365 Care Homes Limited

Delph House

Inspection report

Wisbech Road
Welney
Wisbech
Cambridgeshire
PE14 9RQ

Tel: 01354610300

Date of inspection visit:
11 April 2023
14 April 2023
31 May 2023

Date of publication:
05 October 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Delph House is a residential care home providing accommodation and personal care to up to 22 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 15 people using the service. Delph House is an adapted property on 2 floors with communal spaces for relaxing and taking meals.

People's experience of using this service and what we found
Although we noted clear improvements in many areas, this inspection identified some concerns which were similar to those from the last inspection regarding staffing, safeguarding and oversight. The provider has responded by making some immediate changes to the management of the service which has given us some assurance. However, this is the third consecutive inspection this service has been rated Requires Improvement overall.

Safeguarding concerns had not always been robustly managed and information appropriately shared. The provider took action to address this issue immediately, and retrospectively notified CQC of several safeguarding incidents we had not been aware of. Staff had an understanding of safeguarding procedures and most knew how to identify and raise concerns.

Prior to our inspection there had been concerns raised by healthcare professionals about staff's ability to identify a person's deteriorating health and take prompt action. This placed people at potential risk of harm. We have judged this is both an English language proficiency issue and a matter of some staff needing further development of their skills and confidence. The provider has assured us they will continue to develop staff language and skills to ensure they can manage people's health concerns confidently and keep them safe.

Medicines were mostly well managed. A more proactive approach was needed in some cases to ensure people's potential risks relating to their deteriorating health was always considered, especially those living with dementia.

People were not always supported to have maximum choice and control of their lives as staff did not always support them in the least restrictive way possible. Staff did not demonstrate a good understanding of the Mental Capacity Act (2005) which ensures people consent to their care and treatment. Some staff's understandable concern for people's safety was prioritised over their right to make decisions, even if these decisions were seen as unwise. There was a risk people's rights would not be fully protected and further training and development of staff was required. The provider agreed to take this forward.

People using the service and relatives gave us broadly positive feedback about the care and support provided. People praised the kindness of the staff and there was an acknowledgement that, although further work was required, the service was improving in many areas. Further engagement with staff, people who used the service and relatives was needed to drive the service forward. The provider has been open and

honest with us about the challenges the service has faced and we noted improvements in many areas. However, we have noted similar issues at the last 3 inspections which is a cause for concern.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 09 March 2022). 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 although improvements had been made the provider remained in breach of regulations relating to safe care and treatment and good governance. The service remains rated requires improvement. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 15 December 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 safe care and treatment and good 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 Safe and Well-Led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains Requires Improvement. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Delph House on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches of regulation relating to safe care and treatment and good governance at this inspection. We have also identified a breach of regulation relating to a failure to notify CQC of safeguarding incidents..

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, 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?

Requires Improvement

The service was not always safe.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Delph House

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.

Inspection team
The inspection was carried out by 2 inspectors on 11 April 2023 and by 1 inspector on 14 April 2023. An Expert by Experience carried out telephone calls to relatives of people who used the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Following the receipt of some additional information we undertook a third inspection visit on 31 May 2023. This visit was carried out by 2 inspectors.

Service and service type
Delph House 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. Delph House 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 first inspection visit there was a registered manager in post. However, they had left the service and deregistered by the time the inspection process concluded.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information shared by the local authority quality and safeguarding teams. 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 used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 7 relatives. We also spoke with 2 care staff, 4 senior care staff, the cook, the deputy manager, the registered manager and the provider. In addition to this we received feedback from 3 health and social care professionals.

We reviewed 7 care plans in detail and sections from other plans alongside medicine administration records for 3 people. We observed medicines being administered and reviewed the storage, stock control and disposal arrangements for medicines including controlled medicines. We also reviewed other records relating to the safety and quality of the service.

Requires Improvement

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. The rating for this key question 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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.

● The provider assessed a variety of risks including those relating to falls, choking, pressure ulcers and people's eating and drinking. Care plans documented actions for staff to take to mitigate risk. However, some specific risks required more robust assessment. The potential risks posed by one person's lack of staff supervision during the day had not been fully explored and mitigated. However, by the time of our third inspection visit additional funding had been secured on a trial basis to support this person.
● Some records relating to people's repositioning, to reduce the risk of a pressure ulcer, showed people were not always being repositioned in line with their risk assessment. The provider has told us this was a records issue, but we could not be fully assured.
● Staff made appropriate referrals to other healthcare professionals including the falls team and speech and language therapists to reduce health associated risks. However, healthcare professionals fed back to us these referrals were not always timely as staff had not recognised when someone was deteriorating significantly.
● At the time of our inspection there was a lack of evidence of how risks relating to people's topical creams, had been robustly assessed and understood by staff. Topical creams can pose a risk to those living with dementia and are highly flammable. We requested the provider's topical cream risk assessment, which was provided to us but needs to be readily available to staff and linked to individual fire risk assessments.
●Creams were not always locked in people's medicine cabinets which could pose a potential risk to those living with dementia.
●We found a lack of a proactive approach regarding the main staircase which was accessible to people using the service. Staff told us people were either able to manage this stairway or were constantly monitored for their safety. However, we judged the risks had not been fully considered and reduced to their lowest level. The provider had not shown a robust awareness of people's unpredictable behaviour and/or deteriorating health when assessing this risk.

The provider had failed to ensure people always received safe care and treatment. This was a continued

breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Risks relating to the environment were mostly well managed and much improved from our last inspection. Delph House has been undergoing an extensive refurbishment plan. In addition, the company has been investing in software and IT (including management auditing systems.

● Feedback from relatives about how risks were managed was positive. A person's relative commented, "My major concern when [my relative] went in was [they were]] falling a lot. So, they straight away put a sensor pad in followed by a more sturdy sensor mat. It gave me confidence they were looking out for [my relative's] safety." Another told us, "[My relative's] bed is always at a level that is conducive to [their] safety, as well as [their] door being open, as we have requested."
● There was regular testing and monitoring of health and safety systems and equipment and records were accurate.

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

● When staff administered medicines covertly permissions were sought to agree medicines could be administered in this way and signed off by the GP. Although records were available, they were not kept with the medicines administration record so staff could refer to them which could reduce the risk of incorrect medicine administration.
● Appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. However, despite training, staff understanding of both MCA and DoLS was not robust. Some staff were not clear on people's right to make unwise decisions, should they have the capacity to do so. This meant we did not have confidence people's rights would always be fully upheld. The provider acknowledged some staff needed further training in this area.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding concerns had been identified in recent weeks and months but had not been reported to CQC, as required. We noted safeguarding incidents were logged on the provider's own system but not shared with us. This meant CQC did not have a comprehensive overview of safeguarding risk at the service. One recent safeguarding incident had not been appropriately referred to the police, despite the person concerned requesting this.

The provider had failed to submit required notifications. safeguarding concerns were submitted on the day of inspection. However, the regulation states notifications should be submitted without delay. This was a breach of regulation 18 (2) of the Care Quality Commission (Registration) Regulations 2009.

● We reviewed safeguarding concerns. One recent safeguarding incident had not been appropriately referred to the police, despite the person concerned requesting this. Some were still being investigated by the local authority. We discussed the most recent safeguarding referral with the registered manager and noted that appropriate actions had been taken by the service according to records we saw. We will await the outcome of the full investigation.
● Staff received safeguarding training and were able to tell us about the signs and symptoms which might

suggest a person was at risk of, or was being, abused. Some staff were not clear about how to escalate concerns outside of the organisation.

Staffing and recruitment

● New staff had been recruited from overseas via a government sponsorship scheme. These staff came with a high level of qualification, with most being nurses in their home country. However, some had poor spoken English which could present a risk. Two health and social care professionals had raised concerns about the skills and understanding of some staff. They told us staff did not always recognise and act promptly when a person's health was deteriorating or their needs changing.

● We noted some of these staff had a limited understanding of safeguarding procedures and issues relating to consent and deprivation of liberty. The provider acknowledged this and, with the regional manager, was in the process of producing a booklet of colloquial English terms and acronyms to support staff. We judged the skills and knowledge of some staff required significant support and careful monitoring by the provider.

● Rotas showed staffing was provided in line with the provider's dependency tool. Some people commented on lower staffing levels at weekends, however staffing levels remained stable. We identified staff were occasionally gathering in the staff room on the ground floor, leaving the upstairs and communal areas unstaffed for periods of time. This had also been the case at our last inspection. We discussed this deployment issue with the provider who took action to reduce the amount of time staff used the office base.

● People who used the service, and their relatives, told us people's needs were met and they did not have to wait too long for help and support. One relative commented, "We have gone at all different times to visit. Never been a problem."

● Staff were recruited safely, and the provider carried out checks with the Disclosure and Barring Service to ensure they were safe to work in this setting. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were well managed, and records were mostly accurate. We found a stock control discrepancy with a person's paracetamol which left 2 tablets unaccounted for. The registered manager told us they had changed the procedure for ordering and administering this medicine which aimed to reduce the likelihood of future issues.

● Staff received medicines administration training and had their competency to administer medicines assessed. Staff demonstrated a good understanding of people's medicines, including medicines which had to be given at particular times to ensure they were effective.

● A quarterly medicines audit was in place to review medicines administration practice.

Preventing and controlling infection

● The service was clean and there were no unpleasant odours in any communal areas. We noted one person had a cushion wedge in the bed with them to help reduce the risk of a pressure ulcer. We detected an odour from this, and the registered manager informed us it was impossible to wash. They agreed to get some further advice as it presented a potential infection control risk for this person.

● During our first inspection visit the registered manager told us the main freezer had stopped working and had been repaired by the service's maintenance staff. The cook was unable to give us assurances about what was to happen with the large quantities of defrosted meat and fish which were still inside the freezer and warm to the touch. The cook told us they would be refrozen. We discussed this with the registered manager who went to the kitchen and ensured all foods were thrown out.

● We were assured that the provider was promoting safety through the layout of the premises. We noted some bathrooms had been upgraded since our last inspection.

● 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 making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●The provider had suitable visiting arrangements in place for relatives and friends of the people who used the service. We observed relatives and friends visiting people during our inspection.

Learning lessons when things go wrong
● Incidents were reviewed to see if lessons could be learned and there were processes in place to share any learning.

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 our last inspection we rated this key question Inadequate. At this inspection the rating has changed 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.

At our last inspection the provider had failed to ensure sufficient oversight or people's health, safety and welfare. This was a breach of regulation 17(1) 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●The registered manager had not always demonstrated effective management of safeguarding incidents and the provider did not have clear oversight of safeguarding at the service.

● Care plans, although large, did not always contain all the information needed to clearly outline people's needs. We identified some inconsistencies and gaps in recording which meant we could not be fully assured people were always receiving the care they needed when they needed it. Staff were caring but not always proactive in anticipating people's needs.

● Staff knew people well, but some did not all have a fundamental understanding of their role. Senior staff demonstrated a lack of confidence and a high dependence on the knowledge and skills of the registered manager, even when the registered manager was off duty.

● Audits, to monitor the safety and quality of the service, were in place. However, we identified some concerns. For example, the kitchen staff checked the temperatures of the fridges and freezers daily. No action was documented or repeat reading taken when temperatures fell outside the safe limits. Management audits we viewed did not identify the issue. The water temperatures were also identified as occasionally being above the safe limits, but no action was noted or repeat reading taken. Although we noted a wider scope of audits was now in place not all the issues we raised had been identified by the provider's own processes.

The provider failed to ensure sufficient oversight of people's health, safety and welfare. This was a continued breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

●We received negative feedback from health and social care professionals. People told us staff sometimes lacked the required skills and knowledge to react promptly to people's deteriorating health conditions. We

made the provider aware of these significant concerns and they assured us they would address them to improve the situation. The registered manager told us they were in the process of setting up a meeting with local teams to improve relationships and the provider intended to follow this up.

This was a further breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●However, we also noted good partnership work. Care records showed the involvement of other health and social care professionals and advice being clearly documented and followed. We have judged this could be attributed to the skills and experience of staff on duty at the time. In future, the provider needs to ensure all staff have the confidence, skills and experience to explain their concerns and document and follow advice given to them by health and social care professionals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●We received mixed feedback from relatives about contact with the service and being asked for their views about the standards of care. One said, "No meetings at all, except a questionnaire about a year ago." Another commented, "No, to all of those." The registered manager told us they had been proactive in contacting relatives, having face to face meetings, phone calls and emails but stated family involvement varied from person to person.

●Feedback was sought from staff and health and social care professionals had the opportunity to provide feedback so concerns could be addressed in a timely way and compliments passed on.

●The survey demonstrated people were mostly happy with all aspects of their care, but negative responses were received about the level of staffing which unless addressed could impact negatively on the care they receive.

●The culture at the service had improved from our last inspection and we received positive feedback from staff and relatives. Staff told us they felt able to ask questions and raise concerns if they needed to.

● Further work was needed to ensure staff were always person centred rather than task centred. Staff were observed congregating in the staff office and leaving parts of the service unstaffed. This had also been noted on our last inspection.

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 registered manager understood their responsibility to be open and transparent when things went wrong. They assured us they had worked in line with their duty of candour when recent safeguarding concerns had been raised.

● Relatives gave us positive feedback about how the service kept them informed about their family member. One told us, "They phone if [my relative] has a fall", while another said, "They usually give me a ring on any changes."

Continuous learning and improving care

● The provider was keen to continue improving the service and had made some key staffing decisions to help them do this. They explained to us how they would work with senior staff to drive the changes they wished to oversee. Staff had received training, but the provider intended to widen the scope of training for some staff to ensure all staff had the skills and knowledge they needed.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit required notifications. This was a breach of regulation 18 (2) (e).

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 robustly assess risks relating to the health, safety and welfare of people who used the service. Regulation 12 (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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure sufficient oversight of people's health, safety and welfare. Regulation 17(1).

The enforcement action we took:

We issued a warning notice.