Avery Homes Wellingborough Limited

Duke's Court Care Home

Inspection report

159 Northampton Road
Wellingborough
Northamptonshire
NN8 3PN

Tel: 01933445690
Website: www.averyhealthcare.co.uk/care-homes/northamptonshire/wellingborough/dukes-court

Date of inspection visit:
26 April 2022

Date of publication:
15 July 2022

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

About the service
Duke's Court Care Home is a residential care home providing accommodation and personal care to up to 60 people. The service provides support to both older and younger people, people diagnosed with mental health, physical disabilities, dementia and/or sensory impairments. At the time of our inspection there were 55 people using the service.

The home is set out across three floors which can be accessed via lifts. Each floor has a communal lounge and dining room and all rooms have private en-suite facilities.

People's experience of using this service and what we found
Medicines were not consistently managed safely.

Risks to people from the environment or health conditions were not consistently assessed and mitigated. Injuries were not always monitored for trends patterns and changes. Recording of injuries required improvement to ensure good oversight of the health and safety of people.

Staff were not consistently recruited in line with regulatory requirement to ensure only suitable staff worked in the service.

Systems and processes were not consistently effective in monitoring the safety and quality of the service and driving improvements. The provider had not consistently implemented national guidance and ensured regulatory requirements were followed to keep people safe.

The service was working within the principles of The Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt safe and we observed positive interactions between staff and people.

People were protected from the risk of infection and the home was clean and odour free. Personal protective equipment was used appropriately by staff and the provider was following government guidance in relation to COVID-19.

People and their relatives were included in the care planning process and people felt their choices and independence were respected and supported. People were encouraged to share ideas via regular meetings and feedback.

People felt confident in raising concerns with the provider and the provider was open and transparent when things went wrong.

Staff felt well supported and had regular supervision and felt there was a positive culture within the home.

The provider worked in partnership with health and social care professionals.

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 good (published 12 January 2018).

Why we inspected
We received concerns in relation to increased falls, unexplained bruising, medicines errors, low staffing numbers and neglect of personal care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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.

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 Duke's Court Care Home on our website at www.cqc.org.uk.

Enforcement
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 in relation to the safety and managerial oversight of the service at this inspection.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Duke's Court Care 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 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
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Duke's Court Care Home 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. Duke's Court Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 not a registered manager in post, they had left the service and had not yet deregistered. A new manager had been recruited and was due to start their role and an interim manager was supporting the service.

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 who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and three friends and relatives of people using the service, about their experience of the care provided. We spoke with eight members of staff including the regional manager, deputy manager, maintenance person, domestic staff and care workers.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at three 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.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- People were at potential risk of not receiving their medicines as prescribed. Staff did not always have protocols to follow for people's 'as required' [PRN] medicines; to understand why, how and when to give the medicine and the dosage required. When PRN medicines were administered staff had not always recorded the reason why. This meant the effectiveness of the PRN medicines could not be monitored and we could not be assured it was given as directed.
- Where people had sustained and injury, records were not always in place to guide staff in the management of that injury. For example, we found that body maps had not always been completed when an injury was found, and records did not always include the shape, size or colour of injury. There was no follow up information recorded regarding how or when an injury was healing, how often staff should monitor or if any medical support was required. This put people at risk of harm from unmanaged injuries, and the potential risk of deterioration of injuries.
- People were at increased risks of choking. One person's care record contained conflicting information regarding their prescribed drink thickener and consistency of their modified diet (to reduce the risk of choking) . Staff did not record when and how much thickener was administered. Therefore, we could not be assured that people had the correct food and fluid consistency to reduce the risk of choking.
- People were at increased risk of injury from falls. Risk assessments had not always been updated promptly after a person fell to check if additional strategies were required to mitigate the increased risks to people. Trends and patterns of falls had not been identified, such as and times and places to prevent reoccurrence.
- People were not consistently protected from the risk of fire. We found several fire doors were not operating effectively. This meant there was an increased risk of fire spreading should a fire break out in the home.
- Window opening restrictors were not tamper proof and were therefore not compliant with Health and Safety Executive (HSE) requirements for care homes. This meant there was increased risk of falls from height.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks, and to ensure the safe administration of medicines had been completed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe. One person said, "It's a nice place, if I didn't feel safe, I would say so." Staff had access to the provider's safeguarding and whistleblowing policies for guidance and told us they would

be confident to whistle-blow if needed. People appeared relaxed and comfortable around staff.

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.

Staffing and recruitment
● Staff recruitment files required some improvement. The provider completed safe recruitment checks prior to employment such as, Disclosure and Barring Service (DBS) checks and references from previous employers. (DBS provide information including details about convictions and cautions held on the Police National Computer.) However, when a staff member had a gap in their employment history this had not been explored and there was no system in place to check for convictions and cautions on staff DBS going forward, once they were working in the service.
● Staffing levels were appropriate to meet the needs of the people currently being supported at Duke's Court Care Home. When asked if there was enough staff one person said, "Yes I think there are, they are not really rushed." We observed call bells were responded to in a timely manner and one person told us that response times were "Pretty quick." There was a contingency plan in place for staffing which staff told us worked well.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● 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.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Staff told us the domestic team ensured the home was consistently clean and odour free. We observed that domestic staff were prompt to action areas that required cleaning when discreetly highlighted to them by the care team, this ensured the risk of infection was reduced and people's dignity was maintained.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting. Visitors were given appropriate PPE.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Systems and processes were not consistently effective in maintaining oversight of the safety and quality of the service. For example, injuries had either not been recorded or incomplete recording had occurred, concerns found during inspection around medication and inconsistency in individual care plans had not been identified during internal auditing processes. Where issues were identified there were no target dates for actions to be completed.
● Systems and processes were not consistently in place to ensure all equipment was in good working order. For example, there was no evidence of sensor mats checks to ensure staff would be alerted to support people at risk of falls.
● The provider had not followed HSE guidance for care homes regarding prevention of falls from height. Their internal policy had not been followed by staff and did not reflect current guidance.
● The provider's Internal systems and processes had not identified that staff were not consistently recruited in line with regulatory requirement and a system was not in place to ensure ongoing checks of suitability of staff.

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. This was a breach of Regulation 17 (2)(a) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Care plans reflected people's choices preferences, religion, culture and relationships that were important to them. We observed people were encouraged to be as independent as possible and were taking part in individualised activities as well as included in group activities and entertainment. One staff member said, "All people here are treated as individuals, they have their own interests in activities and preferences in care, care plans are reflective of the care people want."
● Staff told us there was a positive culture within the home and staff and people had developed positive relationships. One person told us, "I always have a laugh with them [staff], they pull my leg and I pull theirs." People felt staff were respectful of their independence. One person told us, "They [staff] don't do things for me, unless I ask them to."
● People and their relatives had been involved in the care planning process and important decisions about people. A relative told us they found staff helpful and they were kept up to date with changes. People told us

they knew how to complain and would be confident to do so if they need to.

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

● The provider had responded in writing to people, and those important to them, when things went wrong. The provider had followed their duty of candour policies and procedures as required. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● People, relatives and staff were asked for feedback about the service. We saw evidence of surveys being completed to allow people to voice any improvements required.

● People and staff were offered meetings to discuss changes and share information. One person told us, "They [meetings] are excellent, they [staff] ask us what we want and what we don't want, meals and everything." Staff told us they felt confident to share ideas and suggestions and that they would be listened to.

● There was evidence of partnership working with other professionals such as GPs, District Nurses, Occupation therapists and end of life care specialists to ensure people's healthcare needs could be met.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently ensured that the service was safe and risks to people were mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not consistently maintained effective oversight of the safety and quality of the service.