Lifeways Community Care Limited

Delphine Court

Inspection report

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Date of inspection visit:
20 July 2020
23 July 2020
30 July 2020

Date of publication:
12 November 2020

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Delphine Court is a residential care home providing accommodation with personal care to adults with a learning disability and autistic spectrum disorder. At the time of this inspection, four people lived at the service.

People's experience of using this service and what we found
Support plans were not person centred. Risks which affected people's health, safety and wellbeing such as nutrition were not addressed or mitigated. Accidents and incidents had not been reviewed and analysed therefore, action had not been taken to reduce risks or identify trends in people's behaviours.

Records did not show staff had been trained or assessed to support people with their medicine administration. Staff were not trained to support people with their specific assessed needs such as trauma and attachment disorder.

The service did not have sufficient infection prevention and control measures in place. Government guidance in relation to COVID 19 was not followed. Communication systems were inadequate. Handover records were poor and inconsistent and relatives we spoke with all reported a lack of communication with the management of the service.

Medicines were not managed safely. Staffing was not provided at the levels for which they were commissioned. Staff reported they had not always felt safe with staffing levels and staff rotas and signing in records we viewed were not completed and confusing. The service was using agency staff and was actively recruiting.

We found unsafe practices in the kitchen such as a defective fridge and inappropriate storage of food. We saw one person's bathroom contained significant levels of black mould.

The service has not addressed issues from previous inspections. Issues from 2018 were still apparent relating to providing a homely environment and documentation such as maintaining a comprehensive training matrix for staff.

Quality checks were not consistent, audits were not effective at highlighting and addressing issues apparent within the service. There was a clear lack of provider oversight as they had not ensured effective and competent management was in place. There was not a registered manager and at the time of our inspection the service was overseen by an area manager with support from other managers from the provider's north east services. Some staff members we spoke with raised concerns about the management of the service.

We did observe people appeared comfortable and happy with staff interaction with them. Relatives we spoke with told us care staff members were kind and supported people in a positive way.

People had access to the community either visiting shops or going for a drive but there was little in the way of meaningful activities reflecting the development of life skills or using people's interests or choices taking place.

The service didn't always (consistently) apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; by not providing a homely living environment, a lack of choice and control over meaningful activities and appropriate staffing levels to enable them to live a full life.

For more details, please see the full report which is on the Care Quality Commission website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (report published 1 May 2020.)

Why we inspected
Serious whistleblowing concerns were received by the local authority safeguarding team in relation to management of the service and the quality of care and support that was being provided. There had been a number of safeguarding concerns raised by other professionals. As a result, we carried out a focused inspection to review the key questions of safe and well-led only.

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 requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence the provider needs to make substantial improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Delphine Court 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 have identified breaches in relation to the safety of people and the risk of harm. We also identified breaches in relation to the management and monitoring of the service, consent, support for nutrition and hydration and staffing at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 six 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Delphine Court

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.

Inspection team
The inspection team consisted of two inspectors. One pharmacy inspector also reviewed medicine records remotely.

Service and service type
Delphine Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 registered manager. The previous registered manager left the service in March 2020, and a new manager was in the process of applying to be registered with CQC, however they had since left the service.

Notice of inspection
We carried out this inspection unannounced.

What we did before the inspection
We attended multiple safeguarding meetings held by the local safeguarding team following whistleblowing concerns that were raised about the service.

We reviewed information we had received about the service since the last inspection. We spoke with local safeguarding authority team members and service commissioners. We spoke with specialist colleagues in community learning disability services. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people, the area manager, deputy manager, two team leaders, and seven care staff members both on inspection and after the inspection during telephone interviews. We also spoke with the relatives of three people who use the service via telephone interview.

We reviewed two care plans, four medicine administration records (MARS), staff rotas, two staff recruitment records and a variety of records relating to the quality of the service.

During staff telephone interviews, the inspectors received information raising concerns about the delivery of the regulated activity. These concerns were about specific individuals and we have shared them with the local safeguarding authority for action and investigation where appropriate.

After the inspection
We requested further information from the area manager.

We shared the concerns we found with the local safeguarding team, Environmental Health department and Infection and Prevention Control nursing team from the local Clinical Commissioning Group (CCG) and various commissioning authorities of those people where we identified as being the highest risk.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected from the risk of infection.
- The provider had failed to implement and follow COVID-19 guidance to reduce the risk of infection. For example, staff were not wearing personal protective equipment (PPE) and social distancing was not being followed.
- Risk assessments were not in place to ensure the risks relating to COVID-19 had been assessed and mitigated for people.
- The provider had not taken risks seriously, we observed senior managers not following guidelines or wearing PPE. One person using the service was known to be in the extremely clinically vulnerable group, we observed staff not wearing PPE and there was no risk assessment in place regarding the risk of COVID-19.

The service had not assessed the risk of, and prevented, detected and controlled the spread of, infections. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The provider did not always keep people safe from the risk of abuse. Staff members concerns about alleged abuse had not always been fully investigated or alerted to the local authority safeguarding team. Staff told us about some of these concerns when we inspected the service.
- The provider did not ensure people's rights were upheld. Following our visit we were made aware by a specialist community nurse that one person's deprivation of liberty safeguard authorisation had lapsed. Staff were routinely recording the content of telephone calls by one person to their family member without their consent or a best interest decision.
- All staff we spoke with said they knew how to raise a safeguarding concern, however, some staff members we spoke with said they did not feel their concerns had been listened to or actioned by the provider or management of the service.

The provider failed ensure systems and processes were in place to keep people safe from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staffing levels were unsafe.
- The provider failed to ensure staff were trained to meet the specific needs of people using the service. For

instance, staff did not receive the appropriate training on trauma or attachment disorder or receive appropriate supervision and support. Training had begun to be delivered to staff to support one person by external community partners.
● Sufficient staff were not always available, and people had been left on occasions without the required level of assessed support. The service was using agency staff members.
● Staff members we spoke with all raised concerns about the level of staffing at the service. Some staff members told us at times they felt "unsafe."
● Records we viewed showed the service had not provided the support hours for which they were commissioned for.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were deployed at the service to meet the needs of people using the service and keep them safe at all times. This is a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment procedures were in place. At the last inspection there were no issues raised around the recruitment of staff. We viewed recruitment records for two recently recruited staff members which showed appropriate checks had been carried out.

Using medicines safely
● Medicines were not always administered safely.
● Staff with the required medication training and assessed competence were not always on duty. This had resulted in people not always receiving their medicines.
● Instructions provided by healthcare professionals to safely administer medicines were not followed. For example, one person's care plan lacked detail on 'as required' medicines which meant they were at risk of overdose.
● We saw records relating to medicines such as audits and stock counts had not been carried out consistently and did not identify missing medicines or gaps in administration.

The provider failed ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risks to people had not been appropriately managed.
● We found poor food hygiene practices. A faulty fridge with out of range recordings had not been addressed and food was poorly stored. This meant people were at risk of consuming unsafe food.
● Risk assessments were not always in place. For example, one person who had an underlying health condition and a shielding letter making them clinically vulnerable to COVID-19 did not have a risk assessment in place. Staff did not wear PPE with the person and there were no measures in place to reduce the risk of cross infection. We observed a staff member in the communal kitchen prepare a meal for this person without wearing any PPE then carry it through the home to their flat.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people required support to manage their nutrition, there had been no ongoing monitoring of their weight and food and fluid charts were poorly completed.

The provider failed to ensure the nutritional needs of service users were met. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Systems and processes were not in place to ensure lessons could be learnt when things went wrong.
- Issues we identified on inspection from 2018 regarding creating a homely environment had not been addressed.
- Accidents and incidents had not been fully recorded or investigated by management. This meant people may be at risk of continuing to receive unsafe care.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 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

- Quality assurance processes were not robust. They did not identify the concerns we found. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, poor records relating to medicines administration and failure to ensure appropriate infection prevention control measures were in place.
- The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run. They did not have adequate monitoring systems to identify significant shortfalls within the service.
- There was no registered manager. There was a distinct lack of leadership and governance and some staff we spoke with told us they felt 'unsupported'.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Investigations and auditing of incidents and accidents were not robust, completed or managed appropriately to mitigate future risks to people.

The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. This was a breach of Regulation 17, (Good governance), 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

- A person-centred culture was not promoted. Some staff told us they felt unable to raise concerns as they felt their confidentiality would not be upheld.
- Staff did not feel supported within their roles. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed. They expressed concerns over the lack of management within the service.
- Relatives we spoke with said there was a lack of communication from the service's leadership.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were deployed at the service to meet the needs of people using the service and keep them safe at all times. This was a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had not been responsive to issues and concerns. Some staff members we spoke with told us they felt they were not listened to when they had raised concerns.
- Whistleblowers had continued to contact the local authority safeguarding team to raise concerns.
- Some relatives we spoke with stated they had asked for specific reassurances and documentation, but this had not been forthcoming from the service's management.

The provider failed to seek and act on feedback provided or concerns raised. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service had not engaged with partners.
- Care plans and risk assessments only contained basic information which meant people's views and preferences about how they wanted their care to be given were not always taken into consideration. Goals and outcomes and activity planners had not been completed in the two care plans we reviewed since our last inspection.
- Professionals visiting the service expressed concerns over the care and support people were receiving.

The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences. This was a breach of Regulation 9, (Person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to protect people from the risk of abuse.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure systems and processes were in place to protect people from the risk of abuse.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure staff acted in accordance with the Mental Capacity Act 2005 and the Human Rights Act 1998.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from 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 failed to assess the risk of, and prevent the spread of infections. The provider failed to ensure that the premises were safe to use. The provider failed to ensure medicines were managed in a proper and safe way.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional needs of service users were met.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider found failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider failed to assess monitor and mitigate the risk arising from unsafe food practices.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide training and appropriate support to staff to ensure they could carry out the duties they were required to perform. You failed to ensure staffing levels were provided at safe levels.

The enforcement action we took:

We issued a Notice of Proposal to vary the condition to remove the location from the provider.