Minster Care Management Limited

Duncote Hall Nursing Home

Inspection report

Duncote Hall
Duncote
Towcester
Northamptonshire
NN12 8AQ

Tel: 01327352277
Website: www.minstercaregroup.co.uk/homes/our-homes/duncote-hall

Date of inspection visit:
02 July 2020
16 July 2020

Date of publication:
04 September 2020

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
Duncote Hall is a residential care home that can provide long and short-term residential nursing care for up to 40 older people, including people living with dementia. At the time of inspection 17 people were using the service.

People's experience of using this service and what we found
Quality systems were not effective in identifying the concerns raised on inspection.

The systems and processes in place to maintain oversight of the service were not effective in ensuring people's needs were met and that staff had all the information required to provide safe care.

Medicine management system needed to be improved. Medicines had not been administered or recorded in line with the provider's policies.

Records of care had not been consistently completed. Audits had not identified the gaps in recording found during inspection.

People who had injuries, bruises or pressure ulcers did not always have these reviewed or treated.

Not all care plans held enough information to ensure staff knew people's individual care needs and the support they needed to stay safe.

People told us they felt safe and that the staff supporting them were kind.

Staff had been safely recruited and completed an induction. There were sufficient staff to meet the needs of people living at Duncote Hall Nursing Home.

The home appeared clean and well maintained.

After the inspection the manager put in a variety of new systems and procedures to improve the care given, however as these are new we have no assurances of these being embedded into 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
The last rating for this service was inadequate (published 2 May 2020) the provider was in breach of regulations 10, 12, 17 and 18.

This service has been in Special Measures since 9 August 2019.

At this inspection enough improvement had not been made/ sustained and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 4 March 2020. Breaches of legal requirements were found in relation to dignity and respect, safety, staffing and governance.

Before this inspection we received concerns in relation to documentation recording and oversight of the service. 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 not changed following this focused inspection and remains inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Duncote Hall Nursing Home 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, safeguarding people from abuse and improper treatment and good governance at this inspection.

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
The overall rating for this service is 'Inadequate' and the service remains 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 provider failed to have adequate systems in place to monitor the quality care being provided.

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

Duncote Hall Nursing 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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

Service and service type
Duncote Hall Nursing home 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. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager. The provider had employed a manager who was in the process of registering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

We contacted health and social care commissioners who have a responsibility to monitor the care of people at Duncote Hall Nursing Home. We used all of this information to plan our 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.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with four members of staff including the manager, area managers, Clinical lead and care staff. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, rotas and training information for staff.

After the inspection site visit
On the 16 July 2020 we spoke with a further three member of care staff. The provider continued to provide updates to their action plan showing the improvements they were putting into place.

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm

The purpose of this inspection was to check a specific concern we had about recording and people's safety. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure people's risks were being assessed and managed appropriately. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● People were at risk from unsafe equipment as equipment in place to reduce risks to people, had not been used correctly. One person's specialist mattress to reduce the risk of skin damage was set at the wrong setting for their weight. Another person's specialist mattress settings had been changed with no explanation of the reason why. This increased their risk of skin damage and developing pressure ulcers. These are preventable if managed correctly.
● People were at risk of skin damage as not all people who had pressure sores had wound care plans in place. The wound care plan identifies what actions and treatment have been taken and records the evaluation of the wound. Without this, staff would not have the information to establish if the pressure ulcers were deteriorating, putting people at risk.
● People who required staff support to be repositioned did not have this support carried out in line with their needs. For example, we found 15 different occasions when people had been left for longer than their prescribed amount of time. This increased their risk of skin damage and developing pressure ulcers.
● Two people who were supported in bed could not summon staff assistance should they need it, as they as they were unable to use their call bell. Their risk assessments stated they required hourly checks to ensure their safety. These hourly checks were not consistently completed. There was a risk that people would not receive support when they needed it.
● Care plans contained inconsistent information. For example, one person had behaviours that put them and others at risk, this had not been identified within their behaviour care plan. Another person who had a specific health condition did not have the details documented within their care plan. This meant that staff did not have the information required to manage this need appropriately.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Using medicines safely
At our last inspection the provider had failed to ensure that proper and safe management of medicines were

completed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● Staff had not followed the PRN protocols put into place.
● One person was prescribed a PRN oral sedation medicine for when they became physically or verbally aggressive. The PRN protocol stated in the first instance only half the prescribed dose should be given, and that staff were required to complete an ABC chart to describe why the sedation was administered. On six occasions the dose given to the person was the full prescribed amount and on five occasions staff had not completed ABC charts.
● Medicines administration record (MAR) were not completed consistently.
● We found that for one person who was prescribed as required [PRN] medicines, their records did not identify specific reasons staff gave the medicines. The provider had not completed any investigations into the reasons for this medicine being given frequently. This meant that people were at risk of being given their medicines not as intended.
● Not all staff who administered specific medicine had their competencies checked regularly. For example, we found no evidence that nurses had their competencies checked to give rectal diazepam. The provider spoke to nurses after the site visit to ensure they felt confident to give rectal diazepam.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse
● The provider had not investigated the reasons for people's unexplained bruises. This meant the cause of the wound had not been identified and measures had not been put in place to reduce the risk of re occurrence.
● Records did not contain sufficient detail about people's injuries, pressure areas or bruising. Body maps did not always contain the relevant information regarding the size or colour of the injury or sore. This meant that people were at risk of not receiving the correct treatment for their injury.
● Staff were knowledgeable about how to report abuse and told us they had access to safeguarding and whistleblowing policies and procedures for guidance.
● People we spoke to told us they felt safe. One person said, "I feel safe, the staff are gentle and understanding. I can tell them if I don't like something."

These issues were a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were sufficient numbers of care staff deployed to meet peoples assessed care and support needs. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.

● There were sufficient care staff available to meet people's needs safely and in a timely way.
● People and staff told us there were enough staff to meet people's needs. One person told us, "The waiting time when I press my buzzer [for support] is much better." A staff member said, "We have enough staff, they are able to do all the jobs without rushing people."
● People were protected against the employment of unsuitable staff. The provider followed safe staff

recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. These are checks to make sure that potential employees are suitable to be working in care.

Preventing and controlling infection
At our last inspection the provider had failed to ensure that procedures relating to infection control had been followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.

● People were protected from the risks of infection as the staff supporting them had undergone training in infection prevention and undertook safe practices when providing care. We saw staff using personal protective equipment (PPE) when providing care for people.
● The environment was clean and there were cleaning schedules in place to ensure regular cleaning took place.

Learning lessons when things go wrong
● After the inspection the manager put new systems and processes in place to reduce the risks found and improve the recording of people's care needs.

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 Inadequate. At this inspection this key question has remained the same. 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.

The purpose of this inspection was to check a specific concern we had about recording and oversight. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last inspection the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● The service did not have a registered manager in post; however, the manager was in the process of registering. The home manager had made improvements to the service, however there were still areas of risk which placed people at risk of harm.
● We found continued issues with management oversight, records and monitoring of risk. These were all identified at the previous inspection. Limited improvements had been made in these areas.
● Audits had not identified issues relating to medicine recording, administration and training and gaps in recording for repositioning checks, safety checks and bowel charts. This meant the provider did not identify where care standards had failed and had not put actions in place to reduce risks to people.
● People were at risk of receiving unsafe care due to the lack of oversight of the service and records. For example, people had their specialist mattresses set at incorrect settings, weights recorded for people were inconsistent and people with pressure marks did not have wound care plans in place.
● Staff did not have all the information they required to provide safe care. The provider did not have systems in place to make sure all risks had been assessed, monitored and mitigated. Care records did not always contain enough information to ensure staff could support people appropriately.
● Staff did not follow people's plans of care. For example, people who required their bowel movements monitored did not have this need met. This put people at risk of serious harm.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance
● Staff told us they felt safer in their roles, this was due to the new manager in post. The staff interaction on the day of inspection had improved.

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.
At our last inspection the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● The provider's systems and processes failed to identify incidents when things went wrong which meant they had not always exercised their responsibility under duty of candour. For example, the provider did not conduct investigations for safeguarding incidents such as unexplained bruising.
● Where systems and processes had identified the need for improvement this had not consistently been actioned. For example, some audit actions remained outstanding and had not been reviewed by the manager.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others
● Representatives from the local authority quality team had conducted monitoring visits and identified concerns with the service. The registered manager was working with the local authority to make the improvements needed.
● People and staff told us the manager was visible throughout the service and was open to feedback and suggestions.
● Staff felt fully supported by the manager and felt able to raise any concerns. Staff told us they felt the manager would action any concerns they raised immediately.