Darsdale Carehome Limited

Darsdale Home

Inspection report

Chelveston Road
Raunds
Wellingborough
Northamptonshire
NN9 6DA

Tel: 01933622457
Website: www.darsdale.org.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Darsdale Home is a residential care home providing personal and nursing care to up to 30 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 24 people using the service.

Darsdale Home has accommodation across two floors, in one adapted building.

People's experience of using this service and what we found
Some changes had been made to the quality assurance systems since the last inspection. However, audit processes remained ineffective at assessing, monitoring and improving key areas of the service.

The action plan developed by the provider following the last inspection was not effective in identifying, prioritising, monitoring and reviewing improvements. There was no detailed and structured plan of how the provider intended to achieve a 'good' rating and improve care standards in the service.

A priority action identified in a fire risk assessment for the external staircase to be inspected by a qualified professional had not been addressed in a timely manner. Until this had taken place, people and staff were potentially at heightened risk of physical harm in the event of an emergency evacuation.

Systems to assess, monitor and manage risks to people's health, safety and welfare were not always up to date and effective. Care planning and risk assessment documentation was not always in place and regularly reviewed. Not everyone had grab sheets or up to date personal evacuation plans to ensure they were supported safely in the event of an emergency hospital admission or fire evacuation.

People were potentially unlawfully deprived of their liberty whilst living in the service. Oversight of applications for people to be deprived of their liberty, where this was necessary, was ineffective. Not everyone who lacked or had fluctuating capacity to make specific decisions had mental capacity assessments in their care records, or documentation showing best interest meetings had been held. Staff knew how to support people to make day to day decisions about their care.

Some improvements were found in medicines processes. Management of controlled drugs was safe. Improvements were required to protocols for 'as required' medicines and medicines care plans to ensure these were personalised and person-centred.

An ongoing programme of redecoration was gradually taking place but the décor in areas of the service was tired and required refreshing. People did not get maximum benefit from the large gardens around the service.

Recent changes had been made to the tool used to calculate safe staffing numbers as well as staffing levels

and shift patterns. These changes required time to embed and their impact upon people's care and safety to be assessed and reviewed.

Checks were undertaken to ensure staff were suitable to work with vulnerable people. Some gaps were found in recruitment files, which were also identified at the last inspection.

Medical care and support was sought, when required, if people experienced falls, incidents or accidents. Monthly analysis of accidents, incidents and falls and sharing lessons learned was introduced following the last inspection but needed strengthening and embedding into practice.

Staff wore personal protective equipment (PPE) to reduce the risk of cross contamination or infection spread. Visitor sign in processes were in place and visiting arrangements aligned with current guidance.

A new safeguarding policy had recently been introduced and information about safeguarding processes was on display in 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 and update
The last rating for this service was requires improvement (published 4 May 2022) and there were three breaches of regulation. We issued two Warning Notices following the inspection due to concerns about poor governance arrangements under Regulation 17 and insufficient staffing levels under Regulation 18. We also issued a Requirement Notice under Regulation 12 due to concerns about people's safe care and treatment. At this inspection we found the provider remained in breach of regulations. Improvements to staffing meant they were no longer in breach of Regulation 18 but there were continued breaches in relation to governance and management oversight, and people's safe care and treatment.

The service has been rated requires improvement in six consecutive inspections and has now deteriorated to inadequate. The service has been in Special Measures since 1 September 2021 due to repeated ratings of requires improvement and the key question of 'well-led' deteriorating to inadequate at the last inspection. During this inspection not enough improvements have been made. Therefore, this service remains in Special Measures.

Why we inspected
We undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also checked if the Requirement Notice we served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

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.

Enforcement and Recommendations
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 have identified breaches in relation to provider oversight and people receiving safe care and treatment.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Darsdale 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 Health and Social Care Act 2008.

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 an inspector, an inspection manager and a medicines inspector. An Expert by Experience made phone calls to relatives for feedback. 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
Darsdale Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Darsdale Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 a manager had recently started in post. They had submitted an application to become registered.

Notice of inspection

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority safeguarding and quality monitoring teams. The provider had not been asked to submit a PIR since the last inspection. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 11 relatives for feedback on their experience of care. We spoke with a director who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with ten members of staff including the manager, deputy manager, senior care staff, activities coordinator, housekeeping and kitchen staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a visiting professional.

We looked at aspects of 11 people's care records and three staff files. We also reviewed 21 medicine administration records (MAR) and eight medicine care plans. We looked at a range of other records including quality assurance checks and information about training and staff supervision.

After the inspection
We reviewed further information about DoLS applications from both the service and local authority. We reviewed the fire risk assessment and updated documents submitted by the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

The key question of 'Safe' has been awarded a rating of requires improvement in six consecutive inspections. Due to the need for further improvements, at this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of staff were deployed to meet people's individual care and support needs which increased the risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of Regulation 18.

● In the weeks prior to the inspection, a new tool had been introduced by the manager to calculate safe staffing levels. There had also been some changes made to staffing and shift patterns during the days, at nights and in the domestic team. These were recent improvements and required embedding, reviewing and sustaining over time to understand the impact upon people and the care they received.
● Recruitment checks were undertaken prior to staff starting work. These included references and Disclosure and Barring Service (DBS) police checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Not all files we checked included a full employment history as required by our regulation. This had been identified at the last inspection and no action had been taken to improve this area.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection medicines processes required improvements and systems were either not in place or robust enough to demonstrate safety was effectively managed. 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 was still in breach of regulation 12.

● Prompt action was not taken to address issues identified in a fire risk assessment undertaken in May 2022. An inspection by a qualified professional of the external staircase was required as an immediate action, but this had not been done. The provider was in the process of arranging this. Other priority actions had been addressed.
● People's risks were not always assessed and reviewed regularly, or as their needs changed. For example, one person moved into the service several months previously, had been assessed as being at a high risk of

falls, but did not have care plans to guide staff in how to provide safe and appropriate care in key areas such as mobility, nutrition/hydration and skin integrity.
● One person had tried to leave the service independently. They were unable to keep themselves safe outside of the care home. There was no risk assessment in place to help identify when this might happen and help staff support the person's need to go out.
● People were at heightened risk in the event of a medical or fire emergency. Two people did not have hospital grab sheets to share essential information if they were admitted to hospital. People's personal evacuation plans were not always up to date, and neither was the chart showing 'at a glance' what support people needed in the event of a fire emergency. The manager updated these records when this was brought to their attention.
● Since the last inspection, protocols had been introduced for medicines administered 'as required'. However, these were not always specific to individuals, so did not provide adequate guidance for staff to follow. For example, they did not set out how a person showed they were in pain if they could not communicate verbally to support staff assess whether they needed pain relief.
● Care plans for medicines had improved since the last inspection but were still not comprehensive and were not always person-centred. For example, one person was on covert medicines which is medicines given without the person's knowledge usually in their food or drink, but their care plan did not reflect this.

People were at risk of receiving care which was unsafe or did not meet their assessed needs due to systems not being robust enough to show safety was well managed. Further improvements were required to medicines processes. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements had been made to some medicines processes since the last inspection. Controlled drugs were managed safely. People received medicines as prescribed and in the way they preferred.
● An issue with topical creams had already been identified. Prescriptions were not specific in where creams should be applied, which staff were following up with the GP surgery. Cream charts had been put in place to support appropriate application.

Learning lessons when things go wrong
● Processes were in place for accidents, incidents and falls to be reported and followed up. Some staff told us they were unsure of how to complete the records themselves, but confirmed they always passed the information to the deputy manager who completed the follow up.
● Monthly analyses of accidents, incidents and falls had started to take place but these required improvements to be effective. Sharing of lessons learned when things went wrong was in its early stages.

Preventing and controlling infection
● 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 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 promoting safety through the layout and hygiene practices of the premises.
● 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.

● The provider's policy confirmed there were no restrictions upon visitors attending the service to see

people. Some relatives told us they had to give advance notice of their visit. The manager confirmed they would ensure relatives were updated this was not required.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes to safeguard people from the risk of abuse were in place. Staff had received training in safeguarding. Some staff were not sure about safeguarding when we spoke with them but were aware of where to find information if needed.

● Since the last inspection a new safeguarding policy had been introduced. Most relatives provided positive feedback about the safety and care of their family members. One relative said, "We feel [family member] is safe and well looked after." A person living in the service told us, "My family know I am safe."

● Since the last inspection there were several safeguarding investigations due to people developing pressure wounds. Staff worked with the local authority safeguarding team to review and investigate the circumstances. Health professionals including district nurses were involved as needed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This last rating of this key question was requires improvement following the inspection of 14 August 2019. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People were potentially deprived of their liberty without the legal authorisation to support this. One person often wanted to leave the service and return to the area they previously lived in. Care records stated legal authorisation to deprive their liberty had been granted. We checked and found no application had been made.
- The tracker system to monitor DoLS applications was ineffective. Some people living in the service were not listed on the tracker. There were five people who applications had not been submitted for, but the tracker stated the opposite. The provider did not have effective systems in place to ensure any restrictions placed upon people's liberty was done so lawfully.
- When people lacked or had fluctuating capacity to make specific decisions, their care records did not always include MCA assessments and records of best interest decisions being made. This placed people at higher risk of having decisions made which were not in their best interests.
- Staff knew how to provide care which supported people to make choices. Staff worked to support people to make their own decisions as far as they were able at any given time.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Care plans were not always reflective of people's needs. We found some care plans did not fully consider

people's care needs including individual cultural or religious preferences. We also found some care and support plans were not reviewed regularly or as people's needs changed. This placed people at higher risk of receiving care which may not meet their current needs.

● Some people had care plans for specific areas of care needs. For example, one person became distressed at times and there were specific reasons for this. A care plan was in place to support staff to understand what may trigger the person to become upset, and how to support them if this happened.

Staff support: induction, training, skills and experience

● At the last inspection we identified some gaps in the training staff received. Since then an improved tracker had been implemented so the provider could monitor completed training and when refresher training was due. There remained gaps in some areas such as end of life care and positive behaviour support which the provider confirmed they were continuing to work on.

● Not all staff had received regular one to one supervision with a senior member of staff since the last inspection. The manager had identified this and was in the process of arranging and holding one to one meetings with staff. Supervision sessions provided opportunities for staff to reflect on their working practices and discuss training and support needs.

● Staff received an induction when they joined the service which included training and time spent shadowing experienced staff.

Supporting people to eat and drink enough to maintain a balanced diet

● People's individual food choices were not always catered for. We saw meals for some people on pureed diets were blended together. For example, meat, potatoes and vegetables. This did not look appetising and reduced the choices available if a person preferred more or less of a specific food during any particular mealtime.

● People were supported to eat and drink safely. We observed staff support people patiently where physical assistance was needed. An up to date chart was used in the kitchen serving area showing people's dietary needs such as soft meals or any allergies.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The deputy manager was due to leave the service and they did most of the communication with other health and social care professionals about people's care and health needs. The manager was working with the team of senior care staff to support them to learn and build confidence with these tasks. This would help ensure there was no disruption or delays after the deputy manager left.

● Staff worked in partnership with health and social care professionals to maintain people's health. For example, the district nurse regularly visited to provide clinical care to people with pressure wounds.

Adapting service, design, decoration to meet people's needs

● Some of the décor and furnishings were tired and required refreshing. There was an ongoing programme of redecoration which was happening gradually. There were large gardens around the service which people were able to spend some time in. Use of the gardens for people's wellbeing and enjoyment was not maximised to its full potential.

● The design and décor was not dementia friendly in all areas. Some signage was in use but navigating around the building was difficult. There were no additional measures in place to support orientation for people who may be confused at times. There were no areas decorated for people's sensory or memory stimulation. For example, vintage or themed areas, or the use of music or colour.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. 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.

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; 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 oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times. This placed people at risk of harm. This was a continued 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.

● Under the leadership of the current provider, the service has been rated, 'requires improvement' in all six CQC inspections since 2017. Although the provider developed an action plan following the last inspection, it was not effective in identifying, monitoring and reviewing the areas which required improvements. Usage of the action plan had not been effective in driving and delivering the required improvements to achieve a 'good' rating in all areas or demonstrating how this was being worked towards in a structured and planned way.
● A manager had recently started in post. The provider had not shared with them the contents of the warning notices issued following the last inspection, so they were not fully aware until the day of inspection of the range and extent of CQC concerns about the service and care people received.
● Although changes had been made to the quality assurance system since the last inspection it remained ineffective and did not ensure the provider had oversight of all key areas. The audits lacked detail and necessary information required to identify and drive improvements in all areas. The provider had made a decision to introduce a new quality assurance system in the near future.
● The provider had not identified some people living in the service were potentially unlawfully deprived of their liberty and there was inadequate oversight of DoLS processes. They did not have systems in place to identify concerns with mental capacity assessments, consent and decision making.
● There remained no audits of the daily monitoring of people's care, for example repositioning or food and fluid charts, or the daily notes recorded by staff. This meant the provider could not assure themselves that people received consistently safe care which met their current needs.

● The deputy manager was due to leave the service and they undertook a range of important tasks related to people's care planning and delivery which were not done by any other staff members. For example, some medicines tasks, writing care plans and mental capacity assessments, liaising with the GP and other health professionals. The extent of these gaps were not identified until the day before the inspection took place which the manager was working with the senior care team to address. A senior carer told us, "We want to change for the better. We are ready to learn, we are all on board."
● There continued to be a culture where people did not always receive person centred care. People did not have sufficient opportunities to do the things they enjoyed and spend time in the way they preferred.
● Audits of falls, incidents and accidents had been introduced but did not identify the lack of consistency in how these were recorded. The audit did not include any analysis to support the identification of themes or trends to potentially improve practice and people's safety.
● A new set of policies and procedures were being introduced. At the time of inspection work was ongoing to personalise these to Darsdale Home. It would take time for these to be rolled out and embedded into staff practice. People remained at heightened risk until the whole staff team were consistently following the new policies and procedures.
● Not all staff received regular supervision in a one to one meeting with a senior member of staff. This meant the provider could not be assured staff had the right support and development opportunities available to them to perform their roles optimally.
● Some improvements had been made to staff training since the last inspection, but there remained gaps in some areas which were identified at the last inspection. For example, end of life care, person centred care and recording.
● The majority of people's care records were maintained on the system which was used primarily by the deputy manager who was leaving. There was no clear plan in place for care planning and oversight of the system moving forwards.

Oversight of the service continued to be ineffectively managed by the provider to ensure people received safe and person-centred care at all times. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider continued to be visible in the service and supportive of the staff team. The manager had been in post a few weeks and was keen to ensure improvements were made and embedded in the service.
● Staff were committed to providing good quality care to people and worked hard to achieve this. One staff member told us, "We pull together, but morale is not good." A relative told us, "The staff are wonderful and very accommodating."

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff worked in partnership with health professionals involved in monitoring and providing care and treatment for people using the service. The service received support from a primary care network co-ordinator who visited weekly to facilitate people's access to health services, for example, occupational therapy or the dietician.
● The provider and manager continued to work with the local authority safeguarding and quality monitoring teams who were involved in investigating concerns and driving improvements. The providers had voluntarily agreed with the local authority not to accept any further admissions to the service until improvements had been made and embedded.
● Improvements were needed to meetings with residents and relatives to ensure they took place regularly and minutes were prepared in a user friendly and accessible format. Relatives told us they were not kept up

to date with developments in the service and some had concerns about high staff turnover. One relative said, "There has been a large turnover of staff recently which is quite worrying since we've not had any information from the management."

● We saw some feedback surveys had been received from relatives since the last inspection, but we could not see that the results had been collated, analysed and acted upon. Some relatives told us they had not received a request for feedback.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Prompt action was not taken to rectify issues found in a fire risk assessment. The provider failed to ensure risks to people were assessed and reviewed regularly. Documentation to ensure people remained safe in emergency situations was not always in place. Medicines processes required further strengthening.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. There was no effective action plan to support the prioritisation and driving of ongoing improvements.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.