Quantum Care Limited

Dukeminster Court

Inspection report

Dukeminster Estate
Church Street
Dunstable
Bedfordshire
LU5 4FF

Tel: 01582474700

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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
Dukeminster Court is a residential care home providing personal care for to up to 75 people. The home is purpose built and consists of 5 units, each with separate adapted facilities. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 67 people using the service.

There was an increased risk of people's oral health needs not being met. Incident reports had not always been completed by staff. People's care plans did not always contain current information on managing risks. Environmental risks were not always identified and managed in line with guidance. People did not always receive their medicines safely. However, infection control measures were robustly followed, and staff had access to sufficient PPE. People told us they felt safe and there were enough staff. Relatives told us they felt free to visit without restrictions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Systems and processes were not always operated effectively to ensure safety and quality risks were well managed. There was evidence that people's preferences around who supported them were not always met. The provider was working through action plans to improve quality concerns they had identified and took action in response to the concerns we found during this inspection. People and their relatives informed us there was a positive culture in the service, and our observations of how staff interacted with people confirmed this.

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

Rating at last inspection
The last rating for this service was good (published 5 January 2022).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained an injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of people's individual risks. This inspection examined those risks. 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. The overall rating for the service has changed from good to requires improvement based on

the findings of this inspection.

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

Enforcement
We have identified breaches in relation to safety and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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.

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.

Dukeminster Court

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by 3 inspectors and 3 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Dukeminster Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dukeminster Court 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 inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually

with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 22 people who used the service and 25 relatives about their experience of the care provided. We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service.

We spoke with 18 staff including housekeeping staff, kitchen staff, care workers, senior care assistants, the deputy manager, the registered manager, the regional manager and the quality and compliance manager.

We reviewed 11 people's care records. We looked at 3 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, quality assurance reports and accidents and incidents.

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 good. At this inspection the rating has changed to 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; Learning lessons when things go wrong

- Risks relating to people's needs and the environment were not always safely managed.
- On the first morning of our inspection, we found some people's toothbrushes were dry, indicating staff had not supported people with their oral hygiene needs. Records did not always evidence a person had regular support to clean their dentures. Care plans were not always clear about if people still had their teeth. A relative told us on several occasions, they found their relative had not been supported to wear their dentures. These findings indicated increased oral health risks to people.
- Records showed staff had not always completed incident reports. This meant the provider could not always ensure appropriate action and reviews had taken place to manage risks.
- People were at increased risk due to their care plans not always containing current information about managing risks to them. For example, one person's care plan stated they should use a walking frame when they could no longer walk.
- A person's care plan needed to be clearer regarding how they needed their food to be prepared to manage choking risks. However, staff were able to tell us about what foods people could safely eat. Our observations and records showed people received food prepared in line with individual needs. Relevant training was available, and further training was booked, which covered supporting people with swallowing difficulties.
- Information displayed in some people's rooms about how their pressure-relieving mattresses should be set was incorrect. Incorrectly set mattresses can increase the risk of pressure sores. The provider corrected this immediately.
- We identified falls risks from windows and balconies had not been managed in line with national guidance. The provider immediately responded by changing window restrictor fittings and removing freestanding furniture from balconies.
- Some freestanding furniture, including a person's wardrobe, had not been secured to walls. Dukeminster Court supports people at increased risk of falls, and at risk of pulling furniture on themselves if they fall. After our inspection, the provider told us they had secured all freestanding furniture.

Using medicines safely

- Medicines prescribed to be taken by people on an as required basis (PRN) were not always managed safely. Records showed people had been given PRN medicines with calming or sedative effects inconsistently or without always documenting why. This meant the provider could not always review whether the administration of these medicines was justified or appropriate. In response to these concerns, the provider immediately carried out an investigation and identified staff members who needed further training.

● PRN protocols did not always have enough information to ensure people received these medicines consistently or if a person should receive a higher or lower dose of variable dose medicines.
● Topical medicines were not always managed safely. We found prescribed creams stored in people's rooms did not always have opening dates recorded. This increased the risk of people receiving medicines that are no longer safe. The provider responded to these concerns by removing and replacing undated medicines.

Preventing and controlling infection
● We found the sluice room had been left unlocked and, after making staff aware of this, found staff had left keys in the sluice room door. This increased infection and safety risks to people. The provider responded immediately by fitting a coded keypad to the door.

Systems had not always been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This increased health and safety risks to people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home was clean and free from malodour. Effective systems were in place to ensure all areas were regularly cleaned and enough housekeeping staff was deployed to maintain standards. Staff had access to sufficient personal protective equipment.
● The provider had identified care plans needed improving before our inspection. Action plans were in progress to make improvements via a service development plan.

Staffing and recruitment
● While some relatives felt there was not enough staff and call bells could take longer to answer, most felt there were enough. We observed staff were busy but had enough time to interact with people, support them with group activities and promote their safety.
● Records showed staff regularly checked on people in line with their care plans. Furthermore, the provider showed us evidence they had used a dependency tool to plan for safe staffing levels and carried out regular checks to promote prompt call-bell response times.
● The provider had increased staffing levels on a unit in response to people experiencing increased falls. The registered manager had done this after completing a monthly management risk review, indicating that increasing staffing on a unit would improve people's safety there.
● Staff were recruited safely. The provider undertook preemployment checks such as obtaining references and Disclosure and Barring Service (DBS) Checks. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People were safeguarded from abuse and avoidable harm.
● The registered manager had made safeguarding referrals to the local authority where required. This meant safeguarding concerns could be independently investigated to determine if any further follow-up actions were needed to keep people safe from the risk of abuse.
● Staff had received safeguarding training and could tell us how and to whom they could report safeguarding concerns internally and externally.
● People told us they felt safe living at Dukeminster Court. For example, a person said, "I feel very safe. My doors are always open so staff can check on me. Staff make me feel safe; there is somebody around all the time."

Visiting in care homes

● We observed many visits taking place during our inspection and observed that visitors were welcomed without restriction.

● A relative told us, "We come because we love to come because it's such a positive, jolly place. If any care home can be bubbly and joyous, this this one."

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)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had not always effectively operated their systems and processes to manage risks and ensure people always received a good quality care experience.
- Complaints and concerns were not always documented in line with the complaints policy. Although the registered manager could describe and provide evidence of how they had responded to concerns and complaints, there was an increased risk of the provider not having enough oversight to identify themes and trends to inform areas needing improvement.
- Care plans were not always of good quality and contained inaccurate and conflicting information. This was despite staff documenting they had recently reviewed care plans. The provider had identified staff completing care plans needed further training and planned actions to improve this.
- Medicines audits carried out by the provider had not identified PRN protocols, did not always have enough information, or topical creams were not always dated when opened. This meant medicines audits had not always been used effectively to ensure people received their medicines safely.
- The environmental risks we identified during this inspection, as cited in the safe section of the report, meant environmental safety checks were not always operated effectively to manage risks to people.
- Systems were not always effective at ensuring people's staff gender preferences were always met. Records showed times when male staff supported people with personal care when they preferred or only wanted female staff.

The provider had failed to always operate effective systems to always ensure the quality and safety of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the time of the inspection, there was a registered manager in post. The registered manager understood their regulatory responsibilities, which included submitting notifications to CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- A lack of storage meant people's continence aids were visible to passersby. The registered manager confirmed they would review storage arrangements.
- Our observations of how staff interacted with people were positive. People were spoken to respectfully, and the staff offered them choices. Staff appeared to have good rapport with people.

● A relative told us, "I am very happy with care and all attention my relative receives from staff. I cannot fault them. Staff are kind, caring and very dedicated, they are very respectful of my relative's wills and wishes."
● A person told us, "I am a resident for over four years, I find this place very comfortable with amazing hard-working carers and I am very happy I have a place here."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider held regular resident's meetings with people. This was used as an opportunity to gather feedback about any concerns they had, activities and their satisfaction with the meals they received. At the time of the inspection, the provider was developing keyworker roles, which aimed to promote better person-centred care and more regular review of people's wishes, goals and preferences.
● Staff felt managers were approachable. A staff member told us, "I feel very well supported and I am happy. Whatever I ask they do support me." Furthermore, we could see from records the registered manager supported staff when needed. A staff member said, "The manager is very hands on here, she will put on a uniform and get stuck in."
● Records evidenced the provider worked well with external health professionals and incorporated their advice into care planning. A visiting community nurse told us "Staff are very welcoming, and the care people received was very good."

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 had a duty of candour policy in place, which promoted them meeting their legal responsibilities. We found no concerns about the provider's understanding of the duty of candour.

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 Systems had not always been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This increased health and safety risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to always operate effective systems to always ensure the quality and safety of the service.