Sure Care (UK) Limited

Derwent Lodge Nursing Home

Inspection report

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Date of inspection visit:
21 June 2021
23 June 2021
29 June 2021
05 July 2021

Date of publication:
29 November 2021

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
Derwent Lodge Nursing Home provides accommodation for up to 46 people who need help with nursing or personal care. At the time of the inspection 39 people lived in the home. The majority of the people living in the home required nursing care and most people lived with dementia.

People's experience of using this service
At this inspection, we identified serious concerns with the management of risk, care planning, the delivery of care, the management of medicines and governance.

Medication management was unsafe. People did not always receive their medicines as prescribed and medicines were not always administered in a safe way. This placed people at serious risk of avoidable harm.

Environmental risks within the home had not been addressed. For example, first floor windows were not secure, some people's pressure mattresses were not set correctly; some bed rails were unsafe and as a result posed a risk of entrapment and multiple fire doors within the home were faulty. These environmental risks placed people at serious risk of injury or harm.

Staff did not always have clear and accurate information on people's needs or, sufficient guidance on the support they needed to keep them safe and well. This placed people at risk of inappropriate or unsafe care and meant good outcomes for people were not always promoted.

The systems in place to monitor quality and safety were not robust. Managerial oversight by the manager and the provider was not effective. Staff practice in the delivery of care did not always adhere to best practice guidance or the provider's own policies and procedures. This meant staff practice was not always consistent or safe.

During the inspection, CQC asked the provider to submit an urgent and immediate action plan for improvement, as the concerns about people's safety were high risk. The provider and manager responded swiftly and a programme of improvements was commenced without delay. However, it should not have taken a CQC inspection to identify and act on these risks.

There were enough staff on duty to meet people's needs and staff were recruited safely. Infection control standards were maintained, and the risk of COVID-19 managed appropriately.

Accident and incidents and safeguarding events were reported and monitored. Learning from these incidents was shared with the staff team to prevent similar incidences from occurring in the future.

People were referred to and received support from a range of other health and social care professionals in respect of their needs. Relatives told us that the staff team engaged with them well and the manager was

approachable.

Staff were observed to be kind and caring. Relatives told us they felt their loved one were happy at the home and with the staff team that supported them.

Rating at last inspection
The last rating for this service was good (published 25 December 2020).

Why we inspected
This focused inspection was prompted by a serious incident relating to environmental safety that occurred at the service. This raised concerns about the safety and management of the service overall. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 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 inadequate. This is based on the findings at this inspection.

For more details, please see the full report which is on the CQC 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.

At this inspection we found breaches of regulations 12 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to the failure to ensure people received safe care and treatment and a failure to ensure the service was governed and managed adequately.

Please see the action we have told the provider to take at the end of this 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

Special Measures
The overall rating for this service is 'Inadequate' and the service has been placed 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.

Derwent Lodge Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide 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 undertaken by three 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 service.

Service and service type
Derwent Lodge Nursing Home is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had 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.

Notice of inspection
We announced this inspection from the car park on the day of the inspection. Due to the concerns found on day one of inspection, we advised the manager we would be returning to the service over the next week but

did not provide a specific date for our return.

We returned to the service on the 23 June and the 29 June for the purposes of continuing a focused inspection.

What we did before the inspection
We reviewed information we had received about the service since the last 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 took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, the deputy manager, two nursing assistants, two care assistants, the maintenance person, the cook and a catering assistant. We reviewed a range of records. This included five people's care records, a sample of medication records, three staff recruitment files and records relating to the management of the service.

We contacted people using the service and their relatives by telephone to seek feedback about their experiences of the care provided.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence. We continue to review evidence in relation to people's care, health and safety and maintenance records. We also liaised with the Local Authority to share information about the service and our inspection.

We concluded the inspection on 05 July 2021.

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 good. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Records about medicines did not always show that they were managed safely. Nurses did not always complete records of administration at the time they administered them. Staff practice in respect of the administration of medication was not safe and did not adhere to best practice guidance.
- One person missed all doses of their inhaler for 12 days because medication records were not accurate. One person missed some doses of their prescribed medicines because there was no stock available. One person was placed at serious risk of being given another person's medicines because the nurse had not prepared medicines in a safe way or checked that the medicines they were about to give were correct.
- People were given doses of some of their medicines too close together or at the wrong times and five people were given the wrong dose because nurses failed to follow the manufacturers' and prescribers' directions.
- Written guidance was not in place when people were prescribed medicines to be given "when required". For example, painkillers and prescribed creams.
- Critical information about people's diabetes for example, information about safe blood sugar ranges was missing, which meant it was difficult to tell if people had their diabetes managed and medicated safely.
- Some people had swallowing difficulties and were prescribed a thickening agent to add to their drinks to help them swallow safely. It was not always possible to tell if people's drinks were thickened appropriately as clear and consistent records were not always made.
- Medicines stored in the fridge for example, people's insulin medicine were not always stored at the recommended temperature. There was no evidence that any action had been taken to ensure these medicines were not adversely affected.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff did not have adequate information or guidance on people's needs, risks, or, the care they required in order to ensure their health and safety was maintained. This placed people at significant risk of inappropriate and unsafe support.
- Risks within the environment that posed a hazard to people living in the home had not been addressed. There was a lack of adequate window restrictors on first floor to prevent a fall from height.
- Some people's bed rails posed a risk of entrapment. Some people's pressure mattresses were not set correctly to give the right amount of pressure relief.
- Multiple fire doors within the home did not close appropriately when the fire alarm sounded in order

protect them from a fire. Some of the fire door guards in place were faulty. We referred the fire safety concerns to Merseyside Fire Authority for further review
● Most people had personal emergency evacuation plans in place to advise staff and emergency personnel how to evacuate them safely in the event of a fire or other emergency. Three people did not have these plans in place. We spoke with the manager about this.

The provider had not ensured risks to people's health, safety and welfare were adequately assessed, and mitigated to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was asked to submit an urgent action plan for improvement with regards to the management of medication and window safety after the first day of inspection. An action plan was submitted, and urgent improvements commenced immediately.
● Accidents and incidents were recorded, and we saw that appropriate action had been taken to seek medical attention when required.

Preventing and controlling infection
● Appropriate Infection prevention control policies and procedures (IPC) in respect of COVID-19 were in place.
● The home's cleaning and decontamination regimes were satisfactory and in line with government guidelines.
● A programme of COVID-19 testing for people living in the home, staff and visitors was in place to mitigate risks of this infection. Access to COVID-19 vaccinations was encouraged and provided.
● Personal Protective Equipment (PPE) was in use and worn appropriately. A relative told us, "When we come to visit all the staff we see are in full PPE at all times, we have to log in and out, take NHS tests before going and show the recorded results. I think they are doing everything they can to tackle COVID-19".

Staffing and recruitment
● Staff were recruited safely. Appropriate pre-employment checks were carried out to ensure staff employed were safe to work with vulnerable people.
● There were enough staff on duty to meet people's needs. The home used agency staff to help staff the service when permanent staff could not fill gaps in the staff rota. One relative said, "They do have agency staff but they are regular ones, so we all know them". Another relative told us, "There seems to be quite a few eastern European agency staff especially at the weekends and I am not sure they can speak or understand English very well".

Systems and processes to safeguard people from the risk of abuse
● During the inspection, CQC made safeguarding referrals for some of the people living in the home due to concerns about their medicines or other aspects of their care.
● Safeguarding procedures were in place and staff knew how to respond to allegations or incidents of abuse appropriately.
● One relative told us, "All the staff are nice and friendly" and another said, "The staff are lovely with my relative".

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 good. At this inspection, this key question has 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.

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

- Serious concerns with the management of the service and the safe delivery of care were found at this inspection. Provider and managerial oversight of the service were insufficient. As a result, the provider and manager failed to ensure the service met its regulatory requirements and failed to ensure risks to people's health, safety and welfare were mitigated. This placed people at risk of avoidable harm.
- The governance systems in place to monitor the quality and safety of the service were not robust. The medication audits in place failed to identify serious medicines issues. Health and safety audits did not identify environmental hazards in order to protect people from injury or harm and care plan audits failed to ensure people's needs and risks were properly assessed, and care planned. This placed people at risk of inappropriate and unsafe care.
- The service failed to promote good outcomes for people as people's care was not always planned appropriately. This meant staff did not always have adequate or clear guidance on people's individual needs in order to ensure they received the support they needed.
- During the inspection, as a result of the serious concerns identified, the provider was asked to submit an urgent action plan for improvement to CQC. The provider and manager responded swiftly and a programme of immediate and necessary improvements was commenced straightaway. However, it should not have taken a CQC inspection to identify and address these risks.

The governance arrangements in place were not robust, managerial oversight was poor and risks to people's health and welfare were not managed sufficiently to protect them from harm. This was a breach of Regulation 17 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; Continuous learning and improving care

- The manager had reported notifiable incidents to CQC as required. For example, safeguarding events and accident and incidents.
- Learning was gained and shared with the staff team from accident and incidents and where improvements to the service were identified.

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

characteristics; Working in partnership with others

● People were referred to and received support from other health and social care professionals as and when required. For example, the Speech and Language Therapy Team, physiotherapists, local GP's and mental health services.

● Relatives told us staff at the home kept them up to date on their loved one's well-being and engaged with them well. Their feedback included, "We are kept aware of any health issues my relative may have"; "The staff have time to have a good chat with us" and "I am confident discussing any concerns or issues with the manager who I have found very approachable".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements in place were not robust, managerial oversight was poor and risks to people's health and welfare were not managed sufficiently to protect them from harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medication was unsafe. The provider had not ensured risks to people's health, safety and welfare were adequately assessed, and mitigated against to prevent avoidable harm.

The enforcement action we took:

Conditions were placed on the provider's registration with regards to medication management.