LJ Care Limited

Deansfield Residential Care Home

Inspection report

Deansfield
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Shropshire
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Tel: 01952603267

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Deansfield Residential Care Home provides accommodation and personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 16 people.

The home is situated on three floors providing bedrooms on the ground and first floor which are accessible via stairs and a passenger lift. People have access to a lounge, dining area and a pleasant outdoor space. Bathrooms and toilets are situated near to all communal areas.

People's experience of using this service and what we found
People could not be assured they would be protected from the risk of potential abuse, as the provider was unable to demonstrate staff would have the skills and knowledge to recognise abuse and act on it and we were unable to discuss this with staff. Risk assessments were ineffective to ensure people received care and support safely. People were not supported by skilled staff to take their prescribed medicines and they did not always receive their treatment. People could not be confident there would be enough staff to support them during the night-time. Infection, prevention and control measures were not effective to ensure people would not be placed at risk of contracting avoidable infections. Lessons were not learnt when things went wrong and continued poor practices placed people at risk of potential harm.

The provider did not have a registered manager in post. Hence, there was no leadership to empower staff and to promote good care practices. Quality monitoring systems were ineffective to ensure people received a safe and effective service.

People and staff were not actively involved in developing the service and the provider did not engage with other professional agencies to improve the quality of the service. There was no evidence of innovation to improve the service in a timely manner.

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 good (published 23 August 2021).

Why we inspected
We received concerns in relation to the lack of leadership, poor management of people's medicines and poor risk management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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 regulation 7, Requirements relating to registered managers, regulation 12, Safe care and treatment, regulation 12.3, Vaccinations as a condition of deployment, regulation 17, Good governance and regulation 20 Duty of candour, at this inspection.

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

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

The 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 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 of 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 safe findings below.

Deansfield Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
On 28 January 2022, this inspection was carried out one inspector and a pharmacist specialist. The inspection continued via a 'Teams' meeting on 4 February 2022 with two inspectors.

Service and service type
Deansfield Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We telephoned the provider from outside the home to find out the COVID-19 status in the home and discuss the infection, prevention and control measures in place.

What we did before inspection
We reviewed information we had received about the service since the provider's last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the nominated individual who was also the registered provider. We spoke with the deputy manager and the cook. Although, at the time of the inspection we were unable to talk with people who use the service and care staff, we observed interaction between both. We reviewed a range of records. This included two people's care records and medicines administration records. Quality monitoring systems and 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 registered provider to validate evidence found. We reviewed the provider's action plan and medicines audits. We requested information regarding their intention in appointing a manager to run the service.

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.

Using medicines safely
• We observed an error on a handwritten medicine administration record (MAR). A topical medicine in the form of a patch, the MAR showed this should be changed every 24 hours and not 72 as was prescribed. This placed the person's health at significant harm.
• We found a medicine that should be administered via injection by a district nurse, on a three-monthly cycle. However, the MAR had been signed daily to indicate this medicine had been administered. Due to the inaccuracy on the MAR, it was not clear if or, when the person had been administered this medicine. If the medicine had been administered daily, as stated on the MAR, this could adversely affect the person's health.

• Another MAR showed a person had not received their pain relief medicines at prescribed times. This may have resulted in their pain not being managed. The frequency of when this medicine should have been administered had been amended on the MAR and was not following the prescribers intended administration times.
• We observed the refrigerator where medicines were stored was switched off. An appropriate thermometer was not used when monitoring fridge temperatures. This meant the maximum and minimum temperatures were not being recorded appropriately. Hence, medicines had not been stored in accordance to the pharmaceutical manufacturers' instructions which, meant medicines may be unsuitable for use.
• The provider was unable to tell us whether the staff member who carried out medicines' competency assessments had the appropriate training to ensure they had the skills and competence to carry out these assessments. This was of concern, as the provider informed us this staff member was responsible for the management of medicines, where we had found a number of shortfalls.
• We observed a number of handwritten MARs that had not been counter signed by two staff members to ensure the information was accurate and up to date. We observed signatory gaps on MARs. This meant we were unable to determine whether people had received their prescribed treatment.

Assessing risk, safety monitoring and management
• We found risk assessments did not provide enough information to ensure staff were aware of how to safely support people.
• We observed one falls risk assessment did not provide staff with any control measures to reduce or mitigate the risk of further falls.
• We looked at two personal emergency evacuation plans. These did not provide any information about the level of support the individual would require to evacuate the building in an emergency.
• We shared concerns with Shropshire Fire Safety Department who carried out an inspection and found

deficiencies with the fire risk assessment which, needed to be reviewed and updated. They identified staff had not received fire awareness training and there was no evidence of fire drills taking place. This meant in the event of an emergency staff may not know what to do to safeguard people and themselves.

Systems and processes to safeguard people from the risk of abuse
• People could not be assured they would be safeguarded from potential abuse.
• The registered provider lacked understanding of when to share concerns of potential abuse with the local authority safeguarding team.
• Prior to our inspection visit we had been informed by the local authority that people had not received their prescribed treatment placing their health at risk. However, the provider did not take appropriate action to safeguard people.

Preventing and controlling infection
• We were not assured that the provider was preventing visitors from catching and spreading infections.
• We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were somewhat assured that the provider was accessing testing for people using the service and staff.
• We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were somewhat assured that the provider's infection prevention and control policy was up to date.

Due to the poor management of medicines, risk management and ineffective systems to ensure people are protected from potential abuse. This placed them at continued risk of receiving an inadequate service. This is a breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• 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 meeting shielding and social distancing rules.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Staffing and recruitment
• Two staff were provided during the night-time. The provider told us three out of 13 people required the support of two staff with their mobility. We were unable to establish the needs of the remaining ten people during the night-time. However, this would mean when two staff provided support to one person, staff would not be available to assist anyone else if needed.
• We were not assured that during the night-time, there would be enough staff to assist people to evacuate the building in an emergency. Shropshire Fire Safety Department informed us, 'Future planning means all non-mobile people will be on the ground floor only.' This raised concerns whether two staff members during the night time would be enough to safely meet people's needs.
• During our inspection, throughout the day, we observed staff were available to assist people when needed,

we also identified staff were very busy attending to people's personal needs. We observed practices were task orientated and no time given for social activities.

This is a breach of regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection we did not find any evidence people had come to any harm with regards to the current staffing levels.

Learning lessons when things go wrong
• Prior to our inspection visit the local authority and the Clinical Commissioning Group had found a number of concerns relating to the care, support and safety of people using the service. We found the provider had not taken any action to improve the service or learn when things went wrong. For example, concerns had been identified regarding people not receiving their prescribed treatment. However, we found poor medicines practices continued placing people at risk of harm.

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 the last inspection this key question was rated as requires improvement. 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

- The registered provider had not complied with their condition of registration which, requires a manager registered with CQC to manage a regulated activity.
- There has been no registered manager in post since July 2021. A condition of the provider's registration, they are required to have a registered manager in post. Therefore, it has been over six months since, there has been any leadership within the home.
- The provider told us they had appointed a manager who would commence employment the following week after our inspection visit. However, on 4 February 2022, they confirmed the manager would not be commencing employment. The provider later informed us a different manager would start working in the home in March 2022. At our inspection In August 2021, the provider told us of their intention to appoint a manager to run the service.
- Medicines quality audits were ineffective and did not identify the shortfalls we found that had a potential impact on people's health.
- Quality audits did not ensure staff had access to detailed risk assessments to ensure people are cared for safely. For example, staff did not have access to detailed falls risk assessments to ensure they knew how to support people safely.
- Quality audits were ineffective to ensure staff had received fire awareness training and to ensure fire safety systems in the home were safe. For example, staff had not received recent fire awareness training. Ineffective monitoring systems meant people could not be assured staff would have the skills and knowledge on how to support them to evacuate the building in an emergency.
- We found the provider's quality monitoring procedures to mitigate the spread of Covid-19 and other avoidable infections were ineffective. Prior to our inspection we had been informed of an outbreak of Covid-19. On the day of our inspection we found Covid-19 monitoring was ineffective. For example, when we arrived at the home we were not asked for our Covid19 passport or our lateral flow test (LFT). These practices placed people at further risk of contracting Covid-19.

Due to the lack of leadership and ineffective systems in place to ensure people receive a good service. This is a breach of regulation 17, Good governance, 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 demonstrated a good understanding of the duty of candour.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We found the provider had very little knowledge of people's care needs and was unable to demonstrate staff had the skills and competence to care and support people safely. The provider had been reliant on the training staff had received from the previous registered provider. Inadequate oversight of staff's skills and knowledge placed people at risk of inadequate care and support.
• We could not find any evidence of a person-centred approach. Records relating to people provided very little information regarding individuality.
• There was no leadership in the home to empower staff to provide a positive culture that was open and inclusive, and this had a negative impact on the quality of the service provided to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider was unable to tell us about people's involvement with the service.
• Due to the lack of leadership in the home, there was no one to empower people to engage or to consider their equality characteristics.

Working in partnership with others. Continuous learning and improving care
• Prior to our inspection visit several agencies such as the local authority and the Clinical Commissioning Group (CCG), not only raised concerns about care planning, risk assessment and the management of medicines but also offered support to the provider about how to improve the service. However, we found at our inspection that no improvements had been made to ensure people's assessed needs were met safely. This demonstrated that the provider had not worked with others to provide a safe and effective 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 People were not supported by staff who were skilled or experienced to assist them to take their prescribed medicines. People did not always receive their medicines as prescribed. Inadequate risk management did not ensure practices would reduce or mitigate the risk to people. The lack of understanding about safeguarding, placed people at potential risk of harm. Infection, prevention and control practices placed people at risk of contracting Covid19 and other avoidable infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff to ensure people were able to engage in meaningful activities. Staffing levels during the night time meant in an emergency, people may not be provided with the support needed to evacuate the building in a timely manner.