Durnsford Lodge Limited

Durnsford Lodge Residential Home

Inspection report

90 Somerset Place
Stoke
Plymouth
Devon
PL3 4BG

Tel: 01752562872
Website: www.durnsfordlodge.co.uk

Date of inspection visit:
13 January 2022
20 January 2022
08 February 2022

Date of publication:
17 March 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Durnsford Lodge is a 'care home' that provides care and support for a maximum of 28 older people, some of whom may be living with a dementia and/or physical frailty. At the time of the inspection 21 people were living at the service.

People's experience of using this service and what we found
People who were able to share their views with us were happy living at Durnsford Lodge, told us they felt safe and liked the staff that supported them. We received mixed feedback from relatives about people safety.

We found the service was not always operating in accordance with the regulations and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

People were not always protected from the risk of avoidable harm. We found where some risks had been identified, sufficient action had not always been taken to mitigate those risks and keep people safe. Key pieces of information relating to people's care and support needs were not always being recorded or followed up. Other risks were well managed.

People were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests.

People's medicines were not always managed or stored safely.

People were not always protected from the risk and spread of infection. Following the inspection, the provider confirmed action had been taken to resolve the concerns in relation to infection prevention and control.

People were not always protected by safe recruitment procedures.

Systems and processes to monitor the service were not undertaken robustly. This meant they were not always effective; did not drive improvement; did not identify the issues we found at this inspection and could not be relied upon as a source to measure quality and risk.

The provider was investing in the home. They had developed a service improvement plan and had made several positive changes to the home's environment, improved facilities and increased people's opportunities to get involved in activities.

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

Rating at last inspection and update
The last rating for this service was good (published March 2019). Since this rating was awarded Durnsford Lodge Limited had been purchased by a new provider. Whilst there had been no change to the legal entity there had been a complete change in the ownership and management of the service.

Why we inspected
The inspection was prompted in part due to concerns we received about the management of risk, safeguarding, infection prevention and control and use of personal protective equipment (PPE). A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only

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.

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

The overall rating for the service has changed from good to requires improvement. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Durnsford Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding, safe care and treatment, need for consent, recruitment and governance at this inspection. We have also made recommendations in relation duty of candour and quality assurance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Durnsford Lodge Residential Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 team was made up of three inspectors, a medicines inspector and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. 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
Durnsford Lodge 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.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. An interim manager had been appointed by the provider to oversee the running of the service.

A registered manager is a person who has registered with the Care Quality Commission to manage the

service. Like registered provider, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority and 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 this information to plan the inspection and took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent time with and spoke with four people living at the service, 11 relatives, eight staff, the interim manager and the provider. To help us assess and understand how people's care needs were being met we reviewed five people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with representative from Plymouth City Council.

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.

Systems and processes to safeguard people from the risk of abuse
Prior to the inspection the Care Quality Commission received concerns that one person had been restrained by staff for the purposes of undertaking a COVID 19 test. This information was shared with Plymouth City Council and the provider prior to the inspection.

• People were not always protected from the risk of abuse and/or improper treatment.
• The provider had clear policies and procedures in relation to safeguarding adults and the use of restraint. The interim manager and staff had received training in safeguarding and were able to tell us the correct action to take if they suspected people were at risk of avoidable harm or abuse. However, records for one person indicated that staff had failed to recognise or report to Plymouth City Council's safeguarding team an incident which had led to a significant infringement of one person's human rights.
• An investigation completed by the services management team failed to fully consider the impact this incident would have had on the person; take appropriate action with all staff involved, including staff who knew about the alleged incident and did not raise concerns. Or identify lessons that could/should have been learnt.

The failure to protect people from abusive practices, improper treatment and to effectively establish systems to investigate and report allegations of abuse placed people at an increased risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• We received mixed views from relatives about people's safety. One relative said, "At the moment I don't feel [Person's name] is safe". Another said, "I have no concerns about [Person's name] safety". We found people were not always protected from risks associated with their assessed complex care needs.
• Some people had been assessed as needing pressure relieving equipment such as pressure mattresses and cushions to reduce skin damage. There was no guidance in people's care plans or risk assessments to instruct staff on what pressure mattresses should be set at and daily mattress checks were not being completed by staff regularly.
•We found three people's pressure mattresses were not set correctly for the person's weight, which meant they could be at risk of unnecessary skin damage.
• One person's care record guided staff to assist this person to change position every two hours to prevent skin damage. Records showed and staff confirmed this person was not being regularly supported to change their position. This placed the person at an increased risk of further skin damage.
• Where risks had been identified, it was unclear what action had or was being taken to mitigate those risks

and keep people safe. For example, some people had been identified at high risk of malnutrition. Staff told us they monitored and recorded their food and fluid intake as part of their daily observations. However, we found people's food and fluid intake was not always recorded in sufficient detail, monitored or analysed.
• Risk assessments and regular checks of equipment had not been sufficiently undertaken to protect people from the risk of harm. For example, we found the inappropriate use of bedrails and the wrong size bumpers [bedrail protectors] had placed people at an increased risk of entrapment.
• Risk assessments carried out by senior staff did not always form part of the person's care plan as it had not been linked to people's care records. This meant staff did not always have the information they needed to meet people's needs safely.
• We found some risk assessments lacked detail information about the nature of those risks; what action had been taken to mitigate risks or contained information that was not accurate.

Failure to effectively manage and mitigate risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider told us that fire safety systems were serviced and audited regularly. Training records showed staff had received training in fire awareness and undertook fire drills.
• Individual personal emergency evacuation plans (PEEPs) indicated any risks as well as any support people needed to evacuate them safely.

Staffing and recruitment
• People were not always protected by safe recruitment practices.
• We looked at the recruitment information for four staff members. Whilst some recruitment checks had been carried out, others had not. For example, two staff files did not contain proof of their identity; contained limited information about previous work history; and the provider had failed to apply for a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• This meant the provider was unable to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• We discussed what we found with the Provider who was unaware of the regulation and the need to meet schedule 3. The provider told us they had not applied for DBS's as they thought they could use their previous DBS under CQC interim guidance on DBS in response to coronavirus (COVID-19).

The failure to establish and operate safe and effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we had received concerns regarding safe staffing levels. This information was shared with Plymouth City Council and the provider prior to the inspection.

• People who were able to share their views with us, relatives and staff felt there were enough staff on duty to support people and keep them safe. Throughout the inspection we saw call bells were answered promptly. One person said, "When I have called for assistance, I have never had to wait long". A relative said, "I have no concerns about the staffing. From what I have seen, there is nothing to suggest that there are shortages.''

Using medicines safely
• People's medicines were not always managed or stored safely.
• On the first day of the inspection we found some people's medicines and medicated creams were not being stored safely and securely. We brought this to the attention of the provider who took immediate

action.
• People's medicine support needs were not assessed. Care plans did not describe how staff should support people to take their medicines safely and in a way that would ensure they were effective.
• Some people were prescribed medicines to be given when required. Protocols to help staff to decide when to give these medicines were not always in place or included enough information to ensure the medicines could be given safely.
• Staff did not understand the difference between covert administration and mixing a medicine with food to help swallowing.
• Staff could not be assured that medicines were stored at the correct temperature in the medicine's fridge. Records showed that the current temperature of the medicine's fridge had been recorded only five times since 23 December 2021. On two occasions the temperature was below the minimum recommended. Staff had taken no action to report this.
• We found one medicine needed for end of life care was five months out of date. This had not been identified during medicine stock checks.
• A medicines audit had been completed in December and actions identified to improve the safety and quality of the service. However, none of these actions had been put into place and we found similar concerns.

The failure to store people's medicines safely and to established safe processes to manage people's medicines is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff did not understand how to apply the principles of the Mental Capacity Act in relation to medicine administration. For example, some people were given their medicines hidden in food or drink. There was no evidence of an assessment under the Mental Capacity Act or a record of a best interest decision.

The failure to gain consent from people, or where people were unable to give consent, involve relevant health or social care professionals in best interest decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• People were not protected from the risk and spread of infection.
• We were not assured that the provider was doing everything possible to prevent people, visitors and staff from catching and spreading infections. Whilst the provider had in place procedures for visitors and staff entering the service, these were not always being followed. For example, On the first day of the inspection we observed a senior staff member enter the home without waiting for the results of their LFD test (lateral flow device).
• We were not assured that staff were using PPE effectively and safely. For example, throughout the inspection we observed some staff members wearing gloves. When asked the interim manager and Provider told us this was to mitigate the risks associated with transmission and/or cross contamination. We found the wearing of gloves may have provided a false sense of security as we did not observe staff changing their gloves regularly between tasks or interactions with people. Although we found hand gel/sanitiser was available throughout the service we did not observe staff actively washing or sanitising their hands between care tasks and/or close contact with people living at the service.
• On the first and second day of the inspection we observed staff not wearing their masks correctly and failing to change PPE following close contact with people or following rest breaks.
• We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. For example, the arrangements for donning and doffing personal protective equipment were insufficient to prevent cross-contamination.

• We were not assured that the current arrangements in place to ensure the home was kept clean and hygienic to reduce the risk of transmission, were sufficiently robust to control and prevent the spread of infection. For example, cleaning records identified that three people's rooms had only been cleaned on one occasion during their 14-day isolation period.
• We did not observe staff cleaning high frequency touch points/areas during our site visits nor did the provider have in place an enhanced cleaning schedule. Staff were aware of the need to carry out enhanced cleaning to reduce the risk and spread of infection but told us they didn't have time.
• We discussed what we found with the provider during and after the inspection who took steps to better protect people, staff and visitors from the risk and spread of infection.

The failure to effectively manage risks relating to infection control and the transmission of COVID-19 is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have also signposted the provider to resources to develop their approach.

• The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives we spoke with told us they had been able to visit their relations regularly. One relative said, "They are fine about visiting. I book an appointment in advance, as they do not want too many people visiting on the same day." Another said, "I am aware of the visiting arrangements and these seem to work fine."

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

We checked and found the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong
● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored, reviewed or used as a learning opportunity. This meant that when things had gone wrong, the potential for re-occurrence was high because insufficient action had been taken to review, investigate or learn lessons.

Systems to assess and improve the quality and safety of the service were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care
• The service did not have a manager registered with the Care Quality Commission at the time of the inspection. An interim manager had been appointed by the provider to oversee the management of the service pending a new manager starting in March 2022.
• The providers oversight and governance of the service was inadequate in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe section of this report.
• Governance processes did not help to keep people safe, protect their human rights and provide good quality care and support. For example, policies and procedures were in place, but a lack of leadership, knowledge and consistency meant they were not always followed.
• Systems and processes to monitor the service were not undertaken robustly. This meant they were not always effective; did not drive improvement; did not identify the issues we found at this inspection and could not be relied upon as a source to measure quality and risk. Issues included concerns with regards to safeguarding, MCA, recruitment, infection prevention and control, management of risk, nutrition and hydration, falls, care planning and the management of people's medicines.
• The service did not have an effective system in place to review staff practice and learn lessons. For example, the provider had not ensured that staff understood the principles of the MCA. This lack of knowledge and understanding risked compromising people's rights.
• Records showed accidents and incidents were recorded, however this information was not being consistently analysed or reviewed. This meant you could not be assured sufficient action had been taken to mitigate those risks, keep people safe and/or prevent/reduce re-occurrence.
• People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs. Nine of the 11 relatives we spoke with told us they had not been involved in the care planning process. One relative said, "I have not had any involvement with care planning or decisions regarding risks to Mum's health.''
• The provider had not ensured the transition from paper to electronic records was effectively managed. As a result, information including people's care records were not easily accessible or easy for staff to navigate.
• Records were not always accurate and had not always been updated to reflect changes in people's needs.
• Records were not stored securely. We found confidential care records relating to one person had not been securely stored and could be accessed freely by people, staff and visitors. This meant people's confidential information was not being stored in accordance with the General Data Protection Regulation 2018, (GDPR).
• Poor judgements/decision making potentially placed people at risk of harm. For example, in relation to infection prevention and control, protecting people from abuse, management of risk and people's

medicines.

Systems were either not in place or robust enough to demonstrate the service was being effectively managed and there was a clear lack of oversight. This potentially placed people at an increased risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We discussed what we found with the provider who acknowledged that some concerns had been a direct result of the lack of oversight of the service. Whilst they had not been fully aware of all the concerns we identified, they were aware of the need to improve and keen to make the improvements needed.
• The provider was investing in the home. They had developed a service improvement plan and had made several positive changes to the home's environment, improved facilities and increased people's opportunities to get involved in activities.

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 interim manager and provider were aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. However, some relatives told us the provider and staff had been slow to tell them when things went wrong; provide information in a timely manner or apologise.

We recommend the provider reviews the systems in place to encourage, support and develop a culture of openness and transparency at all levels.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Although we were unable to view any formal feedback from people since November 2021,most relatives we spoke with told us their relations were happy living at Durnsford Lodge. One relative said, "[Person's name] is quite happy with her room and is comfortable there.''
• Relatives told us the service did not ask for feedback to identify areas that needed improvement or to assess the impact of the service on the people using it. One relative said, "I have not been asked for any feedback about the quality of service.''

We recommend the provider reviews the systems in place to engage, seek and act on feedback about the quality of service provision.

• Staff told us, and records confirmed that regular staff meetings took place. Staff felt able to raise concerns, although some said they did not always feel that they were listened to. One member of staff said, "[Providers name] wants to hear what we have to say, and I have spoken with [Provider name] a number of times, but nothing changes". Other staff were more positive about the new provider and told us they felt there had been many positive changes since they had taken over. One commented, "I really enjoy working here and the providers are really approachable."

Working in partnership with others
• We saw some examples of where the interim manager and staff worked closely in partnership with GPs and district nurses. However, we found advice provided by healthcare professionals was not always followed and the service had been slow to recognise and/or raise concerns about their ability to manage people's needs.
• Professionals we spoke with said communication with the service had been good, although it had been

difficult at times to obtain timely information.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. 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 People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. The provider failed to store people's medicines safely and to established safe processes to manage people's medicines The provider failed to ensure that risks relating to infection control and the transmission of COVID 19 were not being effectively managed. Regulation 12(1)(2)(a)(b)(d)(g)(h)

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 provider failed to protect people from abusive practices, improper treatment and to

effectively establish systems to investigate and report allegations of abuse.

Regulation 13 (1)(2)(3)(4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that recruitment procedures are established and operated effectively. Regulation 19(2)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users, staff and visitors were protected from the risks of infection and best practice was not always followed in relation to infection control which placed people at an increased risk of harm. Regulation 12, (1)(2)(a)(b)(h)

The enforcement action we took:

On the 25 January 2022 the Care Quality Commission served a warning notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with Regulation 12, (1)(2)(a)(b)(h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was required to become compliant with Regulation 12, section (1)(2)(a)(b)(h), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 28 January 2022.