

LJ Care Limited

Deansfield Residential Care Home

Inspection report

Deansfield
Kynnersley
Telford
Shropshire
TF6 6DY

Tel: 01952603267

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07 September 2022

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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

About the Service

Deansfield Residential Care Home provides accommodation and personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 16 people. The home is situated on three floors providing bedrooms on the ground and first floor which are accessible via stairs and a passenger lift. People have access to a lounge, dining area and an outdoor space. Bathrooms and toilets are situated near to all communal areas.

People's experience of using this service and what we found

We found risks relating to the premises not always being safely managed.

Management checks and audits were not always effective at identifying where improvements to safety measures were required and learning lessons after adverse incidents.

Staff managed people's medicines safely, in line with national guidance. People were supported by staff who had been assessed as safe to work with vulnerable adults. People were kept safe from the risk of infection and COVID-19.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The manager and staff were clear about their responsibilities. The service worked in partnership with a variety of community professionals to ensure people received any specialist support they needed. Management sought people's views about the service and acted upon them.

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 30 June 2022).

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 improvements had been made but further improvements were required, and the provider remained in breach of regulation 12 and 17

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 20 April 2022. 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 safe care and treatment and good governance.

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 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Deansfield Residential Care 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 monitor the service and will take further action if needed.

We have identified breaches in relation to maintaining a safe environment, taking action to mitigate risks after adverse incidents and governance of the service at this inspection.

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

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 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 well-led?

The service was not always well-led.
Details are in our well-led findings below.

Requires Improvement ●

Deansfield Residential Care 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.

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 carried out by one inspector.

Service and service type

Deansfield Residential Care 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.

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 a registered manager in post. The registered manager was not present during our visit and the provider made us aware that the registered manager had handed their notice in and would be leaving the service shortly.

Notice of inspection

The inspection was unannounced. Inspection activity started on 7 September 2022 and ended on 15 September 2022. We visited the location's service on 7 September 2022.

What we did before inspection

We reviewed information we had received about the service since the provider's last inspection. We sought feedback from the local authority and professionals who work with the service. 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 that use the service. We also spoke with seven members of staff including the nominated individual, deputy manager, care assistants, and domestic staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed staff providing support to people in the communal areas of the service. We reviewed a range of records. This included three people's care records and medicines administration records. Quality monitoring systems and a variety of records relating to the management of the service, including policies and procedures were reviewed.



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. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

At the last inspection we found risks to people had not been fully assessed. 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 remained in breach of regulation 12

- We found some ground floor window had restrictors that could be overcome without tools and recently a person had been injured whilst climbing through it. We highlighted the need for additional restrictors to the provider who took immediate action to obtain and install them.
- Safety checks were not being consistently carried out. Safety checks were carried out, however, we found that recently there were frequent missed entries on the record sheet. We share these concerns with the provider who advised us that the member of staff responsible had been absent for a period of time. The provider recognised the need for somebody to deputise when this happened and told us that they would make sure another member of staff was competent to carry out these checks.
- The provider was not always using adverse incidents as a learning opportunity to make improvements to the service.
- We saw that the provider had improved the way it reviewed incidents but had failed to identify the improvements needed to the window locks on the ground floor after a person had bypassed them and climbed through.

Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection, improvements had been made to people's care plans and risk assessments. This meant staff now had access to information needed to support them safely.
- At the last inspection, information about people's dietary needs was only available in the kitchen. At this inspection we found that the information was also included in people's care plans. This meant all staff had clear guidance to ensure people's dietary needs were met safely.

Using medicines safely

At our last inspection the provider had failed to ensure that medicines were safely managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach in relation to the management of medicines but continues to be in breach of regulation 12 in other areas.

- Medicines were received, stored, administered and disposed of safely.
- At our last inspection we found that the management of medicines were classed as requiring additional control measure and were not being managed safely. At this inspection we saw that this had been improved and accurate records were being maintained.
- Medication administration records (MAR) were much improved since the last inspection and were fully completed by staff when they administered people's medicines.
- Medicines were now being labelled correctly when staff started a new supply. This meant that the provider could be assured that the medicine would be safe and effective if administered.
- Staff responsible for the administration of medicines had completed further training since the last inspection. This had been followed up with comprehensive competency assessments to ensure that the training had been embedded.
- Regular checks were made of the temperature where the medicines were stored, including medicines that required refrigeration.
- People were consulted as to how they wished their medicines to be administered and clear protocols were in place for staff to follow. This included medicines that were prescribed to be administered "as required".

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Due to space constraints dirty laundry was placed in containers outside the home until it could be washed. Staff put the laundry through a window into the containers. We shared concerns about this practise with the deputy manager who agreed to stop this practise and staff would take it through the nearby door.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The provider's approach for visitors to the service was in line with the current government guidance.

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. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt the service was safe. One person commented, "The home is very good I feel very safe." A relative said, "I do feel they are safe there because [person] is happy."
- The provider had systems in place to protect people from harm or abuse. Staff had completed regular safeguarding training and refreshers and had reminders in the staff room about what process to follow.
- Safeguarding concerns were reported to the local authority safeguarding team and the registered manager worked with them to ensure any issues were appropriately addressed.

Staffing and recruitment

- Staff were recruited safely. Records showed references and Disclosure and Barring Service (DBS) had been obtained before staff commenced their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Throughout the inspection we saw that there was sufficient staff to respond to people's needs in a timely manner.

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. The rating for this key question has remained 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

At our last inspection we found a lack of leadership and ineffective systems in place to ensure people receive a good 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.

- Improvements had been made to the providers governance systems and quality audits since the last inspection. However, we found gaps in the records of safety checks which the provider explained was due to a staff member being absent for a period of time. Further improvements were still required to ensure that safety checks were carried out consistently. We saw no impact on people as a result of this. The provider recognised the need for somebody to deputise when this happens and told us that they would make sure another member of staff was competent to carry out the checks.
- The provider had made improvements to the way that it reviewed accidents and incidents to identify ways improve to the service. Further work was required as the provider had failed to ensure that windows were made safe after an incident where someone had been injured climbed through a ground floor window. When we made the provider aware that the window restrictors were not effective, they took immediate action to replace them.

Despite significant improvements across the service as a whole, further improvements are required to the oversight and governance to ensure that safe environments are maintained, and lessons learnt after adverse incidents. This is a continued breach of Regulation 17.

- At the last inspection we found that medicines audits were not effective. At this inspection we found that these had improved, and the providers audits were now effective at identifying issues and appropriate action was taken to address them.
- The registered manager had notified CQC of events which had occurred in accordance with their legal responsibilities.

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

- People had care plans that were person centred. At the last inspection we found that care plans were not person centred and the management team had since reviewed and improved the plans to reflect people and how they wished their care to be provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were encouraged to take part in meetings where they could talk about the home. For example, at the last meeting people were consulted about how they wished the new conservatory to be decorated.
- Staff told us they have the opportunity to discuss any concerns at staff meetings and performance reviews, but they could approach the registered manager at any time.
- The provider showed us examples of feedback sought from visitors to the home and how these were used to improve the service. For example, staff name badges had recently been introduced after a family member fed back about not knowing the names of staff.

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

- The provider understood their legal responsibility under the duty of candour. We saw that the provider was now considering this duty when dealing with adverse incidents. For example, it was now included as a prompt on medication error forms.

Working in partnership with others

- The provider worked in partnership with other professionals, including the district nursing service, physiotherapy, occupational therapy and local GP's. This meant people received specialist support when required.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure a safe environment by fitting appropriate devices to restrict windows from opening and failed to learn lessons after somebody had climbed through a window by fitting appropriate restrictors</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The providers oversight had failed to identify that safety checks were missed when staff responsible were absent from the service. The provider failed to ensure that suitable window restrictor were fitted to some ground floor windows and failed to respond to a incident where somebody had managed to climb out of the window by installing suitable window locks.</p>