Qualia Care Limited

Duchess Gardens Care Centre

Inspection report

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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

Duchess Gardens is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The manager told us there is no longer a separate nursing unit so the number of places has been reduced to 49. The accommodation is provided in an adapted building and is arranged over four floors.

The service provides personal care and nursing care to people living with dementia, older people, younger adults, people with physical disabilities, people with sensory impairments and people living with mental health issues. At the time of our inspection there were 44 people using the service.

At the last inspection in July 2018, the service demonstrated to us that improvements had been made and was no longer rated as inadequate overall or in any of the five key questions. Therefore, this service is now out of special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. However, while we concluded improvements had been made these needed to be sustained and further developed to make sure people consistently receive safe and effective care and treatment. This is reflected in the overall rating for the service which was 'requires improvement.' Since then we have had some concerns raised with us about safe staffing levels.

At the last comprehensive inspection in July 2018 we found the service was in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Regulation 19 (3) (a) and (b)). This was in relation to staff recruitment procedures which were not being operated effectively and required documentation was not available. The provider sent us an action plan of the action they had taken.

We undertook an unannounced focused inspection of Duchess Gardens on 13th December 2018. This inspection was conducted following information which we received that was of concern which included concerns about the staffing level at the service. The primary aim of the inspection was to check the safety of the service and any risk of harm to people. The team inspected the service against two of the five questions we ask about services; 'Is the service Safe?' and 'Is the service Well Led?'

There was a manager in post who had applied for registration with the CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found there were not enough staff on duty to provide people with timely or person-centred care. We found the manager did not always deploy staff effectively.

We found at breakfast time there were not enough staff to provide people with the support they needed to eat and drink. People fell asleep at the table and were not moved to sit more comfortably in a lounge area.

Staff told us the staffing levels were low. They said people were becoming frailer and they thought more staff was needed. Relatives and people also told us staff levels were low and required improvement.

Whilst systems were in place to monitor training needs, these were not effective.

Redecoration and refurbishment at the home was on-going and we saw areas had improved since our last visit. The home was clean, tidy and comfortable.

Following the inspection, the manager sent us information showing/stating the service has increased its staffing level.

We found two breachs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

There were not always enough numbers of staff deployed to meet the needs of people living in the home, to keep them safe and support them.

Medicines were stored and managed safely.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the time of inspection there was no registered manager in post. The manager had applied to be registered with CQC.

The provider did not have effective systems in place to ensure staffing levels were adequate and deployed to meet the needs of people using the service.

Systems to assess, monitor and improve the service were not always operated correctly.

Duchess Gardens Care Centre

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13th December 2018 and was unannounced. The inspection was completed 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. Prior to the inspection we reviewed recent notifications received from the provider and spoke with the local authority safeguarding and commissioning teams. The inspection took place due to concerns raised from notifications and information we received in relation to staffing levels within the home and keeping people safe.

We looked at the lists of staff, their designation and duty rotas. We spoke with the manager, two senior care worker and five care workers, three visitors and seven people who used the service. We used all the information to make a judgement about the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2018 we rated the 'Is the service safe?' as 'requires improvement'.

At that inspection we found a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulated 2010 (Fit and proper persons employed). Some staff files did not contain photo identification. References had not always been taken up from the most recent employer and some references did not state the dates the person had been employed. Since our last inspection, the provider sent us an action plan of what they had done to address the above issues.

We found at the July 2018 inspection there were enough staff on duty to keep people safe and to provide them with the care and support they needed. At that time there was a nursing unit and separate residential unit. Following the inspection, the provider made a business decision to close the nursing unit and to provide nursing and residential care in one part of the building.

People have since contacted us, telling us there were not enough staff on duty to meet people's needs. During this inspection we looked at the safe domain and found there were not enough staff on duty to provide people with timely or person-centred care.

The accommodation was arranged over four floors with living accommodation on the lower ground and ground floors. Bedrooms were spread across all four floors.

Staff told us the staffing levels on the lower ground floor were adequate at the current time. However, they said people who lived on the other floors were becoming frailer and they thought more staff were needed.

The consensus from staff was at least one additional carer was required on the ground floor to provide additional care and support.

We saw examples of this to support staff concerns:

One person was sitting in a wheelchair in the lounge. A care worker offered to move them into an easy chair but noticed they had been incontinent and needed to be changed. They went to find another care worker to assist them. However, we saw the same person was still sitting in their wheelchair in another lounge 20 minutes later, had not been taken to the toilet and not been changed.

At breakfast time there were not enough staff to provide people with the support they needed to eat and drink. One person, who required assistance, had been left with a mug of tea. We saw no-one offered to assist them with this and the tea mug remained on the table for 45 minutes.

Another person was sitting in the lounge with their breakfast in front of them untouched, clearly needing assistance to eat. After 20 minutes, a domestic worker came and asked why they were not eating and proceeded to assist them with a few spoonful of their breakfast. The person was then left alone for a further

15 minutes, after which the rest of their breakfast was taken away by staff.

A relative told us, "Staffing levels are a bit low. I come at various times on purpose and I've turned up and found food untouched for two or three hours. I've arrived at 2.30pm and found the food still there, uneaten. Some (staff) will sit and feed (their relative's name) but more than once, the food has been left."

The meal time experience for some people who used the service was poor. Not everyone was offered fruit juice or a cooked breakfast. People fell asleep at the table and were not moved to sit more comfortably in a lounge area.

We found the service was in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not enough staff deployed to meet people's needs.

All the above was discussed with the manager who told us they were in discussion with the provider about employing more staff to cover mealtimes.

The day after the inspection, we received written confirmation from the manager that the provider had agreed to more staff being employed at the home. They told us, 'We will be increasing the staffing levels as from tomorrow. The increase will be an extra 84 hours per week.'

We concluded the proposed increase in staff made by the manager, if implemented, would provide enough staff to care for people safely. The manager agreed to keep staffing levels under review. They also acknowledged staffing levels would need to increase as and when new people moved into the home.

We found people were kept safe from abuse and improper treatment. Staff had completed safeguarding training and said they would not hesitate to report concerns. Care records demonstrated risks to people's health and safety were assessed and plans of care put in place for staff to follow.

Where people had moving and handling care plans, we saw there were detailed instructions for staff to follow. Medicines were stored, managed and administered safely. The premises and equipment available helped keep people safe. These included checks on the fire, electrical and gas systems. People were protected from the prevention and control of infection. The home was clean, tidy and comfortable. Accidents and incidents were recorded and analysed to see if any themes or trends could be identified. Action had been taken to try to prevent any re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

The home had a manager who was going through the Care Quality Commission registration process.

When we inspected in July 2018, we found staff training needing to be brought up to date and improvements needing to be sustained over time; this section of the report had been rated as 'requires improvement'. At this inspection we found this still required improvement. The manager had not ensured enough staff were available and deployed to ensure people were always safe.

At the inspection in July 2018, audits were being completed, which were effective in identifying issues and ensuring they were resolved. The provider completed monthly visits. Staff morale was good and staff said they felt confident in their roles. Peoples' views about the service were sought and acted upon. Residents and relatives' meetings were also held to get people's views and the minutes were displayed in the entrance area. We concluded the service was well managed and that significant improvements had been made to the governance and audit systems.

At this inspection we concluded all the above remained the same with the exclusion of the service being well managed.

We found the meal time experience for some people who used the service was poor. Not everyone was offered fruit juice or a cooked breakfast. People fell asleep at the table and were not moved to sit more comfortably in a lounge area. One person had been incontinent and not changed from their soiled clothes for over 20 minutes, despite being removed to another lounge area.

One of the nurses told us they felt staff needed more training in relation to caring for people living with dementia. They had also identified meal times needed to be 'cosier.'

We found the manager did not always have enough staff or deploy staff effectively.

Whilst systems were in place to monitor training needs, they were not effective. We found staff training in respect and dignity required improvement.

Some staff were very aware of people's privacy and dignity needs; however, this was not consistent. For example, one person was moved from a wheelchair to an armchair by staff using a mechanical hoist. During the transfer their thighs were exposed. Staff did not use a blanket to make sure their dignity was preserved.

One person who used the service had food around their mouth when we saw them at 9:15am. The food was still around their mouth at 11:20am.

One relative we spoke with said, "I think there is massive room for improvement. The actual company need to be giving them (the staff at Duchess Gardens) a lot more support. They are under pressure. Proper leadership is lacking. No managers appear to come on site to check or support it (the home)."

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

We discussed the above with the manager. They stated they would address all the concerns raised regarding staff supervision and staff training would be updated.

The manager had worked in partnership with the local authority commissioning team, the local clinical commission group commissioners and local authority safeguarding team to bring about improvements to the service.

Providers are required by law to notify the CQC of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found the service had met the requirements of this regulation. It is also a requirement that the provider displays the quality rating certificate for the service in the home, we found the service had also met this requirement.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively operated to ensure compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This was because there were not enough staff deployed to meet people's needs.