Durham Care Line Limited

De Bruce Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
De Bruce Court is a residential care home providing personal and nursing care to 18 people at the time of the inspection. Care is provided to younger adults and older people, some of whom have a dementia, physical disabilities, learning disabilities or mental health needs. The service can support up to 46 people.

People's experience of using this service and what we found
Right Support
The provider did not always support people to have the maximum possible choice, control and independence. Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Staff did not always adhere to safe practices when wearing personal protective equipment (PPE).

Staff did not always support people to achieve their aspirations and goals. When goal care plans were in place, relatives told us these were not always followed, and records confirmed this.

Healthcare professionals worked in partnership with the provider when people moved to the home, professionals told us this was managed successfully.

Right Care
People were not receiving person-centred and safe care. The ability to provide person-centred care was compromised due to low staffing levels. People could not always take part in activities and interests that were tailored to them. Some people told us they were bored and had nothing to do or could not go out as no staff were available to support them in the community.

Healthcare professionals gave mixed comments regarding staff interventions with people. One healthcare professional complimented staff on following guidance. Whilst others described the lack of support offered.

Right Culture
People's quality of support was not always enhanced by the provider's quality assurance systems. People did not always lead inclusive and empowered lives. People were not encouraged to be involved in the organisation of the home, including menu planning and recruitment. Staff did not always focus on people's strengths or promote what they could do. People were not always supported in line with their cultural and religious needs.

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 good (published 27 July 2021).

Why we inspected
The inspection was prompted by concerns regarding how the service was applying the principles of right support, right care, right culture. We assessed the application of these principles during this inspection.

Initially the inspection was a targeted inspection focusing on Safe and Well-led. However, after some concerns were identified, we widened the scope of the inspection to include all five key questions.

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 will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, consent, dignity and respect and good governance at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive 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**

De Bruce 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.

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
Two inspectors and a member of the CQC medicines team carried out the inspection.

Service and service type
De Bruce Court 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. De Bruce Court is a care home with 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 there was not a registered manager in post.

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 and professionals who work with the service. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. Some people who used the service had difficulty communicating, however, we spent time observing people's daily experiences of the care and support provided.

We spoke with 16 members of staff including the manager, deputy manager, two heads of care quality, administrator, maintenance person, kitchen assistant, two nurses, and seven support staff. We spoke with local authorities placing people at the service and four professionals who regularly visit the service.

We reviewed a range of records. This included five people's care records and six medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We were also provided with evidence requested during feedback and additional information supplied in light of our initial feedback.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Risks to people had not always been recognised and mitigated. Risk assessments lacked detail to support staff to keep people safe.
• Care plans were not always followed. One person had a specific protocol in place to manage their diabetes. We found on two occasions staff should have sought external medical advice. However, no action was taken, and records did not state why the protocol was not followed.
• Effective plans to keep people safe in the event of a fire were not in place. One person's Personal Emergency Evacuation Plan (PEEP) gave incorrect guidance for a safe evacuation and a simulated evacuation had not taken place. PEEPs held in a bag to be taken by staff in the event of an emergency were dated 2020 and contained information about people no longer at the home.
• The provider had failed to recognise fire safety issues. A new fire risk assessment was not completed following the completion of structural work. Key padlocks secured an external exit and staff were unable to find the keys to open them.

The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We informed Cleveland Fire Service of our findings, who advised they would visit the home.

Following the inspection, the provider told us the key padlocks were changed to combination padlocks and a simulated evacuation had taken place.

• The provider had contingency plans in place to ensure people received continued care in the event of an emergency.

Using medicines safely
• Medicines were not always managed safely. Records to support the safe use of covert medicines (medicines disguised in food or drink) were not in place.
• Staff did not always follow the provider's medicines policy. People supported on social leave did not have their medicines recorded when leaving and returning to the home. We found medicines in the waste that had not been recorded in the waste record document.
• Guidance to support staff in the safe administration of 'when required' medicines was not always in place or lacked detail. This meant we could not be sure people received their 'when required' medicines when they need them.

• Medicines audits were in place; however, they had not identified the issues we found on inspection.

The provider failed to keep accurate, complete and contemporaneous records regarding people's care and support. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Infection prevention and control (IPC) was not always safely managed. Staff did not always follow the provider's COVID-19 checks. During the inspection the level of checks on entering the home varied.
• Staff did not always wear face masks appropriately. Donning and doffing stations were not clearly defined nor free from the risk of contamination.
• Some areas of the home were not clean. These included areas that people accessed including the laundry and fridge and microwaves in kitchens.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to ensure infection control procedures were in line with current guidance. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider failed to ensure enough staff were deployed to meet people's needs. Some people told us they could not go out on activities as staff were not available. We twice observed one person who needed one to one support without a member of staff present.
• Activity records showed that when one person was to be supported for 24 hours by one member of staff, at times this was not in place. Health care professionals we spoke with also told us they were aware that the home struggled to support people with their additional support needs such as, one to one or two to one support.

The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm and was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the manager reviewed the staffing levels and the provider has increased the number of staff on duty.

• Checks on agency staff were not effective. The provider did not have a robust system in place to confirm agency staff members' identity, Disclosure and Barring Service (DBS) status and training. Two agency staff were supporting people prior to effective checks being conducted, including identity checks and they had not received an induction to the home.

The provider failed to have effective systems to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The recruitment of staff to the home was safe. Recruitment documentation was fully completed, references were gathered, and confirmation of an appropriate level DBS check obtained.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Safeguarding records were inaccurate. Safeguarding incidents were not always recorded. Two incidents

had been recorded in a person's accident records, but these had not been recognised as safeguarding matters. Failure to capture all the incidents impacts on the provider's ability to analyse the information and take future action to safeguard people.

The provider failed to assess, monitor and improve the quality and safety of the home. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had completed safeguarding training.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the 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.

• The home was not always working within the principles of the MCA. One person's MCA records for the use of covert medicines (medicines disguised in food or drink) showed that the person's advocate, GP and pharmacist had not been involved in the decision as is required.
• Best interest decisions had not always been conducted in relation to restrictions placed upon people. Two people had door sensors on their apartments and no best interest decision records were in place.

Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a system to monitor DoLS applications. The manager had submitted DoLS applications to the local authority for review/authorisation in line with legal requirements.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not always supported in line with guidance from healthcare professionals. One person's care plan had not been updated and staff did not support the person safely.
• The mealtime experience varied on each unit. On our first day, on one unit we observed breakfast sandwiches wrapped in foil and meals covered in clingfilm brought into the unit. People were not

encouraged to sit at a table to eat their meal, it was placed on a small table in front of the chair where they had sat. People were not offered a drink and there was little interaction with staff.
• We advised the manager and the head of care delivery of our observations. The dining experience on that unit had improved on our last day of inspection, but further improvements were required.
• People were not actively encouraged to develop life skills such as shopping for groceries and preparing meals. Staff told us one person was supported to purchase items and to cook. However, their relative told us this was not happening regularly.

Adapting service, design, decoration to meet people's needs
• The home had one working adapted bathroom, which was not decorated and had a clinical feel. People's rooms had ensuite facilities.
• People had limited access to outside areas. The courtyard was not well maintained. Furniture was brought out of the main building if people wished to sit outside. The door to gain access to the main building had been broken for two weeks prior to our visit. This meant people had to alert staff in the main building to let them in.
• The home offered a range of facilities to support people's needs, including a sensory room, large bar area and hydrotherapy pool. Staff told us people enjoyed the sensory room. The hydrotherapy pool was not in use as the provider was awaiting essential repairs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were fully assessed prior to moving to the home. Information gathered was used to create people's care and support plans. Relatives were involved in discussions about their family member's care.
• The provider supported people to transition to the home. Health care professionals we spoke with gave positive feedback. One healthcare professional told us, "They have supported many people with complex needs. They make sure they understand people's needs and that they can support them."
• The provider had Positive Behaviour Support (PBS) specialists. They provided techniques to support people when they experienced emotional distress.

Staff support: induction, training, skills and experience
• Staff had completed mandatory training. Training was delivered face to face and via E-learning.
• Staff did not always receive regular support through supervisions and appraisal. The manager was currently working to ensure these were completed in line with the provider's policy.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care
• The home worked with external healthcare professionals to ensure people's health needs were met in a timely manner. One healthcare professional gave positive feedback to the home, about how staff listened and followed guidance with positive outcomes for the person.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• People were not always actively supported to be independent with their finances. The provider operated a client bank account, where everyone had their monies deposited. People were able to request funds and the provider had a secure monitoring process.

Following a discussion with the provider's head of care delivery they told us they would look into supporting people to have their own bank account.

• People were not always supported to maintain their cultural and religious preferences. One person required gender specific care and dietary support to maintain their faith. Records showed they were not always supported by staff of the appropriate gender and the kitchen was not following the religious guidelines for the preparation or storage of the food.

The service failed to ensure people's personal preferences, lifestyle and care choices were met. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback, the kitchen staff immediately sought advice and changed their practices and the manager was working with the family to address the staffing issue.

• Staff told us they were supporting one person as they were beginning to develop an interest in a religion and they were supported to attend their place of worship.
• Feedback from relatives was mixed in relation to the caring attitude of staff and the care and support delivered. One relative told us, "The staff are supportive, [person] goes out shopping and has a little job." However, another relative said, "Not satisfied with the level of support. First everything is great then they don't do what they said they would." The home was working with the family to address this matter.
• People were not always supported to maintain, or develop, their independence. Although there was some goal planning in place, we only saw two people actively supported to develop new skills.
• People had not always been supported to be involved in identifying their goals or developing new skills. One relative told us, "[Person] needs support to develop skills to look after themselves. [Person] loves cooking but they don't let them."
• We observed some positive interactions between people and staff. People appeared happy in the company

of staff.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to access independent advocacy services.
• People were supported to express their views. Easy read surveys were used to capture people's opinions.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were not always person-centred. Care plans did not outline how the person liked to be supported.
• Staff did not always provide person-centred support with self-care and everyday living skills to people. Some people had goals set but staff were not always available to support people to achieve them.
• People's care plans were held on the provider's electronic systems, which staff accessed using handheld devices. Staff, including agency staff, who were not familiar with people's support needs did not always have access to the handheld devices. Only one handheld device was available on each unit.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• Staff worked closely with health and social care professionals and ensured people were assessed to see if they would benefit from the use of non-verbal communication aids.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People did not have access to meaningful activities. People sat in lounge areas with no meaningful interaction for long periods of time. Some people we spoke with told us they were bored. One person was nursed in bed, and we found their social isolation support took the form of a welfare check.
• People were not always supported to take part in activities in the local community. Records showed people went to local shops and one person attended the gym. One relative told us, "They told us [person] would be out every day and get to know the local area, [person] doesn't get out." The provider advised that if people wished to access the community after 8:00pm staff arrangements would be altered to provide this.
• People who were living away from their local area were able to stay in regular contact with friends and family via telephone and facetime.
• People were not always supported to broaden their horizons and develop new interests and friends. One relative said, "I hoped they would work with (person) to develop new interests, but they haven't."

Improving care quality in response to complaints or concerns

• People, and those important to them, could raise concerns and complaints easily and staff supported them to do so.
• Staff explained to people when and how their complaints would be addressed and resolved.

End of life care and support
• No one was receiving end of life care at the time of our inspection. Staff had discussions with people about putting plans in place, but people chose not to discuss the matter.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The systems in place for checking on the quality and safety of the service were not always effective. Whilst the provider's processes had identified some issues, we found these had not been addressed, although some had been reported as completed. Also, issues including fire safety and the lack of following current IPC guidance had not been recognised.
• Record keeping was poor. Risk assessments did not mitigate risks, daily records did not give an accurate reflection of staff interactions, daily clinical records were inaccurate and medicines had gaps in recording.

Systems were either not in place or not robust enough to oversee the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Due to the poor record keeping and failure to follow the provider's processes the home had not always submitted the required statutory notifications to CQC following significant events at the service. This is being pursued outside of the inspection process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• We received mixed feedback from staff about the management team. Whilst there were some positive comments made about the manager, some staff did not feel well supported by the management team. One staff member told us, "We don't feel listened too. We raise concerns and are just told to get on with things, nothing is done." Another member of staff told us they felt supported and enjoyed working at the service.
• Communication with relatives varied. Some relatives we spoke with were satisfied with the communication, but others told us their family member was the first to advise them of concerns or issues.
• Staff feedback was not regularly sought. Staff meetings had just recently recommenced due to the pandemic.

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 manager and the provider were aware of their responsibilities under the duty of candour.

Working in partnership with others

• Staff worked in partnership with external health and social care professionals who were involved in people's care to ensure people received any additional support they needed. The manager shared positive verbal feedback from a healthcare professional who praised the staff team for following their guidance.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service failed to ensure people's personal preferences, lifestyle and care choices were met. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to ensure infection control procedures were in line with current guidance. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained staff deployed to meet people's needs.

Regulation 18(1)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The home failed to have effective systems to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. The home failed to keep accurate, complete and contemporaneous records regarding people's care and support. Regulation 17(2)(a),(2)(b),(2)(c).

The enforcement action we took:

warning notice issued.