Care Direct UK Limited

David House

Inspection report

36 Sandy Lane South
Wallington
Surrey
SM6 9QZ

Tel: 02086477981

Date of inspection visit:
15 December 2020

Date of publication:
02 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

About the service
David House is a residential care home registered to provide personal care for to up to eight people. At the time of our inspection the service was supporting three older adults with a learning disability in one adapted building. A fourth person was in hospital.

People's experience of using this service and what we found
People's care and support was not always provided safely. This was because staff did not always wear face masks in line with current guidance to prevent the spread of the Covid 19 virus. Risk assessments were not carried out for people or staff to mitigate the risks arising from not wearing face masks.

There were enough staff available at all times to ensure people received their care and support safely as planned. The provider followed appropriate recruitment practices to confirm the safety and suitability of new and potential staff.

Staff stored and administered people's medicines safely and recorded medicines administration accurately. The new manager introduced new protocols for 'when required' medicines which improved people's safety.

The service did not have a registered manager in post. However, the manager, who had been in post for three weeks at the time of our inspection, had begun the process of becoming a registered manager.

The manager took action when things had gone wrong. This included investigating incidents, liaison with health and social care professionals and improving systems and processes at the service.

The manager was developing quality assurance process and had made improvements to medicines and care records. Staff understood their roles and welcomed the recent improvements at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
Right support: People were able to have control of their lives and chose the activities they participated in.

Right care: People's care and their care plans were personalised and unique to them as individuals.

Right culture: The manager was new to the service. In the three weeks since taking up they role they had taken action to improve safety, personalisation and quality assurance processes.

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 22 July 2019).

Why we inspected
We received concerns in relation to the management of risks and people's behavioural support needs . As a result, we undertook a focused inspection to review 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.

We have found evidence that the provider needs to make improvement. Please see the Safe section of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to ensure that staff wear masks when supporting people in line with published guidance.

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

Enforcement
We have identified breaches in relation to infection prevention and control 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 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.

David 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
The inspection was carried out by two inspectors. One inspector visited the service whilst the other inspector spoke to the manager and staff by phone.

Service and service type
David House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 had a new manager who was in the process of registering with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service. This included statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send to us about significant events that take place within services. 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.

During the inspection
We spoke with one person and the manager. We reviewed a range of records including each persons' care records and medicines administration records. We looked at two staff files in relation to recruitment and training. We checked accident, incident and safeguarding records. We also reviewed a variety of records relating to the management of the service, including quality assurance checks and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the manager and three staff. We looked at training data, quality assurance records and safeguarding information.

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 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

● People were not supported in line with current guidance to prevent the risk and spread of infection. Published guidance states that staff in care homes should wear masks as part of a number of measures to protect people and themselves against the Covid 19 virus. At the time of our inspection we observed that none of the staff were wearing face masks whilst supporting people. This included when staff were within two metres of people and when they were in physical contact whilst providing support.

● We were told that staff did not wear face coverings as it caused people to become agitated. However, there were no risk assessments, best interests' meetings, guidance from healthcare professionals or risk management plans to support the decision for staff not to wear masks. Consequently, the provider failed to mitigate the risks caused by the failure of staff to use essential personal protective equipment.

The failure to assess, prevent and control the risk and spread of infection is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notwithstanding the evidence above, we found hand gel was available throughout the service for people, staff, visiting healthcare professionals and relatives.

● Visitors had their temperatures checked before entering the care home and a well-ventilated area was made available for them to put on and take off personal protective equipment.

● One member of staff told us they had been supported to shield. This meant the provider assessed the risks to the staff due to their underlying health needs and took action to keep them safe.

● Adequate stocks of personal protective equipment were available for staff at the service.

Systems and processes to safeguard people from the risk of abuse

● The provider had safeguarding procedures in place. These were updated following the incident which triggered this inspection.

● Staff told us they understood the provider's safeguarding procedures and their role within it to keep people safe. One member of staff told us, "I would tell the manager who would inform the appropriate authorities."

Assessing risk, safety monitoring and management

● People's known, individual risks were assessed and staff followed the guidance in risk management plans to keep them safe.

● Where people presented with health associated risks, these were assessed by healthcare professionals.

The provider ensured that people had medicines available to manage these risks and staff received specific training to support them.

● Staff told us they received the training to support people when they presented with behaviours which may challenge. They explained to us the actions they take to reduce people's anxiety and agitation in line with their care plans.

● Specialist checks were carried out to ensure the care home environment was safe. For example, contractors undertook gas safety, electrical appliance, fire safety and legionella tests.

Staffing and recruitment

● People received their care from suitable staff. The provider's recruitment processes included checks of staff employment history and checks of criminal records data bases. This meant the provider satisfied themselves that staff were safe to provide care and support.

● The manager ensured there were enough staff deployed to meet people's needs safely.

Using medicines safely

● People received their medicines safely and in line with the prescriber's instructions.

● Staff had guidance on the administration of 'when required' medicines to people. This included information about the frequency and doses for 'when required' medicines should be given.

● People received their medicines from staff trained to administer them

● Staff maintained accurate medicines administration records which were checked by the manager

● People's medicines were stored securely to reduce the risks associated with accidental access.

Learning lessons when things go wrong

● The manager was new to the service at the time of our inspection but had reviewed incidents that had taken place at the service before his arrival. For example, new protocols were put in place for the use of 'when required' medicines which included body maps to show precisely where creams had been applied.

● The manager reviewed people's care and support following a safeguarding incident and implemented changes to improve their safety.

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 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The manager was new to the service and had only been in post for three weeks at the time of our inspection.
- Staff expressed support for the new manager. One member of staff told us, "He is supportive with us and that is important." Another member of staff said, "The comradery among staff is good. The relationship between staff, manager and the people who live here is good. I enjoy working here." Whilst a third member of staff told us, "He knows what he is doing and he's making a lot of changes for the better."
- Whilst we found the manager had taken prompt action to improve people's care and support in a number of areas, the service was in regulatory breach in relation to the infection prevention and control practices. This was because staff were not wearing face masks in line with current guidance when supporting people. This put people and staff at risk of contracting Covid 19. Details of this breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 can be found within the Safe key question of this report.

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

- Following an incident when things had gone wrong the manager made changes to how and where staff recorded daily notes. These changes made people's daily care records clearer and easier to review as well as more person centred.
- The manager liaised with local authority social workers, healthcare professionals and CQC in relation to a safeguarding concern that pre-dated their arrival at the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager and staff understood their roles in the delivery of care and support to people.
- The manager understood their responsibility to inform the regulator of important events at the service through statutory notifications.
- Staff attended team meetings at which people's care and support was discussed. Staff told us their views were sought and acted upon at team meetings.
- At the time of our inspection the manager was implementing a plan to improve quality assurance

processes at the service.

● The service worked in partnership with others to meet people's needs. This including working with health and social care professionals and volunteers.

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 failed to prevent and control the spread of infections. Regulation 12 (1) (2) (h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.