table and pushed towards them. This person could not reach the meal properly as the table was not placed close enough. The person attempted to eat the food with their fingers, no assistance was provided. A small amount of food was eaten, and the plate was then removed by staff. This person had been observed in the lounge from 9.30am and had not been offered a drink until lunch time.
- People requesting support were not always given this in a timely or responsive manner. One person had asked for staff to take them to the toilet, this person waited over 30 minutes for carers to arrive and support with this. Another person was complaining of being in pain and requested pain relief. Care staff acknowledged the person's pain and informed them they would let the nurse know. This person had not received any pain relief or was seen by the nurse for over an hour after they requested it.
- We observed people in their rooms with doors open and catheter bags positioned facing the door. This showed a lack of respect for people's privacy and dignity in relation to their continence care.
- Staff were not always respectful of people's bedrooms and were not understanding of people's privacy. We observed two staff members sat in a person bedroom while they were asleep. One staff member was sat in the chair and the other staff member was sat on the cabinet completing people's care files.
- We found some staff did not know the needs of the people they were caring for. Information was not shared robustly with agency care workers. This impacted on the quality of care people were receiving as the home relied heavily on agency staff members.
- Feedback on staff from people was mixed. Some people said staff were brilliant and others said it depended which staff members were working as to whether the care was good.

We found no evidence that people had been harmed. However, we observed practice which showed a lack of respect for people and occasions when staff should have been more thoughtful. This was a breach of Regulation 10 (Privacy and Dignity) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● We did observe some caring interactions from some staff members, and we found some of the staff knew people well and showed kindness towards them.
● Activities were taking place on inspection days which we observed to be music related, sing a long and old time music. People appeared to be enjoying this.

Supporting people to express their views and be involved in making decisions about their care
● People were not always involved in decision making. One person had a leak from the toilet in their room. They were temporarily moved up stairs into another bedroom. The person told us that they wished to have some of their personal effects around them, such as clothes and a music player. We shared this with the registered manager and identified that there had been no discussion with this person regarding the move and how to make it more comfortable for them. There was no regard for how this would affect them, they had not been involved in the decision making.
● Feedback from people and relatives was mixed in terms of whether staff supported people to be involved in decision making.
●Some people told us "Staff do listen to me, if I ask for a drink of pop or juice, they bring it eventually." Another person told us, "I am quite content".
● Another person told us "There are good and bad ones [care staff], the bad ones ignore me when I press the buzzer, others turn it off at the wall."
● On the residential floor we observed a staff member engaged in a specific activity making chocolate crispy cakes with people who had chosen not to go to the planned music activities. People's choices were respected, and they were provided with alternative activities. This was not replicated across the other three floors in the home.

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. At this inspection the rating for this key question has remained inadequate. 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.

Before this inspection, Duchess Gardens Care Centre had been rated as Inadequate at the last two consecutive inspections, and prior to these the service was rated as Requires Improvement at the previous inspections. This is the fourth consecutive inspection where we have identified a breach of regulation regarding systems of governance. This meant the improvements necessary to achieve a rating of good or outstanding overall have consistently not been met.

At our last inspection the providers systems to ensure oversight had not been found to be effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and we found new concerns which means the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Significant shortfalls had been identified at the last three inspections. We found continued breaches of regulations relating to the management of risk, and good governance. We also found new regulatory breaches relating to safe environments, medicines, the safe recruitment of staff, privacy and dignity, safeguarding and infection prevention and control.
- Issues around people not receiving dignified care were identified at the previous three inspections. We observed practices at this inspection which showed this was still a concern.
- At the last two inspections we identified care plans and risk assessments were not up to date or lacked detail. We looked at care plans and risk assessments at this inspection and found the same issues. The provider was updating these at the time of inspection however, we found the updated versions still had inaccuracies throughout and lacked people's involvement. This showed prompt action had not been taken to update the care plans robustly following the last inspection findings.
- We were not assured of effective oversight in the service. Quality checks and daily documentation had not improved since the last inspection. There was lack of monitoring for food and fluid charts, moving and positioning, and safety checks.
- The home was still running on high agency usage and had not been successful in employing their own nurses and was solely relying on agency nurses. We found the floors lacked effective leadership as a result of this.
- Staff were not clear about their roles or responsibilities. On the first two days of inspection, nurses were

unsure which people required nursing care and were unable to agree with the clinical lead on who was responsible for the documentation on the daily hand overs. The management of staff, expectations and roles was disjointed and poorly managed. This resulted in shortfalls in the systems and processes which put people at risk.
● A variety of audits had been carried out by the registered manager and other senior leaders for the provider. Some of these audits identified issues that needed to be followed up and were not, such as the medication audit completed in December 2021. Audits had not identified the issues we found on inspection.

The above evidence demonstrated that people were placed at the continued risk of harm through the lack of effective governance systems. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
●The provider could not demonstrate continuous learning and improvement. The significant shortfalls identified at the last three inspections had not been addressed. The service had been supported by the local authority and commissioning team to improve standards. However, during the inspection we found there was a failure to make the necessary improvements.
● The provider had not addressed issues raised at the last inspection.
● Accidents and incidents were being recorded however, records showed there was no investigation or follow up action plan to identify how the accident occurred and what would be done to mitigate future risks. There was no evidence of lessons learnt from these.
● We were not assured the provider was sharing notifiable information with the CQC and safeguarding. We found examples of injuries to people which had not been reported as a notification. For example, one person had an unwitnessed fall which resulted in a skin tear. This was not reported to CQC.

The provider had failed to ensure their audit and governance systems remained effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider was unable to demonstrate they understood and acted on their duty of candour responsibilities. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.
● Relatives spoke positively about the service and noted some improvements. One relative told us "It is better now. When I wasn't able to come, they didn't let me know how he [family member] was. They are doing that better recently."
● We saw evidence of resident's meetings held with people in the service and monthly staff meetings being held.
●Relative satisfaction surveys showed several responses showed mainly positive feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, and working in partnership with others.
● The majority of relatives told us they knew who the registered manager was and said, "[The registered manager] is lovely, and "[The registered manager] seems to be good." People spoken with also knew who

the registered manager was.

● The majority of staff feedback was positive, with staff telling us, "The registered manager is approachable and supportive," and another said "It's much nicer to work here now than before."

● We saw evidence of partnership working with a variety of health professionals to meet people's needs.