Mr Roy Kent

Driftwood House

Inspection report

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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
Driftwood House is a residential care home providing personal and nursing care to 21 people aged 65 and over at the time of the inspection. The service can support up to 28 people. The accommodation is located over two floors with communal living room and dining room on the ground floor.

People's experience of using this service and what we found
Systems and processes to manage the quality of care were not always robust. Risk assessments sometimes lacked detail on action to take to manage risks and audits did not always include detail about which records had been checked. We found some equipment in use that had not been removed from service due to damage. The manager took immediate action to remedy this. However, this damage and potential risks to people had not been identified by the service's own monitoring processes.
There was a very warm and welcoming environment in the home, staff knew people well and understood their needs. People, their relatives and staff were very positive about the manager and described the home as being 'like a family.'

People told us they felt safe living at the service. People received their medicines as they were prescribed. The service was clean and had infection prevention and control measures in place to manage risks associate with Covid 19.

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 25 March 2019) and there was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 improvements had been made and the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found there needed to be improvements made to some of the checks on the quality of care and the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We reviewed the information we held about the service. 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.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has remained the same. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what further action we have asked the provider to take at the end of this full report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will continue to monitor the progress made to improve. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Driftwood 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 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
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Driftwood House 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave a short notice period of the inspection to ensure we could manage any risks associated with the Covid 19 pandemic.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us 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 carried out a site visit on 29th September and due to the Covid 19 pandemic carried out the rest of the inspection remotely, reviewing documents and making calls to staff and relatives. We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, senior care workers, care workers and the cook.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three 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 a range of records relating to the governance and quality of care.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to protect people against the risks associated with the unsafe management of medicines. They had also failed to protect people against the risks associated with the unsafe storage of cleaning products. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, there were some areas which required improvement.

• We found two slings on hoists in communal areas that were damaged. When we highlighted this the registered manager removed these slings from use. They told us one was for a hoist which was not currently in use. However, the other sling was for a hoist that we later observed staff using. Had the sling not been removed the sling would have remained available for staff to use.
• Staff knew people well and understood how to manage risks associated with their care but sometimes the management actions in the risk assessment documentation required more detail.
• People received their medicines as they were prescribed. Each person had a medicines care plan which described what medicine each person was prescribed and how they preferred to take them.
• Where people received their medicines covertly, for example hidden in food, there were appropriate risk assessments and mental capacity assessments in place.
• Where people had medicines to be given to people 'as required' (PRN) there were protocols to provide guidance to staff on when to administer the medicines.

Systems and processes to safeguard people from the risk of abuse
• There were systems and processes in place to safeguard people and to report concerns to the local authority and CQC.
• People and their relatives told us they felt safe at Driftwood House. One relative told us, "[Family member] is in as safe an environment as [they] could be at Driftwood House. All staff are respectful, caring, dutiful."
• Staff had been trained and had a good understanding of how to identify signs of abuse and how to report concerns.

Staffing and recruitment
• There were enough staff to meet people's needs. People and their relatives felt there were enough staff to support people.

• There was a very stable staff team that people knew well and who worked together to cover any absence so that the service did not have to use agency staff.
• Systems were in place to carry out checks to ensure staff employed were suitable to work in the service.

Preventing and controlling infection
• We observed staff were using the same slings for people in communal areas without them being washed in between. We highlighted this to the registered manager as an infection control risk and they put in place a system where everybody had their own sling all the time.
• We were assured the provider was taking action to reduce the risk of visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• 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 accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• 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.

Learning lessons when things go wrong
• There were systems in place to record accidents and incidents and to record action taken to prevent things from happening again in the future. For example, if people had a fall, measures were taken to reduce the risk of falls such as reviewing the use of assistive technology.
• However, there was not a regular review of all accidents and incidents across the service to assess whether there was any learning from trends or patterns of incidents across the home.

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 Requires Improvement. At this inspection this key question has remained the same. 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 provider's governance systems were not robust enough to independently identify shortfalls and address them. The registered manager was not aware of shortfalls identified during this inspection until we pointed them out. For example, there were no visual checks for slings. During our inspection we identified two slings that were damaged and should have been removed from use. The registered manager took immediate action to remove them and told us one of the slings was for equipment not currently used by any of the people using the service.
• Audits of care documentation required more detail, for example they did not state what records had been looked at, whether there were gaps in the records or comment on the quality of the recording. This meant it was not clear whether records had been missed in the auditing process or whether records were fully completed correctly.
• There were no cleaning schedules in place for communal areas. The service was clean, and staff understood the tasks they needed to carry out, there was no way for the registered manager to assure themselves that cleaning had been carried out correctly. This would be particularly important if at any point the service recruited new staff or needed to use agency staff.
• The provider did not have robust systems in place for learning from when things went wrong. They did not analyse safety incidents for patterns and trends in order to identify where improvements could be made across the service.
• Risk assessments did not always include sufficient detail. For example, risk assessments for staff around additional vulnerabilities to Covid 19 did not contain detail about action that would be taken if there was an outbreak of Covid 19 within the home. When we spoke with staff they told us the registered manager had spoken to them about the issue and they felt supported. However, the lack of comprehensive records meant that if the registered manager was absent it would not be clear for another manager to understand what action the home would take to protect staff if there was an outbreak of Covid 19.
• Individual risk assessments for people did not always contain information on the action staff needed to take to manage risks. For example, a risk assessment for a person in relation to falls gave guidance on how to mitigate the risk when a person was in their bedroom but did not contain guidance on how to mitigate the risk in communal areas.

Failure to ensure there are robust auditing systems and processes in place to monitor the quality of care is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

• The registered manager took immediate action in regard of concerns we highlighted; they removed the damaged slings from use and put in place a system of ensuring visual checks on equipment. They also put cleaning schedules in place for communal areas.

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

• There was a strong person-centred ethos in the home. There was a friendly and warm atmosphere in the home. Staff knew people well, and people and their relatives described the home as, "Like a family."
• People, their relatives and staff spoke highly of the registered manager. One relative told us, "I have total confidence in [registered manager] and [their] team. I think [they are] brilliant... I think it's really hard work what [they are] doing, keeping everyone safe and happy. I think [they have] done everything in [their] power for the best."
• Staff told us they felt supported and listened to by the registered manager. There were handover meetings, team meetings and senior meetings to discuss the care in the home and how they could improve.
• People and their relatives had been consulted on an ongoing basis during the Covid 19 pandemic around visiting arrangements for relatives to ensure they kept people safe while also being mindful of their mental wellbeing.
• The registered manager was open and honest and understood their responsibilities for reporting to external agencies such as the local authority safeguarding team or the Care Quality Commission.
• There was a complaints procedure in place to ensure complaints were dealt with in a timely manner. People using the service and relatives knew who they could speak to if they needed to make a complaint.

Working in partnership with others
• The home worked in partnership with others and was an integral part of the local community. The registered manager had recently been nominated for a community award for their hard work keeping people in the home safe during the Covid 19 pandemic.
• The home worked in partnership with other health and social care professionals. The registered manager had recently worked with the tissue viability nurse completing a course to improve their knowledge relating to skin care and pressure ulcers.

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 17 HSCA RA Regulations 2014 Good governance Governance systems to monitor the quality of care were not always robust. Regulation 17 (1) (2) (a) (b)