

Mr & Mrs M Sharif

# Dearnlea Park Residential Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Dearnlea Park Residential Care Home is a residential care home providing accommodation and personal care for up to 67 people over two floors of a purpose-built building. The service provides support to older adults and younger people, some of whom are living with dementia or experiencing mental health issues. At the time of our inspection there were 41 people living at the service.

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

Medicines were not managed safely. We were not assured of staff competency in this area. There was not always guidance for staff on how to administer medicines safely. People's care records did not accurately reflect their needs. Risks to people had not been fully assessed and there was limited guidance for staff on how best to manage these risks. There were no effective systems in place to monitor and improve the quality of the services provided. The provider had failed to keep oversight of the service.

Not all staff were provided with an induction and relevant training to make sure they had the right skills and knowledge for their role. There were systems in place to recognise and respond to any allegations of abuse. Safe recruitment procedures made sure staff were of suitable character and background. There were enough staff deployed to meet people's care and support needs in a timely way.

We saw staff were kind and caring in their interactions with people. They clearly knew people well. 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.

People told us they enjoyed the food served at Dearnlea Park Residential Care Home. People were encouraged to maintain good health and have access to health and social care services. The registered manager had been in post since January 2023 and staff told us they were supportive.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The last rating for this service was requires improvement (published 29 November 2021) and there were breaches of regulations. 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 the provider remained in breach of regulations.

### Why we inspected

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

We carried out an unannounced focused inspection of this service on 9 November 2021. 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 medicines management, assessing risks, health and safety, and 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 of Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service has remained as 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 Dearnlea Park Residential Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

We have identified continued breaches in relation to medicines management, assessing risks, and governance.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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 effective?

The service was not always effective.

Details are in our effective 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** ●

# Dearnlea Park 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 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 team was made up of 2 inspectors and 1 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

Dearnlea Park Residential Care Home '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. Dearnlea Park Residential Care 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch, Barnsley. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all this information to plan our inspection.

#### During the inspection

We spoke with 12 people living at Dearnlea Park Residential Care Home and 4 of their relatives about their experience of the care provided. We met with the registered manager and the provider. We spoke with 6 members of staff. We observed daily life in the service including part of the lunch time service. We looked around the building to check environmental safety and cleanliness.

We looked at written records, which included 6 people's care records, 4 people's medicine administration records and 4 staff files, including recruitment records. A variety of records relating to the management of the service were also reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. This included reviewing some of the provider's policies and procedures.



# 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. At this inspection the rating 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.

### Using medicines safely

At our last inspection the provider had failed to establish systems to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of Regulation 12 (1) (Safe care and treatment) 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.

- We were not assured of staff's competency in medicines management. CQC had been notified of recent significant medicines errors where people had not been given their medicines as prescribed. Not all care staff with responsibility for medicines management had had their competency checked in line with the provider's own policy of twice per year. Not all staff training in this area was up to date.
- Care staff were not always given guidance on how to safely administer people's medicines. For example, people's care records did not always contain guidance as to when a person may need their 'as required' (PRN) medicines.
- There was not always guidance available for staff on where to apply topical medicines, such as creams and lotions. We were told this guidance was available in people's electronic care records and it should then be recorded in people's daily notes when applied by care staff. Where people were prescribed topical medicines, it was not recorded in the associated care records we looked at.
- Recent medicines audits had taken place. However, there was a recurring theme of running balances not being kept for some medicines. This meant action had not been taken each month to address the issue.
- Medicines were stored securely however, not always within safe temperature ranges. Not all medicines with a short shelf life had been dated with when they had been opened.

The provider had failed to establish systems to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risks associated with people's care were mitigated. This placed people at risk of harm. This was a breach of regulation 12(1) (Safe care and treatment) 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.

- Risks to people were not fully assessed. Where risks to a person had been identified there was not always an associated care plan with guidance for staff on how best to manage and reduce the risks. For example, we saw two people had been assessed as 'high risk' in their 'behaviour care plan'. One did not have an associated risk assessment. The other person's corresponding risk assessment had very little detail.
- Risks to people in the event of a fire were reviewed, however work still needed to be done to ensure all actions from the fire risk assessment had been completed. People had individual personal evacuation plans in place to be followed in the event of an emergency.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Regular checks of the buildings and the equipment were carried out to help keep people safe.

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

- People told us they felt safe and well cared for. One person told us, "It's nice, I like it [living here]. It definitely [feels safe] I didn't feel safe in my [previous home]" and "The staff, the place, everything makes me feel safe."
- Staff confirmed they received training in safeguarding, however training records showed that a significant amount of staff were not up to date with this training. Our conversations with staff told us they were confident any concerns they reported to managers would be dealt with appropriately.
- There were some systems in place to record any safeguarding concerns raised with the local authority. These were disorganised and therefore difficult to track.
- Accidents and incidents were recorded. The provider had a system in place to track and analyse events in order to establish whether there were any trends and any lessons learnt to be shared with staff.

#### Staffing and recruitment

- The process of recruiting staff was safe. We saw recruitment files contained references to confirm the applicant's suitability in previous relevant employment, proof of identity, including a photograph and a Disclosure and Barring Service (DBS) reference number. DBS checks provide information including details about convictions and cautions held on the Police National Computer. These checks help employers make safer recruitment decisions.
- There were enough staff deployed to meet people's needs in a timely way. People we spoke with confirmed this to be the case. Comments included, "Yes, [staff come quickly], when I first moved in, I pressed the buzzer and they came straight away", "I've never waited really, I've always got help when I needed it" and "Oh yes, there's always [staff] around all the time."
- Staff told us they would benefit from more staff on each shift. However, they agreed they were able to meet people's care and support needs. A member of staff told us, "Staffing levels are OK. We could do with some more but as it is we are OK."

#### Preventing and controlling infection

- We were somewhat assured the provider's infection prevention and control (IPC) policy was up to date. IPC audits had not been completed effectively as they had not actioned the areas for improvement we found during this inspection.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene



practices of the premises. Some furniture and fittings needed replacing. For example, in the upstairs dining room laminate was peeling off a shelf and some tabletops were chipped.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- 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 responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

#### Visiting in care homes

There were no restrictions on visiting in accordance with the current government guidance. Staff did request visitors try and avoid mealtimes.

# 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.

At our last comprehensive inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider had introduced an electronic care record system. This had the ability to provide staff with details of each person's care needs and any support needed to meet those needs. Not all care records were up to date or contained the level of detail staff needed to provide effective care.
- Not all care records had been completed fully. Some were missing information on the person's social history, and their likes and dislikes. Information was not always recorded in the correct section making it difficult for staff to get a full understanding of the person.
- The provider told us they were looking to employ a consultant to work with staff to improve people's care records.

Staff support: induction, training, skills and experience

- Newly employed staff completed an induction. This included mandatory training and shadowing more experienced members of staff. There were no records of agency staff completing an induction when they first came to work at the service.
- Staff were expected to regularly complete training. Staff told us most training was completed online, although practical subjects such as moving and handling were taught face to face. Training records showed a large number of staff were behind on completing their training within expected timescales.
- Staff told us they felt supported by the registered manager. However, not all staff had received supervision in line with the provider's policy of 4 times per year. There were no records of any staff appraisals taking place within the last 12 months.

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

- The majority of people we spoke with were complimentary about the food served at Dearnlea Park Residential Care Home. Some people did tell us they would like a little more choice and variety. Comments included, "It's [food] lovely, I've never left any here, it was lovely", "It's lovely [food], I don't eat much, but I like the shepherd's pie" and "It's alright [food] but I could do with a bit more."
- We observed part of the lunchtime service on both floors. We found there was a noticeable difference. The dining experience downstairs was much more relaxed. Staff were not rushed and were able to chat with people. Music played and the tables were nicely set up. Upstairs the dining experience was brusque. There were no tablecloths, napkins, or condiments on the tables. This gave the upstairs dining experience an institutional feel.
- Staff encouraged and supported people to eat and drink as required. Some people had specific dietary needs. Staff were knowledgeable about people's different needs and were able to cater for them.

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

- People told us they were supported to access health and social care services. Comments included, "They [staff] look after us well" and "There's no worries here and if you take ill, they [staff] will [help] get you better".
- People's care records contained details of the professionals involved in their care. We saw recent records of professional visits taking place.

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

- There was some signage and picture displays to encourage reminiscence. However, more could be provided to engage and support people living with dementia. For example, photos of meals options were not available. Not all clocks in the communal areas were showing the correct time.
- The premises were tired and in need of a refresh. For example, there was out of date information on display, walls and skirting boards were badly scuffed in places.
- People did have access to a courtyard outside. People's bedrooms were personalised.

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's care records did not always contain up to date information about their needs or choices. It was not always clear when people did not have the capacity to make decisions.
- There was not always a record of signed consent or best interest meetings taking place when significant decisions needed to be made. For example, where there was a need for potentially restrictive interventions, such as bed rails.
- The registered manager understood their responsibilities with regard to the MCA. People had DoLS in place as appropriate. The registered manager kept a summary record to track each person's application.
- Not all staff were up to date with MCA and DoLS training. However, staff were aware of the need to give people choices. We saw evidence of this throughout the day of the inspection site visit.

# 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. At this inspection the rating 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; Continuous learning and improving care

At our last inspection we found the provider had failed to establish effective systems and processes to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17(1) (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.

- The provider had failed to keep oversight of the service. Following the last inspection, the provider gave reassurances to CQC that the service would improve. They had recognised improvements were needed and produced a service improvement plan. This had not been fully implemented as the provider remains in breach of regulations.
- Effective quality assurance systems were not in place to check the quality of the service and manage risks. Some audits had been introduced by the registered manager when they came to the service in January 2023. However, they did not pick up on the issues we found during this inspection. No provider audits were undertaken. There was no overall action plan to track any issues identified by audits.
- The registered manager had not established quality performance checks. For example, observations of staff practice were not undertaken.
- The provider had comprehensive policies and procedures in place. However, some policies did not have an associated procedure. For example, the safeguarding policy did not include contact details for local safeguarding teams. Not all staff could access them via an app on their phone, there were no printed copies available. The provider was not always following their own procedures. For example, care plans and risk assessments were not as detailed as their care planning policy and procedure stated they should be.

The provider had failed to establish effective systems and processes to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

outcomes for people

- It was clear from our conversations with staff and our observations of staff interactions that they knew people well and were committed to providing people with good care. A relative told us, "You can see they've [staff] got the residents welfare at heart."
- Staff told us they thought the registered manager was approachable and the service was starting to improve as a result.
- The registered manager operated an 'open door' policy where people living at Dearnlea Park Residential Care Home, their relatives and staff could speak with them at any time. However, some people and their relatives told us they would like the registered manager to spend more time upstairs.

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

- There were some systems in place to gain feedback on the service. Staff confirmed they had some team meetings with the registered manager. There were minutes from recent meetings with different groups of staff, such as senior care staff and night staff.
- There were no records of any recent meetings with people living at Dearnlea Park Residential Care home or their relatives. The registered manager assured us these were going to be introduced straight away. A person confirmed there was no meetings they could attend. The person told us, "They [staff] just come and ask if everything is okay."
- The provider had distributed satisfaction questionnaires to people living at Dearnlea Park Residential Care Home, their relatives and visiting professionals. We saw the results from the most recent questionnaires in March 2023. The responses were mostly positive. The results had been analysed and were displayed on the notice board in the reception area.

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

- The registered manager understood their role in terms of regulatory requirements. They were aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008.
- The provider and registered manager told us they were working in partnership with Barnsley Metropolitan Borough Council and Integrated Care Board to improve the service.

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  12(1) The provider had failed to establish systems to ensure the proper and safe management of medicines.  12(1) The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  17(1) The provider had failed to establish effective systems and processes to demonstrate safety was effectively managed.