Care UK Community Partnerships Ltd

Darlington Court

Inspection report

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Date of inspection visit:
01 December 2020
23 December 2020

Date of publication:
16 February 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Darlington Court is a residential care home providing nursing care and support for up to 61 people. People were living with a range of needs associated with the frailties of old age and some people were living with dementia or other mental health needs. There were 45 people living at the service on the days of our inspection.

People's experience of using this service and what we found
We found that staff did not always follow policies and procedures that were put in place to protect people and staff during an outbreak of COVID-19. We identified issues in the way people were admitted to the service, staff following specific safety procedures and the recording of some cleaning tasks designed to reduce the risk of infection.

There were enough staff working to provide the support people needed. However, the COVID-19 pandemic had created an increased level of sickness amongst staff and required the high usage of agency staff and the need for permanent staff to carry out tasks that were not usually part of their role.

Staff were wearing appropriate PPE in-line with government guidelines. Staff had completed infection prevention and control (IPC) training. People received their medicines safely, when they needed them. COVID-19 testing was in place and the management of the service worked closely with other stakeholders, such as the Local Authority and Public Health.

People received care from kind staff who were committed to keeping them safe and meeting their needs. Quality assurance systems were in place and ensured good quality care in many aspects of the service. Staff felt supported by management, and senior managers had implemented systems and training to drive improvement of the shortfalls identified.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Rating at last inspection
The last rating for this service was Good (published 10 March 2020).

Why we inspected
We first undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about an outbreak of COVID-19. A decision was made for us to inspect and examine those risks. Subsequently after the first day of inspection, the provider received test results that confirmed a further significant number of people living at the service had contracted COVID-19. After these test results, a decision was made for us to inspect and examine those further risks. We returned for a second day and undertook a focused inspection in light of concerns we had

received. We reviewed the key questions of Safe and Well Led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Darlington Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection
The first day of the inspection took place on 1 December 2020 and was announced. After receiving further information of concern, we returned for a second day of inspection on 23 December 2020 which was unannounced.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Darlington 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.

Notice of inspection
We gave a short notice period on the first day of the inspection. This was because of the COVID-19 (coronavirus) pandemic. We needed to know about the provider's infection control procedures to make sure we worked in line with their guidance. Due to the COVID-19 pandemic, we needed to limit the time we spent at the service.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used this information to plan our inspection.

We used the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
Many people living at the service were either self-isolating or unwilling to speak with us. We spoke with the registered manager, a regional quality manager, a manager from another service within the group, a registered nurse and four care staff. We spent a short time in the service whilst people were eating their lunch. This allowed us to safely look at areas of the service and gave us an opportunity to observe staff interactions with people.

We reviewed a range of records. This included four people's care records, medicine records, and further records relating to the quality assurance of the service, including policies and procedures and cleaning schedules.

After the inspection
We spoke with three relatives of people living at the service by telephone to gain further feedback around the admissions process to the service and the care delivered.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection in January 2020, this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

● On the first day of our inspection, the service was in the process of managing an outbreak of COVID-19 and we were assured that people were protected by the prevention and control of infection. However, following on from the first day of our inspection, the provider received test results that confirmed a further significant number of people living in the service had contracted COVID-19. After these test results, and further information, there were concerns in respect to the management and control of infection. We therefore returned for a second day of our inspection to look at these concerns and found areas of practice in need of improvement.

● On both days of the inspection we looked at the provider's 'outbreak management plan'. The plan stated that during an outbreak, the service must cease all respite care admissions. Furthermore, any permanent admissions to the service, either through private or NHS channels, needed to be agreed by a senior regional member of staff.

● After our first day of inspection, despite the service being in an outbreak, three people were admitted to the service for respite care, and one person was admitted permanently without agreement from senior regional staff. We asked management staff why these people were admitted to the service during an outbreak of COVID-19, but they were not able to tell us why the provider's outbreak management plan had not been followed. Feedback from relatives of the people admitted to the service was mixed in respect to the amount of information they were given regarding the COVID-19 status of the service before their relative was admitted. We therefore could not be assured that the provider was admitting people safely to the service.

● The service appeared clean and well maintained, and we observed staff cleaning throughout both days of the inspection. An important part of preventing the spread of infection to ensure that 'touch points' such as hand rails and door handles are cleaned regularly, as these are areas where infection can be passed between people moving around the service.

● We looked at records of touch point cleaning that were recorded after the first day of our inspection. We found there were gaps and omissions in the recording of cleaning tasks. A senior member of staff told us that due to high levels of staff sickness and absence there had been days when other colleagues and agency staff were supporting as best they could with touch point cleaning. However, records were not always updated. Touch point cleaning may have happened on the days that records were not completed, however due to the nature of the outbreak at the service we could not be assured the provider was promoting safety through the hygiene practices at the premises.

● An important part of infection prevention and control is to limit ways in which infection can transfer throughout the service. Good practice is to ensure that staff are allocated to specific areas of the service.

Staff should work in pre-planned cohorts and ensure that 'clean zones' are available for staff to change and rest.

● Senior staff told us that staff entered the service in their own clothes and had a dedicated area to change, that staff were allocated areas to work in and should not access other areas of the service. However, they told us that these practices had been impacted by high levels of sickness and the use of agency staff. They stated that on occasion it could not be helped that staff accessed different areas of the service as they were needed to support people with their care and keep them safe.

● This was echoed by staff we spoke with. One member of staff told us, "I think we are struggling with the zoning of staff and making sure we didn't cross units and floors. We've not always had enough staff to do this and we have other tasks to do like extra cleaning." Another member of staff said, "We've had a lot of sickness, there was nothing we could do, we had to switch between units to help people."

People had been placed at risk as the provider had failed to assess the risk of, and ensure the, prevention, detection and controlling of infections. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider's infection prevention and control policy was up to date. However, based on the evidence we saw at this inspection, it was not always followed by staff.

● Staff were observed to be socially distancing and assisting people to do the same. We saw signage and information for staff to inform them of which people were shielding.

● We were assured that the provider was preventing visitors from catching and spreading infections. The service was closed to visitors. Visitors who had to enter the service, such as health and social care professionals, were required to wear personal protective equipment (PPE), had their temperatures taken and completed a COVID-19 safety questionnaire before entering the service. Hand-washing facilities and antibacterial hand rub were also available.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

Staffing and recruitment

● The provider had a dependency tool which helped them assess their staffing levels. This tool was accurate and informed the management of the service how many staff were required to meet people's assessed needs, and our observations supported this. However, due to COVID-19, many staff were isolating and not at work. This had resulted in high usage of agency staff and the need for some staff to carry out tasks that were not part of their usual role.

● Staff had worked exceptionally hard during the outbreak to keep people safe and meet their needs. However, due to staff changes and modification of roles there had been an impact on the care people received, such as in levels of cleaning at the service and the ability to zone and cohort staff adequately to reduce the risk of infection.

Using medicines safely

● Registered nurses and care staff were trained in the administration of medicines. A member of staff explained the medicines procedures to us. They were knowledgeable and knew what medicine people needed and how they liked to take them.

● The medicines people took were recorded in Medication Administration Records (MAR). The MARs we saw were completed accurately and correctly. We saw evidence of audit activity that showed where any errors were found, corrective action had been taken and recorded.

● Medicines were stored appropriately and securely in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were

disposed of safely. Nobody we spoke with expressed any concerns around medicines.

Assessing risk, safety monitoring and management;
● Staff knew people well and understood risks associated with their care. Care plans contained information regarding people's mobility and falls risk.
● Where people had health conditions, there was guidance and risk assessments in care plans. Staff had received appropriate training, had competency assessments and were following assessed guidance issued by health professionals to manage people's specific health needs. People with behaviours that may challenge were understood and supported well.
● A relative told us, "I have no concerns about the care being delivered to [my relative] or their safety."

Systems and processes to safeguard people from the risk of abuse
● Staff had received safeguarding training and updates. There was also information on how to raise any issues or concerns displayed around the service.
● There had been some recent safeguarding investigations carried out by the local authority safeguarding team. We saw evidence staff had assisted and complied appropriately with all investigations.

Learning lessons when things go wrong
● Staff took appropriate action following accidents and incidents to ensure people's safety. We saw that specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Requires Improvement

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 last inspection in January 2020, this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Policies and procedures in place had not always been followed. Policies and procedures such as the provider's outbreak management plan and the pandemic plan were in place to keep people and staff safe and to try and mitigate risk of further infection. New admissions to the service had been requested by stakeholders that including the Local Authority. Staff at the service had facilitated these new admissions to the service during an outbreak of COVID-19, which was against policy and guidance from the provider. The provider's systems of governance should have had oversight of this and prevented these admissions, in line with their policies and procedures. We have identified this as an area of practice that needs improvement.
- Senior management at the service subsequently put systems in place to protect people and improve the service. For example, closing the service to admissions, bringing in management staff from other areas of the business to analyse the reasons behind the outbreak and help the most vulnerable people and to train and support staff.
- We also saw a number of audits, checks and monitoring systems including medicines and training and supervision. These systems had ensured quality in their specific areas, showed where shortfalls were, and enabled staff to take action.
- Notifications had been sent to the CQC in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Despite the COVID-19 pandemic, the culture of the service was positive and inclusive. Staff told us about the positive impact they made to people living at the service. Although we only spent a short time in the service, we saw staff supporting people with kindness. Staff spoke about people with care and compassion. They told us of the importance of keeping people safe and well-looked after especially during the COVID-19 pandemic. Staff also told us how they felt supported in these difficult times by the managers of the service. One member of staff told us, "The manager has really helped us. We've all pulled together, it's a very difficult time". Another member of staff added, "The manager has been very supportive she has worked so hard for everyone". Relatives spoke highly of the service. Their comments reflected the kindness of staff. One relative told us, "I can't fault the care they provide, they always keep me informed. [Relative] is confined to her room, but she tells me she is happy, and they are all very kind to her". Another relative said, "It's a tough time for all at the home, but they always seem upbeat when I call them".

Working in partnership with others; Continuous learning and improving care

● The service had liaised with organisations within the local community. For example, the Local Authority, Public Health and the Clinical Commissioning Group to assist each other in investigating the concerns around the COVID-19 pandemic, lockdown, outbreak, visitor restrictions and the safety of people and staff. Managers at the service were keen to address and learn from shortfalls in care and were committed to engaging with the relevant professionals to get the outbreak under control and provide safe care going forward.

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

● Staff were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(h) - Safe Care and Treatment The provider had failed to assess the risk of, and preventing, detecting and controlling the spread of infections. This placed people at risk.