Darsdale Carehome Limited

Darsdale Home

Inspection report

Chelveston Road
Raunds
Wellingborough
Northamptonshire
NN9 6DA

Tel: 01933622457
Website: www.darsdale.org.uk

Date of inspection visit:
15 March 2022
17 March 2022
18 March 2022

Date of publication:
04 May 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Darsdale Home is a residential care home providing personal and nursing care to up to 30 people in one adapted building. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 27 people using the service.

People's experience of using this service and what we found
The provider could not assure themselves staffing levels were safe. The tool used to calculate staffing numbers remained ineffective. Although staffing numbers had improved since the last inspection there were ongoing concerns about staffing levels and deployment to ensure people always received safe and person-centred care. The provider had not identified the workload of the deputy manager was too high. Staffing levels have been raised as a concern in four previous inspections since 2017.

The provider could not assure themselves of the quality and safety of key aspects of people's care. Some areas of people's care were not quality assured by the provider so they could not identify and drive continuous improvements. The provider did not have an improvement plan in place to demonstrate their priority actions, timescales and progress to achieve a 'good' rating in all areas

Some medicines processes remained unsafe and action was taken promptly during the inspection to start addressing these. Some care records were not in place for people who had recently moved to live in the service which was rectified during the inspection.

People were not as involved in decisions about their care as they could be due to lack of staff time, and training in some areas. This included a lack of training in specialist communication techniques to support people express their views and wishes. Staff did not have sufficient time to support people to spend time how they preferred to, for example, going outside regularly, chatting with staff and developing new interests.

People had a range of care plans and risk assessments in place which reflected their care needs and preferences. Processes to ensure these were reviewed regularly were in place but required strengthening.

Accidents, incidents and falls were recorded and followed up appropriately. Safeguarding processes were followed when required.

Staff used personal protective equipment (PPE) effectively to keep people safe and undertook regular testing for COVID-19.

People received care from staff who were kind and compassionate. People's privacy and dignity were respected.

Staff continued to work in partnership with health professionals involved in monitoring and providing care

and treatment for people using the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 2 September 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 2 September 2021. The service remains in special measures.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 21 June 2021. Three breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve in the areas of safe care and treatment, staffing and governance arrangements.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions Safe, Caring and Well-led which contain those requirements.

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 remained requires improvement. This is based on the findings at 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.

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 continued breaches in relation to people receiving safe care and treatment, staffing levels and governance arrangements.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Requires Improvement'. The service was placed in 'special measures' following the last inspection due to the repeated rating of requires improvement combined with breaches of regulation. Following this inspection, the service will remain 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 requires improvement or a rating of inadequate for any key question or overall, 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 of 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 requires improvement overall or 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

Darsdale 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
The inspection was carried out by two inspectors, a medicines inspector 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. Two inspectors visited on the first day with the Expert by Experience. On the second day one inspector returned with the medicines inspector. One inspector returned on the third day.

Service and service type
Darsdale 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. Darsdale 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.

Notice of inspection

This inspection was unannounced on the first day and announced when we returned on the second and third days.

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 commissioning and safeguarding teams. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three relatives for feedback on their experience of care. We received feedback in person, by phone and by email from 17 members of staff which included the deputy manager, senior care staff, care staff, kitchen and domestic staff. We also spoke with the three directors of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at aspects of eight people's care records and two staff files. The medicines inspector reviewed 19 medicine administration records (MAR) and eight medicine care plans. We looked at a range of other records including quality assurance checks and policies and procedures.

After the inspection
Following the inspection we requested and received further information from the provider which included training records, the staff handbook and updated care records.

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 requires improvement. At this inspection the rating for this key question has remained the same. 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.

At our last inspection the provider had failed to ensure sufficient numbers of staff were deployed to meet people's individual care and support needs which increased the risk of harm. This was a breach of regulation 18 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 18

Staffing and recruitment

- The tool used by the provider to calculate safe staffing levels remained ineffective. This was identified as a concern at our last inspection. This meant the provider could not assure themselves they had enough staff deployed at the right times to meet people's person-centred care needs safely. This included care staff during the day and at night, and domestic staff.
- The provider did not always deploy staff effectively or safely. The deputy manager undertook a wide range of responsibilities including the organisation and oversight of care delivery and medication. They were not provided with enough time to complete their managerial tasks. We saw, and feedback from staff confirmed, they spent the majority of their time supporting care delivery and had limited time allocated on the rota to fulfil their additional responsibilities.
- People provided mixed feedback about staffing levels. One person said, "There is not enough staff, only two at night, not many in the day and they don't have time to talk to me. I have a lot of memories, but no one has time to ask me about these." Some people thought staffing levels were satisfactory.
- Recruitment checks were undertaken on staff prior to starting work. This include references and Disclosure and Barring Service (DBS) police checks. We identified some gaps in recruitment files. For example, not all application forms contained a full employment history and the provider had not explored these gaps in applicants' employment history.

People were at heightened risk of harm due to the provider's continued failure to effectively calculate and deploy sufficient numbers of staff to meet people's person-centred care and support needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recruitment and retention had improved since the last inspection. Feedback from staff confirmed this. The provider had successfully recruited a number of overseas nurses who had started work in the service. This also reduced the amount agency staff, which improved the consistency of care provided.

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 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

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

● Some medicines processes remained unsafe. 'Controlled drugs' require specific processes to be followed by law for their storage, administration and disposal. We identified an issue with how the disposal of controlled drugs was recorded, which meant stock counts were potentially inaccurate and this increased the risk of medication errors. The deputy manager took immediate action when this was brought to their attention.

● There were no protocols in place for medicines administered 'as required'. This meant staff did not have guidance on the circumstances these medicines should be offered and did not have key information such as the frequency or maximum dosage in any given period. We found one person had been administered medicine for pain relief which should have been administered as a sedative because of this. The deputy manager began work on these straight away and sought advice from the pharmacist to ensure good practice was followed.

● When people required patches to be applied directly to their skin, for example for pain relief, body maps were not in use to ensure they were rotated to different areas of skin each time. Similarly, when creams were applied there were no body maps to guide staff as to where it should be administered. The deputy manager put these in place during the inspection.

● People who most recently moved to live in the service did not have all required care records in place including care plans, risk assessments and hospital grab sheets. This placed them at higher risk of receiving unsafe care. This was immediately rectified during the inspection.

● There was no system in place to learn lessons when things went wrong or share any learning with the staff team. For example, there was no regular analysis of accidents, incidents and falls to look for trends or patterns so that measures could be put in place to reduce the risk of the same or similar things happening again. The provider and deputy manager made improvements to their processes during the inspection.

Medicines processes required improvements and some 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.

● People had a range of risk assessments in place to support their safe care. This included health conditions such epilepsy and known risks, for example, falls and skin breakdown.

● We found improvements in the assessment, monitoring and review of people's care. The deputy manager had driven improvements in this area, and this was reflected in feedback from staff and relatives. Improvements needed time to be embedded and sustained in practice.

● Accidents, incidents and falls were reported. The number of falls had reduced due to better assessment of people's needs. This meant the right equipment was put in place to help keep people safe, for example, sensor mats and call bells.

● A range of improvements were found in medicines practices since our last inspection. People received their medicines from trained staff. The deputy manager undertook regular audits which had successfully identified and taken action to reduce a series of medicine errors.

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.

Systems and processes to safeguard people from the risk of abuse
● Information about safeguarding and whistleblowing procedures was not clearly on display around the service. Staff feedback confirmed they were aware of safeguarding processes if they had any concerns.
● Referrals were made to the local safeguarding team when required. The deputy manager planned to add an easy reference tracker to the safeguarding folder to assist with monitoring of any ongoing issues.
● Systems and processes to safeguarding people from the risk of abuse were in place. Staff had received training in safeguarding.

Preventing and controlling infection
● Cleaning of high touch point areas such as door handles and handrails was increased during the inspection to help reduce the risk of cross contamination. Some carpets were dirty which increased the risk of infection spread. Carpet renewal to some areas of the service had been postponed due to the outbreak of COVID-19.
● We observed staff promptly set up PPE stations outside of people's rooms. We also saw clear signage being put on people's doors when they tested positive for COVID-19 to support their safe isolation where possible.
● 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 making sure infection outbreaks can be effectively prevented or managed.
● At the time of inspection, the service was experiencing their first outbreak of COVID-19. Indoor visiting had been stopped temporarily because of this. The provider planned to review their visiting guidance when the outbreak was over to ensure it complied with government guidance in this area.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This key question was last inspected in 2019 when it was rated good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- Some people were not as involved in decisions about their care as they could be as staff were not trained in their preferred style of communication. For example, staff would not be aware of what people were asking for or expressing if they did not use the same communication method, for example, the Deafblind Manual alphabet. People in Darsdale Home had a variety of preferred communication styles.
- People's emotional wellbeing was not always well supported. For example, people told us they did not have frequent opportunities to spend time outside. One staff member said, "People would like to go in the garden more, or go into town." A person said they would like to go out, "Just for a change of place for a few hours".
- People had limited choices available for how they wished to spend their time or have their care delivered. For example, staff told us the re-introduction of a 'bath rota' was positive as it ensured people were regularly offered their preferred bath or shower. However, there was a risk of people not asking for more frequent or flexible bathing due to not wanting to feel they were causing more work for staff. Staff told us they wanted to spend more time with people following their needs, wishes and preferences.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were knowledgeable about the people they cared for and spoke about people warmly and respectfully. Staff were observed to be compassionate and caring in their interactions. One person told us staff were, "very kind".
- People, relatives and staff told us people were well cared for. A relative told us, "The whole atmosphere has changed (since the registered manager left), staff seem happier, the team have been amazing." A staff member told us, "There's a lot of love in this home. We treat everyone like they are our family."

Respecting and promoting people's privacy, dignity and independence

- We saw that people's privacy and dignity was respected. We saw staff knocking on bedroom doors before entering. People told us their choices were respected. One person said, "One young man [staff member] came in and I told him I wanted a female. At my age you don't want a male to see you. He was very good, and didn't mind."
- Systems were in place to protect people's confidential information.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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 our last inspection the provider had not maintained effective oversight of the safety and quality of 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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Under the leadership of the current provider, the service has been rated, 'requires improvement' in all five CQC inspections since 2017. The provider did not have an improvement or development plan in place to demonstrate how they intended to achieve a 'good' rating in all areas, or how they were working towards it in a structured and planned way.
- The provider did not have effective oversight of all key areas of the service. Quality assurance checks were undertaken by the provider and deputy manager, but these did not cover accidents, incidents, falls and lessons learned. There were no audits of the daily monitoring of people's care or the daily notes recorded by staff. This meant the provider was not able to assure themselves that people received consistently safe care which met their needs.
- The provider had not identified the deputy manager's workload was too high and the impact of this. The deputy manager was efficient and effective in their role and performed managerial responsibilities whilst also working for the majority of time providing direct support to care staff in their roles. The deputy manager was aware of the gaps in records and processes we identified. However, they did not have sufficient time to keep up to date with all expected tasks. When this was brought to the provider's attention during the inspection, they took some action by allocating the deputy manager more supernumerary hours.
- There remained no effective dependency tool in place so the provider could not assure themselves staffing levels were consistently safe. Dependency tools help assess people's care needs and determine safe staffing levels. The provider had not taken the action set out in their action plan submitted to CQC following the last inspection to rectify this.
- In At this inspection, we found staffing levels remained a concern. This included during the day, at night and in the domestic team. The provider had not taken action to review and amend staffing levels following

the last inspection to ensure people received consistently safe and person-centred care at all times.
● The provider did not promote a culture where people had sufficient opportunities to do the things they wanted to, and spend their time in the way they preferred. This culture had developed over time and was exacerbated by longstanding concerns about staffing levels identified in inspections since 2017.
● Since the last inspection improvements were made to some policies and procedures. Further work was required to ensure all policies and procedures were up to date and maintained. For example, the COVID-19 policy was out of date, the IPC policy was not submitted when requested and the whistleblowing policy did not provide guidance on where staff should report any concerns to externally.
● There were gaps in staff training which the provider had not identified. For example, staff had not received training in areas such as end of life care, person centred care, recording or safeguarding children. They had not identified the lack of staff training in specialist communication skills, for example, the Deafblind Manual alphabet, to support some people living in the service communicate in the way they preferred.
● Staff received support through supervision and team meetings, but records of these required improvements.

We found no evidence that people had been harmed however, oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times. 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.

● Staff worked very hard to promote a caring culture and ensure people were well looked after, and were committed to achieving this.
● During the inspection the provider and deputy manager took prompt action when issues were brought to their attention. Analysis of accidents, incidents and falls were introduced along with a lessons learned process.
● People and staff told us they felt supported by the provider, and were confident if they raised issues these would be looked into. One person said, "If I had any problem, I would have a quiet word with staff and they would sort it out."
● We received positive feedback from staff about the deputy manager, One staff member described them as "absolutely brilliant', adding, 'She does so much." Another member of staff told us the deputy manager was "amazing' adding they were, "always there to help and support". One staff member confirmed the views of many staff when they said, "She has so much on her plate. The place would fall apart without her."
● There was no registered manager in post. The provider was visible in the service and supportive of the staff team whilst recruitment was ongoing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.
● Regular meetings for residents took place. Pandemic restrictions had impacted upon meetings with relatives. The provider was considering the best way to re-introduce these.
● Feedback surveys had previously taken place for people, relatives and staff. The provider planned to issue feedback surveys shortly and use the results to help drive improvements to the care people received and service overall.

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 Systems were not robust enough to ensure people's consistent safe care and treatment. Some medicines processes remained unsafe. Not all care records including care plans, risk assessments and hospital grab sheets were in place. Processes to analyse accidents, incidents and falls and share lessons learnt were not embedded.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure sufficient staff were deployed, and did not have an effective dependency tool in use to calculate safe staffing numbers

The enforcement action we took:

We gave the provider a short timescale to make improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have effective oversight of all areas of the service to assess, monitor and improve the quality of the service.

The enforcement action we took:

We gave the provider a short timescale to make improvements