Mrs Brigid O'Connor

Dunraven House and Lodge

Inspection report

Dunraven Registered Residential Home
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Wiltshire
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Tel: 01722321055

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dunraven House and Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This was an unannounced inspection. At the time of our inspection 40 people were receiving accommodation and personal care from the service.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff did not always recognise when people were raising allegations of abuse and action was not always taken promptly to report concerns and ensure people were safe.

Most people said they felt safe living at Dunraven House and Lodge. However, we also received feedback from some people who were concerned at the way they were treated. One person raised concerns with us about the way a member of staff had spoken to them. We also received feedback from a social worker that a person who was in hospital at the time of the inspection had said they did not want to return to the service because they did not like the way they were treated. This was being investigated by Wiltshire Council through the safeguarding processes.

The provider did not always ensure the principles of the Mental Capacity Act were followed. The service had supported one person to move from Dunraven House and Lodge to another service provided by the registered manager. The move had happened without consultation with the person's relatives or their social worker. The person had been assessed to lack capacity to make a decision about where to live. The person had been supported to move from the home without a thorough process to ensure the move was in their best interest.

Most people told us they were treated well and staff were caring. We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and spoke with people in ways they could

understand. Despite the positive comments, we also received feedback from two people who did not feel they were treated well. An incident raised through the safeguarding processes demonstrated that people were not always treated with dignity and respect. Although these incidents had been addressed by the registered manager, this had not resulted in sustained improvements in the experiences of some people who used the service. Following the visit, Wiltshire Council's mental health commissioning team informed the service they had been placed on an 'amber alert.' This was due to the number of concerns that had been raised about the service. The council said they would seek additional assurances from the provider before supporting new people to move into the home.

The registered manager did not always ensure notifications were made to the Care Quality Commission when required. Following this inspection visit, we were informed of an incident in which a relative informed staff that money and other personal possessions were missing from a person who used the service. The registered manager had not submitted a notification to us about this allegation. The registered manager had made other notifications to us when required, including other allegations of abuse, injuries to people who used the service and to report incidents which were reported to or investigated by the police.

The management team completed regular audits of the service. However, these systems were not fully effective and had not identified shortfalls in the way staff followed the safeguarding procedures, the failure to work within the principles of the Mental Capacity Act or that we had not been notified of specific events in the service.

Medicines were managed safely and staff had received suitable training in medicines management and administration. People received the support they needed to take their medicines.

There were sufficient staff available to provide the care and support people needed. Staff received a thorough induction when they started working at the service and had completed regular training about their role.

People had regular meetings to provide feedback about their care and there was a clear complaints procedure.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People who used the service did not always feel safe when receiving support.

Staff did not always recognise that people were making allegations of abuse and action was not always promptly taken to keep people safe.

There were sufficient staff to meet people's needs. Medicines were managed safely and people were supported to take the medicines they had been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow the principles of the Mental Capacity Act when making decisions on behalf of people.

Most people were supported to maintain their health. However, staff had not followed specific guidance on managing a health condition for one person.

Staff received suitable training and support. People were provided with food they liked and supported to follow specific dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Most people spoke positively about staff and the care they received. However, some people felt they were not treated well. An incident raised through the safeguarding process demonstrated a person was not treated with dignity and respect.

Staff communicated with people in accessible ways, that took into account any sensory impairments.

Is the service responsive?

Good

The service was responsive.

Staff had clear information about people's needs and how to meet them.

People told us they knew how to raise any concerns or complaints.

Staff supported people to think about what they wanted at the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not always ensure notifications were made to the Care Quality Commission when required.

The quality assurance systems were not always effective. They had not identified shortfalls in relation to the way staff followed the safeguarding procedures or the failure to work within the principles of the Mental Capacity Act.

Dunraven House and Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 and 31 January 2018 and was unannounced.

The inspection was completed by two inspectors. Before the inspection we reviewed all the information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with the registered manager, the provider, six people who used the service and five support workers. We looked at the records relating to support and decision making for three people. We also looked at records about the management of the service. We received feedback from two social care professionals who have contact with the service. Following the inspection visit we received information from the safeguarding team at Wiltshire Council and attended a safeguarding meeting on 27 February 2018.

Requires Improvement

Our findings

At the last comprehensive inspection in November 2015, we identified improvements that were needed to ensure the service was always safe. This related to support for people to manage their money and the way staff were holding items on behalf of people. At this inspection we found the provider had made these improvements. Staff no longer held any items on behalf of people. One person whose money was previously managed by the provider because they did not have a bank account had been supported to apply to the Court of Protection to manage their finances.

Most people said they felt safe living at Dunraven House and Lodge. Comments included "I have lived here for a long time and I like it; I feel safe" and "I am very happy living at Dunraven". However, we also received feedback from some people who said they did not feel safe. One person raised concerns with us about the way a member of staff had spoken to them. We discussed this with the registered manager, who took immediate action to report the concern to the safeguarding team at Wiltshire Council and to make arrangements for the person to be supported by different staff during an investigation. The following day the registered manager told us the safeguarding team had made arrangements for the person's social worker to complete a full review with them. One person we spoke with during the inspection told us they were not happy living at Dunraven, but said they did not want to tell us why. We also received feedback from a social worker that a person who was in hospital at the time of the inspection had said they did not want to return to the service because they did not like the way they were treated. This was being investigated through the safeguarding processes.

The registered manager had made changes to the staff mobile phone policy following an incident in which staff used their phones inappropriately. The incident was investigated by the local safeguarding team and the provider took individual action against staff members involved. Staff were no longer permitted to use mobile phones at any time when they were in the service. The registered manager said they had instigated a policy that any staff seen with their mobile phone would be sent home.

Following the inspection visit, we were informed of an incident in which a relative informed staff that money and other personal possessions were missing from a person who used the service. Staff had not identified these as safeguarding issues and the allegations had not initially been reported to the Wiltshire Council safeguarding team or to CQC. The registered manager said the relative raised these concerns with them on 23 February 2018. The concern about the missing money had not been reported to the police at the time of a safeguarding Early Strategy Meeting on 27 February 2018. It was agreed that staff from the safeguarding team would raise the issue with the police. The failure to report this allegation to the police and

safeguarding authority at the time it was received increased the risk that any investigation would not find the reason for the missing items.

Staff told us they had received safeguarding training and we confirmed this from training records. Staff said they would report suspected abuse if they were concerned and were confident senior staff in the service would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with. Despite the guidance and training that staff had received, concerns raised about missing money and personal items had not been identified as a safeguarding matter and appropriate action had not been taken.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place to support people to be as independent as possible, balancing protecting people with supporting them to maintain their freedom. Examples included assessments about how to support people to manage their health conditions, support to keep safe when accessing the community independently and support to manage medicines safely. Staff demonstrated a good understanding of these plans, and the actions they needed to take to keep people safe.

There were arrangements in place to deal with emergencies. Staff confirmed there was an on call system in place which they had used when needed. Staff said they were able to contact one of the management team, which enabled them to receive support and guidance. Staff said this system worked well and they received good support.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the records of three staff employed in the last year. These showed that staff were thoroughly checked before they started providing care to people.

Sufficient staff were available to support people. People told us there were enough staff available to provide support for them when they needed it. We observed staff responding promptly to requests for assistance. Staff told us they were able to provide the care and support people needed.

Medicines held by the home were securely stored and people were supported to take the medicines they had been prescribed. A medicines administration record had been fully completed. This gave details of the medicines people had been supported to take, a record of any medicines people had refused and the reasons for this. There was a record of all medicines received into the home and disposed of. Where people were prescribed 'as required' medicines, there were protocols in place detailing when they should be administered. People told us staff provided good support with their medicines, bringing them what they needed at the right time.

All areas of the home were clean and people told us this was how it was usually kept. There was a supply of protective equipment in the home, such as gloves and aprons, and staff were seen to be using them. There were infection control procedures in place and staff said they were followed in practice. All areas of the home smelt fresh and clean.

Requires Improvement

Our findings

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. Care plans contained details about the support people needed to make decisions. Examples included information about the way people communicated and the way staff could offer choices to people.
Following the visit to the home we were informed of an incident in which the registered manager had not ensured support for a person was carried out in line with the MCA. 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Applications to authorise restrictions for some people had been made by the service. The service had supported one person to move from Dunraven House and Lodge to another service provided by the registered manager. The move had happened without consultation with the person's relatives or their social worker. The person had been assessed to lack capacity to make a decision about where to live.

We attended a safeguarding meeting regarding this incident following the inspection visit. At the meeting the registered manager said they had attempted to contact the person's social worker and relatives prior to the move, but they had not been available. The safeguarding meeting identified that there were restrictions in place at the new service for the person which had not been included in their care plan. These related to restricted access to leave the building and the person being encouraged not to watch television in their room. The person had been supported to move from the home without a thorough process to ensure the move was in their best interest.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were supported to maintain their health and follow instructions and guidance from their GP and other health staff. However, for one person, staff had not followed the specific guidance they had received from the person's GP. The person required insulin injections to control their diabetes. Records seen indicated that they were having blood glucose levels tested twice a day. The records for the previous five days were persistently high, between 17.9 millimoles per litre (mmol/l) and 30.6mmol/l. Staff said that the person's diabetes had always been unstable and that their GP was aware of this. They said that they normally contacted the GP when the blood glucose remained high for a period of three days and that they were going to do so on the day of the inspection. A letter from a GP showed that they had reviewed the

person in September 2017 and had recommended that staff contact them should the blood glucose levels go above 20mmol/l and they had ketones in their urine; or when levels reached 30mmol/l without ketones in urine. Records indicated that staff were not always checking for ketones when levels were above 20mmol/l and that they had not contacted the GP when the level had reached 30.6mmol/l the previous day. This was a potential risk to the person's health.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular training to give them the skills to meet people's needs. This included a thorough induction and training on meeting people's specific needs. Training was provided in a variety of formats, including group sessions and observations of practice. Staff told us the training they attended was useful and relevant to their role in the service. The registered manager had a record of all training staff had completed and when refresher training was due. This was used to plan the training programme. Staff were supported to complete formal national qualifications in social care.

Staff told us they had regular meetings with their line manager to receive support and guidance about their work and to discuss training and development needs. We saw these supervision sessions were recorded. The registered manager kept a record of the supervision and support sessions staff had received, to ensure all staff received the support they needed. Staff said they received good support and were also able to raise concerns outside of the formal supervision process. Comments from staff included, "I feel I receive the support I need to do my job well" and "We get good support. I have regular supervision meetings and I'm able to discuss issues with my supervisor or any of the managers".

People told us they enjoyed the food provided by the home and were able to choose meals they liked. Comments included, "The food is good. You can have something different if you don't like what's on the menu" and "I like most things on the menu. You can always have something different if you want. I had a pasty yesterday because I don't like liver". The chef confirmed they were aware of special dietary needs people had. One person told us they ordered their own specific meals each day, which were prepared for them.

The home was well maintained, with people reporting that repairs were completed promptly. Most areas of the home were well decorated, although some areas of The Lodge, including the lounge, corridors, bathrooms and some bedrooms were starting to become worn and were in need of redecoration.

Requires Improvement

Our findings

Most people told us they were treated well and staff were caring. Comments included, "The staff are kind. I like them" and "I have lived here for about five years and like it. The staff are good and treat us well". We observed staff interacting with people in a friendly and respectful way. Staff respected people's choices and spoke with people in ways they could understand.

Despite the positive comments, we also received feedback from two people who did not feel they were treated well. An incident raised through the safeguarding processes demonstrated that a person was not treated with dignity and respect. Although the incident had been addressed by the registered manager, this had not resulted in sustained improvements in the experiences of some people who used the service. Following the visit, Wiltshire Council's mental health commissioning team informed the service they had been placed on an 'amber alert.' This was due to the number of concerns that had been raised about the service. The council said they would seek additional assurances from the provider before supporting new people to move into the home.

The home had two shared rooms at the time of the inspection. The registered manager reported that the people who used these shared rooms had shared for many years, but no-one who moved into the home in future would be offered a shared room. One person who shared a room needed staff support to manage their continence. Staff said they supported the person with their personal hygiene in the bathroom area at night, before the person went to bed and in the morning when the other person had left the bedroom. Staff also said a screen was available should the personal care be required when both people were in the room.

Staff communicated with people in accessible ways that took into account any sensory impairment which affected their communication. For example, documents were provided in an easier to read format, with symbols and pictures to aid understanding.

Staff had recorded important information about people; for example, personal history, plans for the future and important relationships. People's preferences regarding their daily support were recorded. Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided.

People were supported to make decisions about their care plans and were involved in the planning process. For example, people had regular meetings with staff to review how their care was going and whether any changes were needed. Details of these reviews and any actions were recorded in people's care plans. People

told us staff consulted with them about their care plans and their preferences. There were also regular meetings for people, which were used to receive feedback about the service.

People told us staff supported them in ways that helped them to be as independent as possible. Care plans contained information on how to support people to maintain their independence and staff demonstrated a good understanding of the support needed.

Personal information was held in a secure way in the office, with only relevant staff who needed the information to provide care to people having access to it.

Good

Our findings

People had care plans which contained detailed information about their needs. The plans included information on maintaining health, support for people to maintain or maximise their independence and people's preferences regarding their personal care. There was specific information about people's health conditions. Care plans set out how people wanted their needs to be met. The plans were regularly reviewed with people and changes had been made following their feedback.
In addition to the care plans, people had been supported to complete a 'recovery star'. These were used to support people to develop self-esteem and independent thinking skills to enable them to manage their mental health needs. They helped people identify areas of their life they needed more support with and to set goals to help their recovery. This gave staff access to information which enabled them to provide support in line with people's individual wishes and preferences.

People told us they had been involved in developing their care plans and recovery star and were happy with what was in them. People said staff followed the plans and provided them with the support they needed, in the ways they wanted it.

People told us they were supported to keep in contact with friends and relatives and take part in activities they enjoyed. The service used a nearby building to provide social activities for people who lived at Dunraven House and Lodge, as well as other supported living services operated by the provider. As well as a scheduled programme of activities, there was a drop in centre where people could spend time socialising. Activities included computer training, cooking, games, arts and crafts, quizzes, discussion groups and gardening. People also told us they had enjoyed going on trips organised by the service. People who did not want to attend the activity centre were supported to take part in social activities in the home. During the inspection some people were spending time socialising together and staff supported some people to take part in a game of bingo. The service had worked to support people to maintain their personal relationships, for example, keeping in contact with friends and supporting people to welcome visitors into the home.

People said they knew how to complain and would speak to staff, the registered manager or the provider if there was anything they were not happy about. Comments included, "I would speak to [the provider] if I had any problems. They would sort it out". There was a complaints procedure, which was provided to people when they started using the service. Staff discussed complaints with people at their regular care reviews. This helped to ensure people understood how they could make a complaint and assure people any complaints they made would be investigated. Actions were taken to resolve complaints made by people. For example, one person was provided with a new mattress after raising a complaint that their existing mattress

was uncomfortable.

Staff supported people to think about death and any wishes they may have at the end of their life. They had recorded any wishes people had expressed, and where people had said they did not wish to discuss the subject. Staff had completed training on end of life care.

Requires Improvement

Our findings

There was a registered manager in post and they were available throughout the inspection. In addition to the registered manager, the provider worked in the service on a regular basis.

The registered manager did not always ensure notifications were made to the Care Quality Commission when required. At the last inspection in November 2015, we reported on one incident in which the staff called the police for assistance that had not been reported to us. We discussed this with the registered manager at the time of the last inspection, who told us this was due to an oversight. The registered manager said they would take action to ensure all notifiable events were reported in future.

Following this inspection visit, we were informed of an incident in which a relative informed staff that money and other personal possessions were missing from a person who used the service. The registered manager said the relative raised these concerns with them on 23 February 2018; however, they had not submitted a notification to CQC at the time of a safeguarding Early Strategy Meeting on 27 February 2018. The registered manager had not taken the action they said they would following the last inspection, and ensured that required notifications were always made to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had made other notifications to us when required, including other allegations of abuse, injuries to people who used the service and to report incidents which were reported to or investigated by the police.

The management team completed regular audits of the service. These reviews included assessments of incidents, accidents, complaints, training, staff supervision and the environment. The audits were used to develop action plans to plan improvements to the service. However, these systems were not fully effective and had not identified shortfalls in the way staff followed the safeguarding procedures, the failure to work within the principles of the Mental Capacity Act or that CQC had not been notified of specific events in the service.

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

Staff told us they received good support and direction from the provider and the registered manager.

Comments from staff included, "I feel I receive the support I need to do my job well" and "I like it here, everything is good. [The provider and registered manager] are nice, very supportive". There were regular staff meetings, which were used to keep staff up to date and to reinforce how the registered manager expected staff to work. Staff confirmed they were able to raise issues with the registered manager. One member of staff commented, "It's definitely normally 'their way' but they will change their views if we keep chipping away and say something is not working".

Satisfaction questionnaires were sent out regularly, asking people, their relatives, staff and professionals their views of the service. The questionnaires were provided in an easy to read format, to aid understanding for some people. The results of the most recent survey had been received and had been collated by the provider. No concerns had been raised about the support people received. People were provided with feedback from the registered manager, setting out the action they had taken to the responses received. Actions included changes to the activities programme, provision of additional art equipment and refurbishment of some rooms.

Personal confidential information was securely stored in locked offices and cabinets. Staff were aware of the need to ensure information remained secure. Staff followed these procedures and ensured confidential information was not left unattended or unsecured.

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 registered manager had not ensured CQC was notified without delay of allegations of abuse in relation to a service user. Regulation 18 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had not ensured care and treatment of service users was only provided with the consent of the relevant person. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not ensured risks to people's health as a result of medical conditions were managed effectively and action taken to follow the advice of medical professionals. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not ensured there were effective systems and processes to protect service users from abuse and improper treatment. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not ensured there were effective systems to assess, monitor and improve the quality of the service provided. Regulation 17 (2) (a).