365 Care Homes Limited

Delph House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Delph House is a residential care home providing personal care and accommodation to 19 people aged 65 and over at the time of the inspection. The service can support up to 22 people.

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

People's care environment was found to be visibly unclean with some safety concerns also identified. This did not ensure people were kept safe and protected from harm.
Record keeping had not been completed in full in all areas. The provider had not identified this prior to the inspection.
People told us they felt safe and well supported at the service. Staff were observed to be attentive to individuals needs and supported them in a timely manner.
Staff felt clear in their job role and felt the management were approachable and supportive.
People received their medicines on time, and felt able to raise any concerns with staff when required.

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 Good (published 13 August 2019)

Why we inspected

We received concerns in relation to the safe care and treatment of people supported. 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 changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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.

You can see what action we have asked the provider to take at the end of this full report.
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 documentation and storage of medicines, infection, prevention and control, management of risks to people, safeguarding people from abuse and effective governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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.

Delph House

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 two inspectors and one 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.

Service and service type
Delph House 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. The service was currently being managed by the regional manager. The provider is legally responsible for how the service is run and for the quality and safety of the care provided in the absence of a registered manager.

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. 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 sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke to five people living at the service and five relatives about their experience of the care provided. We spoke with eight staff including care and ancillary staff, the business administrator and the regional manager who was currently managing the service. We also spoke with the Nominated Individual (NI) The NI is responsible for supervising the management of the service on behalf of the provider.

We looked at two staff files in relation to recruitment and supervision and a variety of records relating to the management of the service. We looked at two people's care records including their medication records. We also carried out observations of people receiving care and support in communal areas of the home.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at a further five people's care records, policies and procedures and quality assurance records. We spoke with two health care professionals who regularly visited the service, by telephone.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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

● Some risks to people's safety had not been assessed and/or managed well. For example, items that may cause harm if accidentally ingested such as fluid thickener and toiletries were accessible to people living in the service. This included people who were mobile and who lacked insight into risks. Risks associated with this practice had not been assessed. We brought this to the regional manager's attention who told us fluid thickener should be locked away and proceeded to secure these items.

● Care records did not evidence temperature well fair checks of all people supported were completed twice a day, in line with government guidance. This presented a risk that people may develop COVID-19 symptoms, such as a fever and this would be undetected.

● Mobility and falls risks for those within the home had not been fully mitigated. Stairs were left unmonitored even though individuals were known to be at risk of falls and their care plans stated, "Monitor near stairs". This posed a risk that those at greatest risk could freely access the stairs.

● Hygiene records reviewed did not evidence that oral care had been completed daily. No detail had been completed to confirm if the support had been offered, refused or completed and not written down. This presented a risk that oral hygiene had not been completed and this risk had not been identified through the provider's own audits and checks.

● Care plans and risk assessments had not been completed for particular health conditions, including Parkinsons Disease. This placed people at risk of not having their health needs fully understood and supported.

Risks relating to the health and welfare of people were not fully assessed and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider informed us that they have plans to make a secure outside space; this was also noted on the development plan dated May 2020. At the time of the inspection work had not been started. The provider informed us that due to the restrictions and risks that COVID-19 had presented they have been unable to complete these works. This had caused an impact to those being supported. One person told us "I am not allowed to go outside as they are worried, I will fall and they will be liable".

● Health and safety checks were regularly completed for fire equipment, water temperatures and lifting equipment. On the day of the inspection an automatic closer on an internal fire door was observed to not be working correctly and the door itself was being held in place by a table. This was remedied once identified.

● Staff were clear on which people they supported required regular repositioning to reduce risks to their skin. Repositioning was documented within the individuals care notes to ensure people were supported at

the appropriate times.
●Systems were not robust at reducing the spread of the risk of infection.
● We were not assured that the provider was admitting people safely to the service. One person who had recently moved into the service, was not in isolation in line with Government guidance. The risk of not isolating the person had not been assessed. No extra precautions had been taken to reduce any possible spread of infection. This placed other people living in the home at risk of harm.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Equipment was found to be damaged and stained during the site visit. One chair observed was stained and the regional manager asked for this to be removed on the day of the visit. Side tables were identified to be damaged, and no longer an intact clean surface. The Nominated Individual informed us that the new tables were at a sister service waiting to come across. These were then delivered to Delph House on the day of the inspection.
● The service did not have a secure outside space. Due to this, external doors were kept locked. During the day of the inspection we were concerned to find an external door was observed to be open and unattended by staff. Causing a potential risk for people to abscond.
● Commodes were evidenced to be rusty and unclean. Pressure cushions used were unclean. Carpets were observed to be stained, and walls in some communal areas and bedrooms were damaged and marked.
● Cleaning records reviewed did not show in-depth repeat cleaning of high-risk areas. The communal bathroom cleaning record evidenced once a day cleaning. Staff told us "The bathrooms and toilets are the first things cleaned". On the day of the visit a bathroom had become soiled and was not recleaned during the visit.
● We were not assured that the provider's infection prevention and control policy was up to date.

Risks relating to infection, prevention and control were not fully assessed and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. On the day of the inspection both inspectors were asked to produce proof of a recent test being completed. However, our temperatures were not checked and we were not asked to wash our hands in line with current government guidance.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. The staff handover area was observed to be small and unlocked with damaged chairs. Staff would not be able to fully socially distance within this room or keep the environment clean. Staff belongings were stored closely to one another's causing potential for infection to spread.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was using PPE effectively and safely.
● Care staff were all observed to be wearing Personal Protective Equipment (PPE) in line with current government guidance. Relatives told us "face mask, white apron staff all wear them, we had temperatures taken (during recent visit) and wear it too".

Staffing and recruitment
● We found a staff personnel file had missing information on the day of the visit relating to their previous social care employment, in addition to a reference completed prior to their employment started. The reference was produced following the inspection by the regional manager we were also informed the

information relating to a previous social care employment was stored elsewhere.
● Evidence of steps taken to assess risks associated with one staff member working in the service were not available to the inspectors. Evidence initially shared stated that management would monitor this individual. The provider produced an additional risk assessment following the inspection, that was completed when the staff member began employment evidencing risks had been assessed.
● After the inspection, the provider confirmed they have reviewed their processes and employed an administrator who would audit all personnel files.
● On the day of the inspection enough staff were observed to be supporting individuals in a timely manner. Staff rota's shared also evidenced consistent staffing levels. A relative said, "I phone every other day, rarely do staff say not at the moment we have not got time for you to speak to him, they swap me onto the cordless phone".
● Regular training competencies were completed for staff in relation to moving and handling and medication. The regional manager confirmed they did not currently complete PPE competencies but would introduce this following the inspection.

Systems and processes to safeguard people from the risk of abuse
● The appropriate action had not been taken where potential safeguarding concerns had been identified and raised to management. .
● Records showed that a staff member had raised a concern with a senior staff member, that an issue regarding a person's health had not been followed up correctly, alleging this had resulted in an admission to hospital. This concern had not been raised as a safeguarding alert to the local authority as appropriate and no investigation had taken place. The provider confirmed they did investigate this matter internally and found no evidence to support this allegation.
● Staff understood how to report suspected abuse. "If I had a concern I would go to the Senior or manager". Another staff told us "If I notice or saw things that are not nice, I would go to safeguarding. Our responsibility to report things". However, inspection findings demonstrated that where staff had raised concerns these were not acted on by senior staff or members of the management team.
● Following our site visit, Staff confirmed signs and types of abuse and that they would report this to management if they have concerned. One staff told us "previously they have reported a concern, was told to put this in writing and take photographs (of the environment)".

Using medicines safely
●Safe medication practice had not been consistently followed. For example, Medicated patches were not documented that they had been applied as per manufactures recommendations. Clear instructions relating to patch application were not included in people's care plan, placing them at risk of not receiving this medication in a safe manner. This information was relayed to the regional manager to rectify this concern and is further discussed within the well led domain.
● Where people had been prescribed creams to treat skin conditions. No records were in place to demonstrated these had been applied as intended by the prescriber.
● Medication stock control was not effectively managed. Medication counts were not being completed daily for current stock. Carried forward medicines when the service had received a new delivery were not being completed for all medication. Additional stock of medication had also not been counted by staff when received. The temperature had not been monitored for the storage room of overflow medication, to ensure it did not spoil and lose effectiveness.
● Loose medication had been found inside one person's medication box by the inspector. This medication had not been stored in a safe manner and presented a cross contamination risk.

● Gaps within medication administration records were identified with no reasoning for these omissions documented. It was not always clear if medication had been administered as prescribed causing a risk to the persons health. We discuss these concerns further within the well led domain.
● Staff were able to clearly describe the correct process for administrating medication. Staff were also aware of time sensitive medication and the times these were to be administered. A person told us "Medicines yes [they arrive] on time, they [staff] stay and give me a drink and tablets together and stay right until I drink it".
● Alongside individual's medication there was a clear photograph of the individual, known allergies listed and their GPs information to reduce risk when administering medication.

Learning lessons when things go wrong
● Not all steps had been taken to adapt practice where possible, as an outcome of incidents that had happened.
● A previous incident occurred in November 2020 where staff were not clear on life saving steps to take in an emergency situation. Following this the service clearly had on display butterfly stickers in all bedrooms where the individual had a Do Not Attempt Resuscitation (DNAR) in place. The information was consistent within the care plans for the people we reviewed, Staff told us "the butterfly's are to let you know someone has a DNAR".
● Not all incidents that staff had raised had been reported to the appropriate bodies and investigated. Therefore, the service hadn't had an opportunity to learn lessons from these concerns to minimise the likelihood of these reoccurring.

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 was rated as good. At this inspection this key question has now deteriorated 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.

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; Working in partnership with others

- Oversight and governance by the provider was not been effective. Numerous audits had been completed prior to the inspection by the management but they had failed to identify areas of concern found during the inspection.
- The existing governance systems in place had not ensured contemporaneous records had been kept regarding the care provided to people. For example, we found gaps in medicines records, cleaning records, personnel files and care records. Some health and safety checks had also not been effective and concerns had not been identified internally.
- Care plans failed to identify risks in relation to unsafe items not being stored securely within the home, environmental factors such as unsupervised access to the stairs and the potential risk for those with mobility issues and risks relating to COVID-19.
- Policies and procedures were not all up to date with current guidance and were not all applicable to the service. For example, the COVID-19 policy did not give the correct PPE guidance to staff. The medication policy made reference to medicines being in locked cupboards within the treatment room which was not correct.
- Incidents including safeguarding concerns that had been raised to management had not been investigated, recorded or learnt from to reduce risks to people's safety.
- Equipment had become worn or damaged and had not been identified via internal governance or oversite. This damaged equipment presented an infection control risk to people.

Sufficient oversite had not been maintained by the provide. This was a breach of regulation 17 (good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A development plan had been shared by the regional manager dated May 2020 but not all areas had been highlighted and progress had not been made in a timely manner to ensure the equipment and service remained safe for use.
- Due to insufficient measures being in place during the inspection, the regional manager told us they were exploring new electronic systems to evidence repeat cleaning.
- The service has had a high turnover of managers which have affected the oversite and direction the service had taken. The provider had not taken relevant steps to ensure sufficient oversite during this time.

● After the inspection the regional manager confirmed to the inspector an external organisation had been approached to assist with policies and procedures. However, this action will take time to be embedded into practice.
● The regional manager confirmed the service has a portable electronic device to be used for videocalls to maintain contact between the relatives and people supported. .

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● One person who used the service, told us they had recently been visited by their family in the visiting pod. "This was a very poor experience, there was a loud noise from the lounge and mowing the lawn so I could not hear my daughter". This experience made the person upset.
● Staff were observed to be respectful and supporting individuals in a timely manner on the day of the visit. One person told us, "Yes I am happy here, everyone is so friendly, the food is good, I feel wonderful sitting here (in lounge) being waited on hand and foot."
● Meetings had taken place for the people living at the service as an opportunity for them to give feedback. The meetings from the most recent meeting lacked detail and actions to be taken forward to ensure the activities requested by the people happened. The minutes had not been signed by those in attendance, and it was unclear who chaired this meeting.
● Relatives told us they are not always updated on their loved ones health. One relative told us " They have had had a couple of operations and I was not contacted, the operation was cancelled and I was not told, the October operation I was not told of and rang just to find how they were and was told they were back from the hospital."
● External health care professionals told us they were not always clear on who to approach within the staffing team when they had information to discuss due to regular changes in the internal management team.
● Feedback regarding communication to the relatives of people supported was mixed. One relative told us "I have called weekly and got a comprehensive summary from the manager or the senior". Another relative told us "I cannot always get through on the phone, the signal is pants", "Carers are using their own mobiles so that I can video call with my relative".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Staff told us they felt clear in their job role and felt they had suitable training to work effectively, this was reflected during observations completed during our site visit.
● The regional manager said additional quality monitoring forms have now been implemented following our visit. These forms include a daily and monthly summary. The Nominated Individual confirmed a quality manager had been hired to further monitor quality within the service following our inspection. .
● Staff who were non-compliant with their mandatory training have now been removed from the service. Regular agency staff were being used to support the service. Staff told us the agency staff "They are brilliant, they don't stop."

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 Risks relating to the health and welfare of people and the risks of infection, prevention and control were not fully assessed and managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Sufficient oversite had not been maintained by the provider.