Botany House Limited

Danesmoor Residential Care Home

Inspection report

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Tel: 01706216862

Date of inspection visit:
09 September 2020

Date of publication:
06 October 2020

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
Danesmoor Residential Care Home is a residential home registered to provide accommodation and personal care for 24 people aged 65 and over. At the time of the inspection, 17 people lived at the home. Some people were living with dementia.

People's experience of using this service and what we found
People told us they were satisfied with the care provided and had no complaints. The environment was clean in all areas seen and people had personalised their rooms with their own belongings.

There were sufficient staff on duty, and they responded to people's needs in a timely manner. However, people's care plans had not been updated and staff employed by an agency had no access to written information about people's needs and preferences, including risks associated with their care. There was no evidence to indicate staff had received training on the operation of the electronic care planning system and records of personal care had not been accurately maintained. There was limited evidence to show new staff had completed induction training and the provider's mandatory training, which includes safeguarding vulnerable adults.

There was a log of accidents and incidents in April 2020, however, there were no further accident records or any analyses. This meant it was difficult to determine if any lessons had been learned and if any learning had been passed on to the staff team.

There were sufficient supplies of personal protective equipment, however, two ancillary staff were not wearing face masks and one care staff was wearing a face mask inappropriately. The manager gave assurances this issue would be addressed immediately.

Overall, there were significant shortfalls found in the record keeping and quality monitoring systems. At the time of the inspection, the new manager had been in post for three days and along with the provider, she was committed to making the necessary improvements to 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 rating at the last inspection was requires improvement (published 31 May 2019). At this inspection enough improvement had not been made and the rating remains requires improvement. This service has been rated as requires improvement on the last three consecutive occasions.

Why we inspected
This inspection was prompted in part due to concerns received about the operation of the service. A decision was made for us to inspect and examine any risks to people's health and safety and the

management systems. This report only covers our findings in relation to the key questions Safe and Well-Led.

We also 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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Danesmoor 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 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 identified two breaches in relation to record keeping and the ongoing monitoring of the service and a failure to update care plans to reflect current risks to people's health and safety.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

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.

Danesmoor 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
The inspection was carried out by one inspector.

Service and service type
Danesmoor 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. The Care Quality Commission (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 CQC. This meant the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager left the service in February 2020 and another manager started work in the home in March 2020, they left the service in August 2020. A new manager was appointed in September 2020.

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. We sought feedback from the local authority and reviewed information from statutory notifications sent to us by the service about incidents and events that had occurred at the home.

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 six people who lived in the home, two staff, the cook, the housekeeper and the manager. We also spoke over the telephone with a friend of person who had recently lived in the home.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to confirm evidence found. We looked at records sent to us before and after the inspection.

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider had policies and procedures on safeguarding vulnerable adults and had made arrangements for the investigation of safeguarding alerts.
- People told us they felt safe in the home and were satisfied with the care provided. One person told us, "I have no complaints or worries." However, the manager agreed to raise a retrospective safeguarding alert in relation to one person's experiences during the pandemic. The provider had previously taken action to resolve the issues and the person expressed contentment with their situation at the time of the inspection.

- Whilst the manager and a member of staff told us they were committed to providing people with safe care, there was no evidence seen to indicate the staff had received safeguarding training. The manager was aware of the lack of staff training and was making arrangements to ensure staff had access to appropriate training.
- There was an accident log completed in April 2020, however, there were no further records seen pertaining to accidents and incidents in the home, including falls. This meant it was difficult to determine if any lessons had been learned and if any learning had been disseminated to staff.

Assessing risk, safety monitoring and management

- The provider had established systems to assess and monitor risks to people's health and wellbeing. However, we looked at the electronic care planning system with a member of staff and found people's care plans had not been updated to reflect current risks associated with people's care.

The provider had failed to ensure current risks to people's health and safety were appropriately assessed and recorded in people's care plans. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had arrangements to carry out maintenance and safety checks on the installations and equipment. However, the portable appliance testing, and the gas safety checks were overdue. The manager explained the portable appliances were due to be tested the week of the inspection and she would liaise with the provider to ensure the gas safety certificate was renewed. This may have been delayed due to the pandemic and the restrictions on visiting care homes.
- Whilst the business continuity plan was out of date, the generic service level risks had been reviewed and updated. We also noted there was a Coronavirus risk assessment and contingency plan.

Using medicines safely

- People told us they were satisfied with the support they received with their medicines.

● Whilst the medicine administration records were well organised and up to date, there was an error in the controlled drugs register and staff had not completed body maps following the application of transdermal skin patches. There was also one unlabelled tube of prescribed topical cream in one person's bedroom.
● We were advised staff medicine competency checks had been carried out and were sent copies of two competency checks following the inspection. However, we saw no evidence to demonstrate the staff had received appropriate medicines training and no evidence to demonstrate an audit of medicines had been carried out.

Staffing and recruitment
● At the time of the inspection, there were three care staff on duty, two of whom were employed by an agency. The home was calm, and staff attended to people's needs promptly. However, the agency staff had no access to people's electronic care planning records and had not been given any written information about people's needs.
● Whilst a recruitment system had been established for new staff, there were minor shortfalls in the recruitment records. There was limited evidence to demonstrate staff had completed induction training.

Preventing and controlling infection
● On arrival, we conducted a full tour of the premises with the manager. We saw the home was clean and hygienic in all areas seen. People's bedrooms were appropriately decorated and had been personalised with their own belongings.
● There were sufficient supplies of personal protective equipment (PPE). However, two ancillary staff were not wearing face masks and one agency member of staff was not wearing a mask appropriately. This was contrary to the latest government guidance on the use of PPE in care homes. The manager gave assurances this situation would be addressed with the staff team.
● There was no evidence seen to demonstrate infection prevention and control audits had been carried out.

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 requires improvement. At this inspection this key question has remained the same. 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; Continuous learning and improving care

● Since the last inspection, the registered manager left the service in February 2020 and a new manager started work in the home in March 2020. They left the service in August 2020 and another new manager was appointed in September 2020. During the pandemic the provider's representative was unable to visit the home, but maintained regular email and telephone contact with the home.
● We found significant shortfalls in record keeping and the quality monitoring systems. People's care planning documentation had not been updated and was not reflective of their current needs and risks to their health and safety. There were a limited number of audits and no audits seen past May 2020. New staff had not received appropriate induction training or mandatory training. Personal care had not been accurately recorded and there was no evidence seen to demonstrate accidents and incidents had been recorded and analysed after April 2020.
● The lack of records and effective monitoring was further compounded by a high staff turnover, which in turn has meant a new staff team has been recruited.
● There was no evidence seen of ongoing analysis and evaluation to demonstrate continuous learning and ongoing improvements.

The provider had failed to operate effective systems to assess, monitor and manage the quality and safety of the service. This a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of the inspection, the new manager had been in post for three days and was in the process of organising the office and recruiting new staff. The manager explained she intended to implement new systems and ways of working across the whole operation of the home. The manager was supported by the provider.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 and manager were committed to delivering a person-centred service which achieved positive outcomes for people. However, whilst staff were attentive to people's requests for assistance, they had no

access to up to date information about their needs and preferences.
● Apart from one staff meeting, held by the provider, we saw no evidence on staff files to demonstrate they had received appropriate supervision and guidance.
● The manager and provider understood the duty of candour and their responsibility to be open and honest when something went wrong. A member of staff told us the manager was approachable and they were confident improvements would be made to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People told us they were happy living in the home. One person said, "Things are alright here. I have no worries" and another person said, "I have no quibbles with the staff."
● People's views were sought through daily discussions and a satisfaction survey had been carried out in May 2020. We looked at the collated results and noted people had indicated they were satisfied with the service.
● A friend of a person who had recently lived in the home, confirmed they had been kept up to date with any changes in the person's wellbeing. They said, "We were very happy with the care. The staff were kind and caring."
● Whilst the care planning system took account of people's equality characteristics, the plans had not been updated with people's needs.
● At the time of the inspection, the manager had only been in post for three days. She expressed a commitment to build positive relationships with social care and healthcare professionals.

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 The provider had failed to ensure current risks to people's health and safety were appropriately assessed and recorded in people's care plans. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and manage the quality and safety of the service. (Regulation 17 (1) (2)).