Drayton House Care Home Ltd

Drayton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Drayton House is a residential care home providing personal care for up to 19 people, including older people and people who may be living with dementia. At the time of our inspection 13 people were living at the service. The home is a grade II listed building in the middle of the town of Bridport. Accommodation is over two floors with stair lift access, some rooms had en-suite facilities others did not.

People's experience of using this service and what we found
People were at risk of harm because the systems in place to ensure they received safe and appropriate care were not effective. After the last inspection in March 2021 the provider told us they would ensure appropriate action was taken in response to all concerns we identified at the inspection. This had not happened.

Some improvements had taken place in relation to staff training and recruitment, but people's experience had not improved or been considered. We found further concerns at this inspection in relation to care plans and individual risk assessments not being reviewed or updated.

The provider's quality assurance processes remained ineffective. Audits had not been completed to identify care plans and risk assessments had not been reviewed or updated. Therefore accurate, complete and contemporaneous records had not been kept for people. This meant that people were at risk of not receiving the care they required in a consistent way.

People remained at risk of infection due to poor infection control processes in the home. Records in relation to cleaning schedules were not complete to enable monitoring or demonstrate compliance with good practice. There was no oversight to ensure cleaning was undertaken on days the cleaner was not working and the visitor process was not being followed in relation to COVID-19 checks.

The oversight of the day to day maintenance by the provider was still not always effective and people remained at risk.

Fire management did not ensure people would be safe in the event of a fire.

A reduction in staff levels in the afternoon had increased the workload for staff. Staff told us they needed to rush to get everything completed. This meant people were not getting good quality care. The provider's representative told us this reduction was a misunderstanding and would be rectified.

Medicines continued to be safely managed and staff understood how to identify and report abuse and spoke with care about the people they supported.

After our last inspection the provider had voluntarily agreed not to admit new people to the home until further improvements were made. This agreement remained in place. The service was being supported by

the quality assurance team from the local authority to help ensure the required improvements were made.

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 (report published 14 May 2021) with six breaches of regulations. At this inspection improvements had not been made and the service had deteriorated to inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We followed up six ongoing breaches of safe care and treatment and good governance found at the previous focused inspection.

The inspection was prompted in part due to a safeguarding concern and concerns about infection control.

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.

Ratings from previous comprehensive inspections for the key questions we did not inspect were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Drayton House 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches in relation to safe care and treatment, staffing and overall governance 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
The overall rating for this service is 'Inadequate' and the service is therefore 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Drayton House

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.

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

Service and service type
Drayton House 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. 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. The manager had applied to the Care Quality Commission (CQC) to become the registered manager and was being processed. The day after the inspection we were informed by the provider the manager had withdrawn their application and would be leaving the service and they would be recruiting a new manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received from the provider and others since the last inspection such as an action plan and a training matrix and feedback from local professionals. We used all of this information to plan our inspection.

During the inspection
We met the majority of people who lived at the home and spoke in depth with three of them. We looked at four people's care records and at medicine records.

We spoke with the manager and the nominated individual (the person responsible for supervising the management of the service on behalf of the provider), and with five other staff which included a senior care assistant, care staff, housekeeping and the administrator.

We reviewed a range of records, this included five people's care records, four staff files in relation to recruitment and at records of staff training and supervision. We reviewed quality monitoring records, such as checklists, handover records, cleaning schedule, complaints folder, accident and incidents and maintenance records.

After the inspection
We continued to seek clarification from the provider's representative to validate evidence found. We held a meeting with the provider, provider's representative and manager on 26 June 2021 to feedback our findings. We contacted the local authority to make them aware of our findings.

Inadequate

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 this key question was rated as requires improvement. At this inspection this key question has new deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At the last inspection in March 2021 systems were either not in place or robust enough to demonstrate safety was 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.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

Assessing risk, safety monitoring and management

- Day to day maintenance was still not always effective. Since our last inspection some repairs to people's bedrooms had been completed but these had not been completed to a good standard. The person told us, "they started to paint it, but they have left that bit white…I don't know if they are coming back to finish it." The flooring in the communal areas had not changed and the décor remained tired. This meant the risk to people of tripping where the floor was lifting had not changed. We saw that the provider had purchased new flooring, but this had not been laid and was stored in the large lounge area along with laundry being dried and staff belongings. One person told us, "There is nothing wrong with the staff, but I don't like the environment."
- Maintenance was not being monitored or prioritised. A ground floor toilet did not have a toilet seat and another toilet was in need of repair. Staff continued to use the ground floor toilet because they told us "That toilet is essential". After the inspection the manager said they were having the toilets repaired. This meant people were using a toilet without a toilet seat.
- Action had been taken after the last inspection to ensure windows had been restricted to ensure vulnerable people were not at risk of falling out and causing themselves harm. However, a monitoring system had not been put in place to ensure the restrictors remained effective.
- Fire management did not ensure people would be safe in the event of a fire. Since our last inspection the provider had commissioned an external fire risk assessment. This had been completed on the 10 May 2021 and had identified several areas of concern and rated the home as a moderate risk. The report stated 'It is considered that the potential consequences of fire at these premises is: Moderate Harm. It is essential that actions are carried out to reduce the risk.' The report identified seven high concerns and stated they needed to be carried out by 17 June 2021. At the time of the inspection no action had been taken to address these concerns.
- At the last inspection we highlighted that a chest of drawers was obstructing a corridor to an external fire exit and were assured this would be removed. At this inspection the corridor remained obstructed by the chest of drawers and additional equipment. The manager assured us this would be removed.
- People's individual risk assessments had not been completed since our last inspection. For example, their

nutritional assessment and skin integrity. This meant we could not be sure people were not at risk of malnutrition or skin breakdown and action being taken to mitigate the risks. We identified a risk to people with capacity issues accessing inappropriate foods. This was because condiments on the tables at mealtimes were in pots with spoons. We observed a person taking a spoonful of pepper and asking what it was.

Preventing and controlling infection

● At the last inspection we identified shortfalls in the infection prevention and control measures at the home. We reviewed these and found improvements had been made but there were still concerns and we were not assured. This meant people were not protected from being exposed to COVID-19.

●A new housekeeper had been employed who worked five days a week. On the days they were not working care staff were required to undertake cleaning tasks. There was no delegation or monitoring that staff had completed cleaning. The cleaning schedule in the week starting 10 May 2021 showed only two days cleaning had been completed. One person told us that their bedroom was cleaned very often. The manager told us they were trying to appoint a second cleaner.

●Records in relation to cleaning schedules were not always complete to demonstrate compliance with good practice. Guidance during the pandemic states areas regularly touched should be regularly cleaned to prevent cross infection. There was no system to ensure touch points were cleaned regularly to prevent cross infection of COVID-19.

● Although a visiting procedure was in place there was no evidence in the signing in book to show that when visitors arrived it had been followed. When the inspectors arrived, the procedure was not followed.

●We were not assured staff were using Personal Protective Equipment [PPE] correctly to reduce the transmission of infection. Throughout our visit the manager on numerous occasions removed their mask. This is contrary to the guidance currently in place.

●The laundry area was in the basement at the home. We saw soiled laundry piled up on the floor in front of the washing machine. This was a cross infection risk.

At our last inspection risks to people's health and well-being were not effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

□●The provider was failing to ensure risks were mitigated in regards the environment.

□●Maintenance concerns at the service were not being monitored or prioritised.

□●The provider failed to ensure effective Infection Prevention Control measures were in place to keep people safe.

□●The provider failed to ensure care plans contained suitable and sufficient risk assessments to effectively manage risks.

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

At the last inspection in March 2021 there were shortfalls in staff recruitment procedures which 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, enough improvement had been made and the provider was

no longer in breach of regulation 19.

Staffing and recruitment

●Recruitment procedures had improved. All new staff employed at the home since our last inspection had undergone a robust recruitment process. This included employment and criminal record checks and reference requests to ensure staff were of good character to work with vulnerable people. A new checklist of recruitment requirements had been put into place which had been completed before new staff had started work at the home. However, checks had not been completed on all staff that had been working at the home before our last inspection. We were assured by the manager these would be completed in the next two weeks.

●The manager told us they had been actively recruiting but had been having difficulties filling some positions. They said gaps in the rota were being covered by staff working additional hours and by agency staff. The manager had also needed to undertake cooking duties on three occasions.

●Since the last inspection the manager had implemented agency staff profiles. However, there was no evidence to demonstrate they had completed a lateral flow test (LFT) to test for COVID-19 before working at the home or undertaken an induction. The manager told us the agency staff also worked at other homes. This meant people could be placed at risk of being exposed to COVID-19 and to staff who were not orientated to the home and what to do in the event of an emergency.

●There were not always enough staff to meet people's needs. Since our last inspection staffing levels had been reduced. A reduction in the cooks' hours had meant care staff were required to deliver the evening meal. This meant that there were only two staff available to undertake care tasks. At the last inspection three care staff were allocated on duty from 8am to 8pm. This had changed and one staff member finished at 7pm. Staff told us it was very difficult to meet people's needs on the evening shift. One staff member commented, "There is not enough in the evenings-… we have everybody ready and prepared for bed by nine so the night staff just support them into bed…we are expected to do cleaning and tidying of the kitchen" They went on to say "at seven a staff member goes home… so cost cutting… made to rush as have to do doubles and clean the kitchen, get care plans filled in. Not giving people the time that they need, feel hurried all the time." The provider's representative said the cook finishing in the kitchen at two was so they could then support activities and was not a cost cutting exercise. This had been misunderstood by the manager. They assured us they would remedy this shortfall in staffing. We requested a revised copy of the next two weeks rota to assure ourselves. The rota's showed that the staff levels had been amended to ensure there were sufficient staff to support people in the evening.

Using medicines safely

●Medicines continued to be safely managed. A new staff member had taken on responsibility of overseeing the medicines, completing the ordering and disposal.

●The manager had implemented a medicine trolley on both floors which we were told by staff had made administering medicines a lot easier.

● We discussed with the manager that medicines waiting to be checked in were not stored securely. They took action and had the cupboard locked.

●The manager had completed medicine competency assessments with eight staff and told us they had further staff to assess.

Systems and processes to safeguard people from the risk of abuse

● Staff knew how to recognise and report abuse. They had received training in safeguarding adults and children. All staff asked, said they were confident action would be taken by the manager if they reported any concerns

Learning lessons when things go wrong

●At the end of the last inspection the provider told us they would ensure appropriate action was taken in response to any concerns identified at the inspection. This had not happened. This meant the provider failed to learn lessons when things went wrong in the service.

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 the last inspection this key question was rated as Requires improvement. At this inspection this key question has new deteriorated to 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.

At the March 2021 inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider remains in breach of regulation 17.

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

- The provider's quality assurance processes remained ineffective as they had not identified the concerns found at this inspection or acted upon concerns from the last inspection. There was a lack of scrutiny by the provider to ensure that their systems for assessing and monitoring the quality and safety of the service were implemented effectively.
- The provider had appointed a consultant to assist with improvements in the home. The consultant had provided an action plan. The implementation of the action plan had not delivered sufficient improvements to the safety of people's care and treatment.
- The systems in place for checking on the quality and safety of the service were ineffective. Audits failed to identify the concerns highlighted on this inspection such as risk assessments, care plans, maintenance issues, the visitor process not being followed and a risk to people with capacity issues accessing inappropriate foods because condiments on the tables at mealtimes were in pots with spoons.
- Accurate, complete and contemporaneous records had not been kept in respect of each person living at the service. Audits had failed to identify a lack of effective monitoring of people's care plans, risk assessments, nutrition and fluid charts. We found people's care plans and individual risk assessments had not been reviewed since our last inspection. Although staff completed food and fluid charts there was no system to monitor people's intake. This all meant there was no monitoring that people were receive an adequate fluid intake and action being taken to prevent dehydration.
- People's records had not been kept securely; records in relation to cleaning schedules were not complete to demonstrate compliance with good practice.
- The oversight of infection control processes regarding the COVID-19 pandemic had remained not effective.
- Monitoring checks on people's care and quality of their daily experiences were not being completed or monitoring of the handover sheet where staff recorded all issues. Audits did not consider people's experiences.
- There had been a significant lack of leadership at Drayton House and a lack of understanding about roles and responsibilities. The manager was supported and advised by a consultant as the provider's

representative had not been to the home. At the service, the manager was supported by a senior care assistant who worked full time during the day and a senior care assistant who worked two nights a week. A third senior care assistant had been employed but although they had been working at the service for nine weeks had not undertaken the role or had their medicine administration competence assessed. This meant there were periods of time when no management or senior staff were working at the home to guide and support staff.

●Staff said they felt supported by the manager. Comments included, "I think she is doing a good job considering what she is up against" and "Approachable…changes are the owners and getting things we need."

● The service did not have a manager registered with the Care Quality Commission. The manager had applied to the Care Quality Commission (CQC) to become the registered manager and was being processed. The day after the inspection we were informed by the provider the manager had withdrawn their application and would be leaving and they would be recruiting a new manager.

At our last inspection quality monitoring systems had lapsed. This meant the provider had not mitigated risks relating to the health, welfare and safety of people using the service. 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 the provider was still in breach of regulation 17

●Audits failed to identify the concerns highlighted at our inspection, such as, risk assessments, care plans, maintenance issues.

●There were not accurate, complete and contemporaneous records kept in respect of each person living at the service.

●Risks were not identified, or where they were, they were not adequately managed in a timely way to reduce risks.

●There had been a significant lack of leadership at Drayton House and a lack of understanding about roles and responsibilities.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The manager said they had sent out surveys to gain people, relatives and health and social care professionals views about the quality of care being provided. The manager explained they had only received a few responses. We did not see these responses. Since our last inspection the manager had held a residents meeting, where they had discussed the menu's and what colour people wanted the large lounge to be painted.

● The manager sent us a monthly update on the 8 May 2021, telling us 'Relative's meeting to take place this month either individual or through Teams.' We discussed this with the manager who said she had spoken to a few relatives, but these conversations had not been recorded. This meant we could not see who the manager had spoken with and whether they had completed this month's target of speaking with relatives.

Continuous learning and improving care

● The lack of effective audits led to mistakes not being identified, therefore lessons were not learnt and

improvements not made.

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; Working in partnership with others

● Following our concerns and feedback after our last inspection the provider had produced an action plan in response. This action plan had not been followed but they have told us the provider's representative will be visiting the service to start to rectifying issues identified.

● The local authority quality assurance and improvement team were also working with the management team to ensure improvements were achieved.