Sure Care (UK) Limited

Derwent Lodge Nursing Home

Inspection report

197 New Ferry Road
New Ferry
Wirral
Merseyside
CH62 1DX

Tel: 01516431494

Date of inspection visit:
28 March 2022

Date of publication:
09 May 2022

Ratings

Overall rating for this service	Requires Improvement

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

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 23 people lived in the home. Most of the people living in the home required nursing care and most people lived with dementia.

People's experience of using this service
At the last inspection serious concerns were identified with regards to the management of risk, care planning, the delivery of care, the management of medicines and governance. At this inspection, we found that while some improvements had been made, further action needed to be taken to make sure the service was safe and well led.

People were not safe. At the last inspection visit, we identified concerns in relation to medicines management. The safety of medication management had improved at this inspection, but there were still a number of concerns relating to medicines that had not been properly addressed.

Information about people needs, risks and care had been reviewed. Care plans now contained much better information about people's day to day care needs. They failed however to contain adequate details of people's medical conditions and the clinical care they required to keep them safe and well. This was found at the last inspection but had not been acted upon.

Wound care management and the monitoring of fluid intake required improvement to ensure that people's pressure sores were cared for properly and the risk of dehydration mitigated.

We spoke with the new manager and regional manager about these ongoing concerns and asked them to address them without further delay. They told us they would do so.

At the last inspection, the systems in place to monitor quality and safety were not robust and managerial oversight of the service and people's care was poor. At this inspection, a new manager was in post and we saw that action had been taken by them to improve the systems in place, but these improvements had not been fully embedded and further improvements were required.

The new manager had only been in post eight weeks at the time of this inspection, but we found they had had a positive impact on the service so far. Managerial oversight had improved, action had been taken to address any shortfalls in staff practice and the support people received, and feedback from people living in the home and their relatives about the difference the new manager had made was positive.

The provider had a system in place to determine safe staffing levels. However, some people and staff felt that at times more staff were needed on duty. We fed this back to the manager to review.

The home was clean and well-maintained. There was a staff and resident COVID-19 testing programme in place and appropriate safety measures in place for visitors and new admissions to the service. Some of the government's guidance in respect of assessing risks to the workforce and the taking of people's temperatures twice daily during an outbreak had not been followed as recommended. We asked the manager to review the guidance in relation to this.

People and their relatives told us they felt the service had improved since the new manager had been in post and that they felt more involved with the service and the care provided.

Rating at last inspection
The last rating for this service was inadequate (published 01 December 2021).

Why we inspected
At the last inspection, the provider was found to be in breach of regulations 12 (Safe care and treatment) and 17 (Good Governance). CQC placed conditions on the provider's registration in relation to these concerns, which restricted admissions to the service and required them to take specified action in respect of medicines.

We undertook this inspection to follow up on the action we had previously told the provider to take and to check whether the provider was now compliant with the Health and Social Care Regulations in the domains of Safe and Well-led.

During 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 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.

At this inspection, we found that the provider had made some improvements to the service, but further improvements were still required. This service remained in continued breach of regulations 12 and 17. However, improvements made in relation to Regulation 17 and the management of the service has resulted in the overall rating for this service changing to requires improvement, at this inspection. The conditions on the provider's registration have also been removed.

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 always governed and managed adequately.

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

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
At the last inspection, the service, due to its rating of inadequate, was placed in special measures. At this inspection, the overall rating for this service had changed to 'Requires Improvement'. The service however, will remain in 'special measures due to its inadequate rating in the 'Safe' domain. 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?

Requires Improvement

The service was not always 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 with personal or nursing care. 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had recently commenced in post and had applied for CQC registration.

Notice of inspection
This inspection was unannounced. The inspection took place on the 28 March 2022.

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 new manager, the regional manager, a nurse, a member of the care staff and the maintenance person. We reviewed a range of records. This included two people's care records, a sample of medication records, two 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 liaised with the Local Authority to share information about the service and our inspection.

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

Using medicines safely
At the last inspection, 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.

At this inspection, not enough improvement had been made and the provider remained in breach of Regulation 12.

- Some improvements to the way medicines were managed had been made. The system in place to record the administration of medicines was now being used properly and showed most medicines were given as prescribed.
- Some medicines however could not be properly accounted for. For example, stocks of insulin, inhalers and creams. This meant it was difficult to tell if these medicines had been given correctly.
- Some people had swallowing difficulties and were prescribed a thickening agent to add to their drinks. Thickening agents ensure that people's drinks are made to a certain consistency to help the person swallow safely. It was not always possible to tell if people's drinks were thickened appropriately because accurate records had not always been made.
- Critical information about one person's diabetes was missing and other information was confusing to follow. This made it difficult to know whether the person's diabetes was being managed safely.
- Some people were prescribed anticipatory end of life medicines to be given via a syringe driver. There was no syringe driver available in the home at the time of our inspection for staff to use to administer these medicines if the need arose.
- There were written protocols in in place for most 'as and when' required medicines such as painkillers, but staff lacked guidance on how to choose the correct dose of medicine to give when there was a choice of dose or which medicine or cream to use when more than one was prescribed for the same ailment.
- Effective checks were not in place to ensure all medicines were in date or to ensure waste medicines were stored in line with current guidance.

The management of medication remained unsafe. This was a continued 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

At the last inspection, people's needs, risk and care was not adequately assessed or mitigated to prevent harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider remained in breach of Regulation 12.

● Information on people's day to day needs, risks and the care required had improved but staff still lacked adequate information on people's medical needs and the clinical care they required. This was identified at the last inspection but had not been acted upon. We asked the manager to address this without further delay.
● Some people had pressure wounds that required specific wound plans to be followed. However, these plans had not always been followed to maximise the healing process.
● People's fluid intake and output were not always appropriately recorded to enable staff to be confident that people's fluid intake was sufficient to prevent them becoming dehydrated.

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

● Environmental risks identified at the last inspection in respect of window and fire safety had all been addressed. During our visit, the premises were safe and well maintained.
● Everyone living in the home now had a personal emergency evacuation plan in place to advise staff and emergency personnel how to evacuate them safely in the event of a fire or other emergency.
● Accidents and incidents were recorded and monitored.

Preventing and controlling infection
● Government guidance in respect of assessing risks to the workforce and people living in the home had not been followed. At the time of the inspection, the home was experiencing a COVID-19 outbreak. Guidance in relation to the taking of people's temperature twice daily to monitor for the spread of the virus had not been followed as recommended.
● The home's cleaning and decontamination regimes were satisfactory in terms of the spread of infection. The home was clean and well-maintained. People living in the home confirmed this.
● A COVID-19 testing programme for people living in the home, staff and visitors was in place to mitigate risks of this infection.
● Personal protective equipment (PPE) was in use and worn appropriately.
● There were procedures in place to ensure that visitors and new admissions were safe to enter the home.

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.
● On the day we visited, there were five care staff and a nurse on duty to support people living in the home. The provider had a system in place to show these staffing levels were safe.
● Some of the staff and people we spoke with however ,felt at times there were not enough staff on duty. Their comments included, "I don't think they have enough staff to do everything"; "They (the person) often has to wait a long while to get put back in to bed and when they ask, staff say they will do it as soon as they can but that's something that could be better even though they have two nurses and four staff it's never enough" and "Staff are overworked, pressured and not happy".

Systems and processes to safeguard people from the risk of abuse
● Safeguarding procedures were in place and followed appropriately.
● People and their relatives told us they felt safe with the staff team.

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 inadequate. At this inspection, this key question has improved 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.

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

At the last inspection, the management of the service was not robust and failed to protect people from the risk of harm.

At this inspection, some but not enough improvement had been made and the provider remained in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some of the medicine concerns identified at the last inspection had not been addressed. This showed that the provider had not taken timely or robust action to ensure that medicine management was safe.
● The systems in place to assess and plan people's care had improved. However, staff still lacked clear information on people's medical needs which placed them at risk of inappropriate or unsafe care. This was identified and discussed with the provider at the last inspection but had not been acted upon.
● Other aspects of people's care were not delivered in accordance with their care plans or in a safe way, for example wound management and fluid intake monitoring. The governance arrangements in place had not identified or addressed this.
● A new manager commenced in post approximately eight weeks prior to this inspection. A different regional manager was also now involved with the service. These new managerial arrangements had started to make a difference.
● People and their relatives told us the new manager had a positive impact on the service. One person told us, "She makes me feel comfortable and I've seen such a big difference since she came. She's very approachable and I can talk to her". A relative told us, "It's definitely improved with the new manager".
● Improvements made to the service so far, were designed to promote good outcomes for people. Staff had better information about people's needs and care; staff practice was now being monitored consistently and the managerial oversight of the delivery of care was stronger. These improvements had just been commenced and needed to be further embedded in the service to ensure improvements were sustained.

The governance arrangements had improved but were still not robust enough to ensure that risks to people's health and welfare were managed sufficiently to protect them from harm. This was a continued 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

- Notifiable incidents had been reported to CQC as required.
- Regular staff meetings took place to share learning and ideas to improve the service.

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 a range of other health and social care professionals as and when required. For example, the Speech and Language Therapy Team, local GP's and dieticians
- People and relatives were kept informed of their loved one's progress and told us the new manager had encouraged them to become more involved with the service. Their comments included, "I definitely feel more involved and informed now" and "The new manager listens to what we say and what we want and then makes the changes, so I think it's well managed now, unlike before".

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 12 HSCA RA Regulations 2014 Safe care and treatment The management of medication remained unsafe. The provider had not ensured all of the risks to people's health, safety and welfare were adequately assessed, and mitigated to prevent avoidable harm.

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 had improved but were not robust enough to mitigate risks to people's health, safety and welfare.