West Bank Residential Home Limited

Dunmore Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dunmore Care Home is registered for 32 older people, including people living with dementia. There were 20 people at the service at the time of the inspection. Bedrooms are located over four floors. There is a small passenger lift to access all floors. There is some accessible outside space.

People's experience of using this service and what we found
Due to poor management of risk, people were at risk of harm. We found multiple examples of poor care and inadequate monitoring of risk in relation to malnutrition, dehydration, personal care, oral care, weight loss, incontinence, fire safety, infection control and pressure care. Some people looked unkempt. People were restless; some expressed sadness and worry at the changes in the home, and the lack of social activities. People told us they were bored and there was nothing to occupy them. We observed people sitting for long periods of time in their wheelchair with nothing to do and no interaction with others.

People's dignity was not maintained; people's clothes and belongings were lost. Complaints were poorly managed and long-standing issues were not effectively addressed. People told us they did not feel listened to, and relative's expressed frustration that their concerns were not addressed. They did not feel confident in the new management structure.

There had been many staff changes, including in care, catering, administration, housekeeping, maintenance and management. There had been changes in the running of the home and this had impacted on staff confidence and morale. The changes had not been explained to people. People told us they were not kept informed of changes; they said, "We would like to know more, to be kept in the loop."

People were unhappy with the food. People told us their lunch was lukewarm, and meals were very rarely hot. Another person sent their meal away complaining to a staff member it was cold. This was an on-going problem according to minutes from a residents' meeting.

Infection control was poorly managed, particularly in the laundry.

Medicines were administered safely, but audits did not pick up on concerns we identified during the inspection. This included action not being taken when medicines were not stored appropriately, for example not being stored at the appropriate temperature.

Records of care tasks were not always completed. We found gaps in the recording relating to the repositioning people which should have been carried out to help prevent skin damage. Fluid and food intake were poorly monitored putting people at risk of weight loss, malnutrition and dehydration. Care plans did not consistently have the required information to support staff in understanding a person's individual needs.

Staff were recruited safely. However, staff training and induction were not effectively managed. Supervisions did not routinely take place and staff competency checks were poorly completed.

During our inspection, we saw actions and heard conversations that showed us some staff were compassionate and kind. People responded to their kindness and smiled or laughed with them. However, relatives said the atmosphere at the home seemed rushed and staff had less time to interact with people.

People were not routinely supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible or in their best interests. This included people living with dementia; improvements were needed to ensure they had equal choices to those people who were not living with dementia.

Systems and processes were not effective in ensuring the safety of people or the environment. Systems in place to monitor and review the quality of care had not been effective in improving standards, and ensuring the service, and staff, were meeting people's needs safely and effectively.

During the inspection, we raised individual safeguarding concerns for some people living at the home. This was to ensure risks to their health and well-being were assessed and reviewed by health and social care professionals.

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 12 November 2020) with breaches in Safe Care and Treatment and Good Governance.

The provider completed an action plan after the last inspection to show what they would do to improve. This included timescales. At this inspection not enough improvement had been made, and standards had deteriorated further. The provider was still in breach of the two regulations identified at the inspection in September 2020, with an additional seven breaches. This service has been rated Requires Improvement for the last three consecutive inspections which all took place in 2020.

Why we inspected:
This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. We were not assured infection control was being managed appropriately.

We have found evidence that the provider needs to make a number of improvements; some of which were urgent. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

During the inspection, the provider was given short timescales to rectify environmental risks. We checked these had been addressed during our inspection.

Follow up:
We have met with the provider, so they have a clear understanding at the level of our concerns. During the

inspection, and afterwards, the provider was required to complete action plans to show us how they would address the risks to people's safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we identified nine breaches in relation to environmental and individual risks to people's safety, infection control, person-centred care, maintaining people's dignity, safeguarding, nutrition and hydration, staff training and deployment, complaints, consent and the running and oversight of the service.

CQC took enforcement action against the provider. The provider made the decision to close the service. People living at Dunmore Residential Home were supported to move to alternative homes by the local authority

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Dunmore 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 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
On 24 November 2021 two inspectors, an assistant inspector and a medicines inspector began the inspection. On 30 November 2021 and 1 December 2021 there were two inspectors on both days. The medicines inspector was also present on 1 December 2021.

Service and service type
Dunmore Residential Home 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 did not have a manager registered with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 this information to plan our inspection.

During the inspection
An Expert by Experience spoke with nine relatives on 30 November 2021 to gain their feedback on the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also used the Short Observational Framework for inspection (SOFI) on 30 November 2021. SOFI is a way of observing care to help us understand the experience of people who were not able to comment specifically on the service. The inspection concluded on 10 December 2021 and written feedback was provided via e-mail on the same day.

During the inspection, we looked at seven people's care records including assessments of people's personal care, emotional and social needs. We also ensured we met everyone living at the home; we spoke with 12 staff, including agency staff.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at two 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 training data and quality assurance records. We spoke with health and social care professionals who are either in contact with the service or regularly visit the service.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the management of risk had deteriorated further. The provider was still in breach of regulation 12. This the fourth time the provider has been in breach of this regulation since January 2020.

● Risk assessments did not accurately reflect people's risks or contain the guidance staff needed to mitigate them. For example, risk assessments relating to the access to the steep flight of stairs near bedrooms were ineffective as they did not consider key risks. On the three days of our inspection, the gate was not closed at the bottom of the stairs, so mobile people had access to the steep flight of stairs to the ground floor. In a general risk assessment for moving safely around the home dated 30 September 2021, it stated, 'In some older properties the stairs are extremely steep and unsuitable for service users. In these instances, the stairs will be protected by safety gates which can be easily opened by staff when needed'. Therefore, the policy had not been acted upon. This left mobile people at risk of harm due to unsafe environment.
●People were at risk of harm and deteriorating mental health because risk assessments did not provide the guidance staff needed to understand and manage the risks. For example, one person's actions were seen as 'challenging' by staff. There was no practical guidance in their care plan to enable staff to support them appropriately. This put the person and others at risk.
●Risks to people's mental health were further increased by a lack of support or stimulation. Relatives expressed concern their family members were becoming isolated and withdrawn.
● People were at risk of harm because they were not always able to summon staff in an emergency. On the three days of our inspection, there were no call bells in communal areas and little staff oversight. People said they were unhappy as they could not call for staff if they needed help, or if others did. We saw people who were assessed as at risk of falling moving furniture around, putting themselves and others at risk of harm.
●Call bells were not always in reach for people in their bedrooms. During the inspection we found a person in a wet bed because they had been incontinent. They said they were cold and were unable to see or reach the call bell. A visitor told us there had been no call bell in their relative's room for three days so their relative could not call for help when they needed assistance to use the toilet.
● People were at risk of harm due to constipation because there was no oversight of how often they opened

their bowels. The record chart for one person showed they had not opened their bowels for 10 days; no action had been taken. This left the person at risk of faecal impaction which is potentially life threatening. We found another person was also at risk of harm due to poor monitoring of their bowel movements.

● People were at risk due to poor oral care. Multiple oral care records either had gaps or stated the person had refused. Some people did not have toothbrushes. Poor mouth care can impact on people's ability to eat and therefore leaving them at risk of malnutrition.

● Ineffective pressure care provided by staff increased the risk of harm to people who were vulnerable to skin damage through immobility, incontinence and poor health. We raised concerns about one individual's care as their records were poorly completed. The records showed the person was not being re-positioned regularly, which increased the risk of damage to their skin. Community nurses were called to review the person's skin and graded an injury as a high-level pressure sore. This meant there was a failure to provide appropriate care to promote good skin health which resulted in harm to an individual. We found other people were at risk of not having their skin care needs met. We found another person was also at risk of harm due to poor monitoring of their pressure care.

● There was poor oversight of some people's personal care including one person who would only accept help from a family member. The manager said they did not know when this support had last been given. There was no oversight of the person's personal care. This meant there was an increased risk of potential skin damage.

● Some equipment used to prevent or reduce pressure damage was not fit for purpose. During the inspection, we saw a person was clinging to the side of their pressure relieving mattress, which had folded around them creating a V shape. We reported this to the management team who advised the pressure mattress was damaged. People were at risk of harm due to pressure damage, as well as a risk of suffocation for the individual as they were facing the side of the mattress.

● Aspects of the environment were not safe which put people and staff at risk. This included fire safety.

● On the first day of inspection, we saw the door to the basement opened directly onto a steep flight of stairs. This door was in an area accessible to people. The door was locked. However, the key code had been handwritten above the lock on the door. This placed all mobile people at risk of harm from falling down the stairs. Other examples of environmental risks included exposed, hot radiators; and unlocked doors to rooms that people were accessing which contained trip hazards, stacked furniture and equipment.

We found evidence that people were at risk of harm, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was in breach of regulation 12 for a fourth time.

We took steps which required the provider to take immediate actions (within 24 hours) to make people safe, including undertaking reviews of each person living at Dunmore. The provider sent us photographs to show the actions they had taken to make the environment safer. On the second day of our inspection, we also checked on these actions. Action plans were also completed but these did not provide us with reassurance that staff were provided with necessary information to care for people appropriately. They also did not effectively manage the risks we had identified during the inspection.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from risk of harm. When people had unexplained bruising there was no follow up or actions taken. For example, staff should have made a referral to the local authority safeguarding team. People were exposed to further risk of harm because of a lack of action to protect them.

● Staff did not consider the impact of people's behaviour and emotions which might detrimentally impact

on others living at the home. For example, staff had recorded that one person living at the home walked into other people's rooms, shouting at them, threw drinks at staff, as well as hitting and biting. No safeguarding referral was made to the local authority. This meant people were put at risk of further harm because these safeguarding concerns were not identified, escalated or appropriately managed.

● The management team did not ensure staff members treated people equally. This meant there was a culture where some staff chose whose care to prioritise based on their perception of the individual person, not on their needs. Staff did not understand or disregarded the harm or lack of dignity people may have been experiencing. This left people at risk of harm because they did not get the care they needed in a timely way to keep them safe.

● Due to the level of our concern about people's individual safety we made six individual safeguarding alerts during our inspection to help protect them and others.

Poor safeguarding systems, processes and practices at the service, placed people at risk of harm. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were administered safely, but audits did not pick up on concerns we identified during the inspection. This included action not being taken when medicines were not stored appropriately, for example not being stored at the appropriate temperature. Staff had not reported this or taken any action. This was not in line with the home's policy and meant that there was no assurance that medicines were being stored at appropriate temperatures.

● The medicines room was untidy with large quantities of unwanted medicines waiting to be sorted and returned to the pharmacy.

● There were duplicate records relating to medicines which were required to be stored safely, and poor management of stock balances and of returning unused medicines to the pharmacy.

● The management of medicines prescribed to be given 'when required' was poor. For example, two people were prescribed sedative medicines but there was not suitable person-centred guidance to help staff decide when it would be appropriate to give a dose. This was not in line with the home's policy. One service user's medication support plan stated that the sedative could be given covertly (given without their knowledge) in coffee as advised by the GP. However, records showed the GP had advised not to give covertly, and staff confirmed that they had been told not to give the medicine in this way. Giving medicines in liquid or food must be authorised by a doctor, as the efficacy of some medicines can be affected when added to foods or liquid. This meant there was the risk agency staff might give medicine covertly if they were not aware of the verbal instructions not to administer in this way, and the efficacy of that medicine would be negatively impacted.

The failure to ensure the safe management of medicines is a breach of breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●People were at risk because measures to prevent and control the spread of infection were ineffective.

● On the first day of inspection we found the laundry was unclean with no designated areas for dirty and clean washed laundry to be separated. This increased the risk of cross contamination between dirty and clean laundry.

●On the first day of inspection we found people did not have their own mobility equipment, such as slings for hoists. This potentially increased the risk of cross infection because the equipment was used by different people.

● The cleaner, appointed a month before the inspection, had not completed infection control training. On the first day of inspection they were working alone and unsupervised. They had been provided with one mop to clean all of the flooring throughout the home, increasing the risk of cross infection. There should have been different mops for different areas of the home, such as the toilets and the dining room.
●There was no infection control lead at the home to oversee infection control practice and to implement current infection prevention and control guidelines. This increased the risk of cross infection in the home leaving people at risk of harm through infection. And meant the provider's own Infection Control Policy had not been followed.

We looked at how the provider was managing risks related to Covid 19.
● We were not assured the provider was preventing visitors from catching and spreading infections. There was poor communication with people and their relatives about visiting the service.
● We were not assured the provider was admitting people safely to the service. The manager said due to a suspension on admissions they would have to check guidance before admitting anyone in the future as they were not up to date.
● We were not assured the provider was using PPE effectively and safely. We had to remind a staff member repeatedly during our inspection to adjust their mask to ensure they were wearing it effectively. We asked if they had tried a different style of mask, they said they would. However, they only wore a mask that fitted correctly after we raised the issue again on the second day of our inspection, this was six days later.
● We were not assured the provider was accessing testing for people using the service and staff. For example, there was poor oversight of staff members' test results.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The laundry layout did not promote good infection control practices as there were no defined areas for soiled and clean clothes; the laundry building and floor were not clean.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed. During our inspection there was an outbreak at the home. Health professionals raised concerns about how people were not being appropriately shielded from those people who had tested positive for Covid 19.
● We were not assured the provider was meeting shielding and social distancing rules. External professionals had to ensure staff considered how they supported people who were mobile during an outbreak at the home.
● We were not assured that the provider's infection prevention and control policy was effective. For example, there was only brief references to Covid 19; it did not provide detailed guidance to staff about the steps they should take to reduce the risks to people's safety.
● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Since the inspection, a relative has raised concerns about the current visiting arrangements, which is being investigated.

We have also signposted the provider to resources to develop their approach, including seeking advice from local infection control teams.

The failure to manage risks related to the spread of infection is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● We did not find evidence at this inspection that lessons had been learnt following our last inspection in November 2020. We had served a warning notice because there was a failure to ensure the governance of the service was effective. The compliance date was 1 December 2020. At this inspection we found the

warning notice had not been met and the manager and area manager said they had been unaware of it.
● There were poor processes in place for reviewing accidents and incidents, and safeguarding concerns. This meant the provider had no oversight or analysis of the information to identify any patterns and trends. For example, care records documented unexplained bruising which the management team were unaware of. Consequently, no action had been taken to investigate and safeguard people.
●There were no processes in place to review and analyse records related to people showing their distress through their behaviour. This meant the causes and triggers for their distress had not been identified, or adequate guidance given to staff to help them understand and support the person effectively.

The failure to understand and manage risks and keep people safe is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●There had been a high turnover of staff at the service, and consequently they had not yet recruited to full staffing levels. A relative told us, "I feel there is inconsistency and lack of care about the place. They are just so short staffed and new staff don't know the needs of people in there."
● The current staffing arrangements at the home were unclear as rotas were not kept up to date.
● Due to there not being a full complement of staff, there had been a reliance on agency staff. However, agency staff working at the home were not given the personalised information required to inform them about individual people's care, preferences and social needs. This was essential as many people were living with dementia and could not always explain what support they needed and how they wanted this to be provided.
●Staff were not deployed effectively, which put people at risk. On several occasions throughout the inspection, there was an absence of visible staff in communal areas. We observed people who were at high risk of falling were attempting to move furniture and acted to alert staff. Some staff also prioritised putting up Christmas decorations rather than responding to an emergency call bell when a person had become trapped in their bed rails.

The failure to ensure the effective deployment of suitably competent and experienced staff is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had been recruited safely with appropriate checks completed before staff started working. For example, references had been obtained and checks with the Disclosure and Barring Service (DBS) undertaken to ensure staff were suitable to work with vulnerable people living at the home.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At a previous inspection in November 2020 this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of malnutrition and dehydration. Food and fluid charts were poorly completed, showing minimal food and fluid consumption, and indicating the person as receiving a poor diet. There was no oversight of these records, which meant concerns were not identified or escalated, and action was not taken to promote nutrition and hydration.
- There was no oversight of unsupervised people eating their meals in their own rooms, or regular support from staff to encourage them to eat. This increased their risk of malnutrition. Food charts recorded people regularly refused food. A relative told us, "I feel he is losing weight. I know on one occasion, they forgot to bring him a meal. We've insisted he is taken to the dining room for his meals. His breakfast was still sitting on his table at 11am when we went in."
- During 2021, people had not been weighed regularly. This meant their weight was not effectively monitored; health professionals said some people had lost significant amounts of weight. A relative told us, "Since moving here [family member] has lost weight. I asked to see their Care Plan and it did show that this was the case, but there were big gaps in the plan - no regular monitoring."
- People with diabetes were at risk because there was no information in care plans about the support they needed to remain well and safe. They were eating foods which could place them at risk of harm because of their sugar content and the lack of monitoring of blood sugars.
- Staff wrote in records to say a person had eaten before they were given the meal. This meant records indicated people had eaten when this was not the case, exposing them to risk of harm through malnutrition.

The failure to meet people's nutritional and hydration needs is a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

- Staff did not have the training, support and supervision they needed to provide safe and effective care. This placed people at risk of harm. Staff induction, training, supervision and competency assessments were ineffective, leading to unsafe practice and a lack of person-centred care. For example, staff had failed to use bed rail bumpers appropriately and a bed wedge had been wrongly placed by staff, causing friction burns and entrapment.
- An agency cook had been employed. The provider had not checked what skills and knowledge the staff member had. They did not consider that someone who had not worked in residential care would not have the skills or training to meet the dietary needs of people at risk of choking or living with diabetes. Therefore, they could not meet the dietary needs of people who were at risk of choking safely, because the cook did

not have the appropriate knowledge to prepare food safely when people were at risk of choking.
● The majority of relatives who spoke to us did not have confidence in the quality of the care provided by staff. One relative commented, "I accept the care is there 24/7 and the place is clean and tidy, but things are on the slide…"
● We received mixed information from staff about what the induction entailed and when it was needed. Inductions were not included on the staff training matrix. Four people in a group conversation told us that new staff used to shadow experienced staff but not now. They said, "Poor souls just have to get on with it."
●On the first day of the inspection we found there was no collated training record in place to act as an overview of staff skills and training. This meant the management team and the provider did not have oversight to ensure staff had received the training required for their roles, and their knowledge was up to date.
●Training records showed gaps in key areas of training for care staff. For some staff this included training in nutrition, Deprivation of Liberties, safeguarding, oral care and care planning. Records showed no staff had received training in fire safety, infection control and safeguarding.
● The providers processes to check the competency of staff were ineffective. The competency check tool was an unclear assessment tool which did not make it meaningful. Following the inspection, the management team completed staff competency checks for seven staff, covering communication, personal hygiene, pressure care and incontinence care. They found some staff, including senior staff, were not competent in key areas, including the management of risks linked to people's health. These issues had not been identified before the inspection.

Staff were not suitably qualified, competent and skilled to meet peoples' needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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. 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 MCA.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Peoples rights were not protected in line with the MCA (2005). A relative told us, "We're trying to get a DoLS for [family member] since September. They get lost and confused and wait for someone to help them find their room. We ask the care home but still the form they should complete hasn't been sent on to us."
●We observed one person had bedrails in an upright position on their bed. There had been no assessment of the person's capacity to consent to them, or decision made in their best interest to use them. Bed rails had not been included in the person's DoLS application. There was no legal basis for the use of bedrails for this person.
●Care plans did not routinely record that people had consented to their care, or other forms of support.

●People's representatives for people living with dementia who were unable to consent to care themselves were not consulted. Relatives were not involved in best interest decisions linked to changes to people's care or asked to contribute to care plans. Comments included, "They tend to do things without telling us, like when they changed her mattress," and, "I've not been involved in a care plan - I don't know of it."

Care was not consistently delivered with peoples consent and in their best interests. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●The care and support provided did not reflect current evidence-based practice and standards.
● Assessments were not updated or reviewed in a meaningful way. They did not evidence how people had been involved in them. In a multi-disciplinary meeting, staff said there were two people whose needs they were struggling to meet. Their care and mental health needs were known at the time of their admission, which shows assessments were not meaningful.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support.
●Records showed staff worked with a range of community professionals. However, there were issues with communication and expectations which undermined the effectiveness of working together to maintain and promote people's health. For example, health professionals raised concerns about delays in reporting changes to people's health and welfare.

Adapting service, design, decoration to meet people's needs
● Dunmore is an adapted period building. The previous manager had made changes to the décor to promote a comfortable and relaxing environment.
● As an older building, the corridors were narrow and winding making navigation difficult. Moving and handling assessments did not make reference to the narrow corridors and did not guide staff as to how to move people safely. Assessments did not consider how some people might find narrow spaces impacted on their mood or behaviour, particularly when people came face to face and had to move around each other to get past one another.
● In communal areas, there were no items for people to engage with, such as books, newspapers or magazines. We saw people left sitting at dining room tables, opposite one another, with nothing to do but look at one another. We observed some people moved empty cups around the table as something to do.
● Work had started to improve the outside space for people; however, this work had not yet been completed due to the pandemic.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection where this key question was rated it was Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● Throughout our inspection, we saw people were wearing stained or dirty clothing. A relative said when they had recently visited their family member, they were wearing a jumper with stains on it.

● People's dignity was not maintained as staff did not ensure they wore their own clothes. Nine relatives described how people were regularly given clothes to wear that were not theirs. For example, a relative said "[They] are often to be found wearing other people's clothes and I find that upsetting when [they are] wearing someone else's pyjamas or trousers." We saw a staff member give a person a cardigan to wear after they complained of being cold in the lounge. The staff member left the lounge; the person struggled to put the cardigan on as it appeared too small. They kept repeating "This isn't mine." They looked distressed and were tearful. This meant their dignity was not respected as staff did not ensure clothing belonged to them, fitted them or that they were able to dress themselves.

● People's personal property was not kept safe or respected. Nine relatives said peoples' clothes were regularly lost, as well as personal items, such as a hairbrush, electric razor, electric toothbrush, a teddy bear, slippers and glasses. This meant people's belongings were not treated with respect and negatively impacted on their dignity and well-being.

● There was inadequate oversight on the welfare and well-being of people in their bedrooms.
We met a person in bed who was distressed as they wanted to get up and not be in bed. They said, "It is easier for them if we're tucked up in bed." They had been incontinent and were lying on a wet sheet. We immediately went to a senior staff member for them to assist the person.

● Task focused staff practice undermined person-centred care and people's dignity. For example, a person was provided with breakfast in the lounge. They were already distressed and weeping but became more so when the jam from their toast fell onto them and covered their hands. They became anxious about the stickiness on them, trying to wipe the jam off and repeating, "What a mess, there's no napkin." This meant their dignity was not maintained as staff did not ensure they were provided with a cloth to wipe their hands which increased their existing distress.

● People's request for personal care to be delivered by a specific gender was not respected, which impacted on their dignity. A person told us staff did not take any notice of their care plan which stated they had requested female care staff for personal care as sometimes a male care worker was sent to help them. They said, "I have to tell them; I shouldn't have to."

Supporting people to express their views and be involved in making decisions about their care

● People's care records did not routinely show how they were consulted about their care. Their views were not recorded in reviews.

● There was a failure to ensure written records by staff respected people's dignity. The language used was unprofessional and might indicate staff judged people negatively and in an unkind way. For example, staff had written a person's care plan was the statement 'can be very stubborn with her fluid…' In a handover sheet, one person was described as complaining of 'bellyache'. This meant staff did not record in a respectful way and potentially created a culture where people were patronised and disrespected.

Poor care practices at the service placed people at risk of their dignity, privacy and independence being undermined. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection, we saw some staff whose conversations with people and their actions towards them showed they were compassionate and kind. People responded to their kindness and smiled or laughed with them. For example, we saw people dancing with staff in the dining room.

● Relatives said the atmosphere at the home seemed rushed and staff had less time to interact with people. They described staff as "caring and nice", "kind, nice and helpful", "…do their very best" and "most of the staff are pleasant enough and a couple are very close to (X)." However, one relative who said "The care of the individual seems to be missing…" which summed up our observations during our inspection.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●People did not receive personalised care at Dunmore Residential Home.

●Records did not show how people and their relatives had contributed to developing their care plan. Relatives commented "I've not seen a care plan since [relative] moved in and [previous manager] was involved. She phoned me and went through things - that was March this year (2021)."

●Care plans stated they were to be reviewed 'monthly or as changes occur.' This had not happened. Some care plans and risk assessments had not been reviewed since March 2021. People were therefore at risk because staff did not have the up to date information required to meet their needs.

●Where reviews had taken place, they contained little meaningful information. For example, one person's medication care plan review stated, "Unsure of what medication [person's name] is on, but currently no change to medication care needs."

● Care plans contained minimal information about protected characteristics or cultural and spiritual needs. They did not contain the information staff needed to meet people's needs according to their individual wishes and preferences. For example, how they liked to be supported, how they wanted to spend their time, what comforted them, and how their needs should be met. One person's care plan stated staff should, "Be aware of any issues and or situations that may trigger distress for [person's name] and be as proactive as possible." There was no assessment of what the potential triggers might be, or guidance for staff on how to support them when they were distressed.

●During the inspection we observed task focussed practice, and little meaningful staff engagement with people. People were left for long periods of time in wheelchairs or sitting at a table with no interaction from staff. We saw one person weeping and distressed. A staff member went in and out of the room focusing on practical tasks, such as bringing a cup of tea and toast but did not stop to reassure the person. A relative told us, "[Family member] has all her faculties but there's no one to talk to. The care staff used to chat to her, but she says they don't anymore, so she feels isolated and the hairdresser doesn't have time for everyone and [family member] misses that."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Care plans contained minimal information about people's history, hobbies and interests, and how they could be supported to engage with them; whether they were cared for in bed or able to use communal areas. One person's care plan who was cared for in bed had minimal information regarding their hobbies and interests. There was no plan as to how these were to be met and no review to ensure they had been

met.
● The activities member of staff had left the service and there were no activities for people. People told us they were bored and there was nothing to occupy them. We asked one person how they spent their time in their room, and they told us they just cried. A relative told us, "Activities are hit and miss since the person left. They used to do quizzes and games but I'm not sure now. I know she would participate. They take her down to the lounge, but she says she's bored and feels isolated. I'm afraid she's becoming withdrawn."
● People were at risk of deteriorating mental health because there was a lack of support or stimulation. On all three days of the inspection we saw one person walking up and down corridors, spending minimal time in communal areas. They told us, "It's a bit miserable. I don't really see anybody. I don't know where they have all gone." Records showed they frequently became distressed and agitated putting themselves and other people at risk. No action had been taken to understand or address this.
● People's social needs were not supported. We saw a person sitting in a wheelchair alone in the dining room. They were unable to mobilise without help. They had been positioned with their back to the dining room door so they could not see people passing by to speak to them. They had been positioned looking at a wall rather than a window or looking out into the room. There was no call bell for them to use. Their care plan stated they were a 'very sociable lady and likes to be around people.' We went to check on their well-being and asked if they were comfortable. Their facial expression and tone of voice was very angry. We reassured them and went to get staff to assist them.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans were not created in an accessible format for people living at the home to read and review them.
●People who wore glasses, according to their care plan, were seen without them. This was also raised as a concern by relatives. For example, "He has three pairs of glasses, all named, but they disappear, and he walks around with none or someone else's. It's not safe." This meant people were at higher risk of falling and their safety was jeopardised. It also meant people were disadvantaged unnecessarily by making engagement with the world around them more problematic as they could not clearly see people or their environment. This was an issue for people living with dementia who were already struggling to make sense of their surroundings both cognitively and visually.

End of life care and support
●There was no information in care plans about how people wanted to be cared for at the end of their lives. One person's care plan recorded an action to discuss this in July 2021 with their family member, but there was no evidence the discussion had taken place. Another person's care plan said, '[Persons name] is DNAR (Do Not Attempt Resuscitation) but for hospitalisation. No funeral plans in place. Family to deal with.'

People's needs were not being met in a person-centred way. People were not supported to avoid social isolation, and individual needs were not met in relation to maintaining interests and hobbies. There was a failure to ascertain and document people's wishes for the end of their lives. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● When people raised concerns, they were not heard and therefore not addressed. One person told us, "No one notices."

● Minutes from a previous residents' meeting documented complaints about food being cold when it was served. During the inspection four people told us their lunch was lukewarm, and meals were very rarely hot. Another person sent their meal away complaining to a staff member it was cold. We raised this issue with the management team who told us they were unaware of the problem, despite people raising it previously.
●All of the relatives we spoke with told us action had not been taken to address on-going complaints, despite bringing it to the attention of staff and the manager. These complaints included lost clothing, missing personal items, poor food quality and quantity, people wearing clothing belong to others, poor personal care, poor monitoring of skin damage and weight loss.

The failure to acknowledge and act on complaints is a breach of regulation 16 (Receiving and acting on complaints) 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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to assess and monitor the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. This is the third time the provider has been in breach of this regulation since January 2020.

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

- Dunmore Residential Home was inspected on three separate occasions in 2020. During 2020, there were a number of concerns raised by whistle-blowers around the running and management of the home. These concerns have re-surfaced in 2021, and again CQC were contacted by whistle-blowers in connection with the running and management of the home.
- Following our inspection in September 2020, we served a Warning Notice because there was a failure to ensure the governance of the service was effective. The compliance date was 1 December 2020. Shortcomings persist meaning the Warning Notice has not been met.
- Systems and processes to monitor and check the quality of care were not established and/or did not operate effectively to ensure compliance with the regulations. There was a failure to act upon feedback and an enforcement notice from previous inspections to address shortcomings and become compliant with the regulations. As a result, people were exposed to the continued risk of harm and poor care.
- During our inspection, the manager and area manager said they were unaware of a Warning Notice being served in connection with Dunmore Residential Home. The provider had failed to ensure the staff members chosen to stabilise and manage the service were aware of the home's previous enforcement history and the previous poor governance of the service. The provider had not ensured relocated managers had the information they needed to help them review the quality of care at the home.
- The provider told us during the inspection they were not aware the Warning Notice had not been met. They had not monitored the work of their Nominated Individual and therefore this meant there was ineffective monitoring of the quality of care in the service to achieve compliance.
- The provider relocated management staff, including an area manager, from other services they owned. However, these staff failed in their remit to assess and review the safety and well-being of the people living at the home. The area manager said they were "shocked" when they reviewed people following our

feedback on people's poor care and experiences. They had been working at Dunmore Residential Home for 6 weeks and had failed to identify or address any of the concerns that we have highlighted in this report.

● The provider had not learnt lessons from previous management structures and arrangements which have failed. For example, the dual roles of registered manager and area manager were not effective as this had been tried before and failed. The provider told us the current manager of Dunmore Residential Home would be supported by a new appointment of a manager at another of their local homes, who would also be the area manager. This meant one person would be responsible for directly managing one home, supporting the manager at Dunmore, and they would also be responsible for overseeing other homes.

● There was a failure to ensure company policies were effectively written and implemented. For example, there was a failure to implement the policy for external contractors working at Dunmore Residential Home. The policy states a risk assessment outlining how they would make the area they are working in safe while work should be carried out. This should include risks relating to when contractors were present and when they were not present, focusing on the area where the work was being carried out. This had not been done in relation to current work being carried out by contractors in the home at the time of inspection.

● There were no effective systems or processes in place to ensure the records which were kept in people's rooms reflected their current care needs. This was particularly important as many shifts included agency staff who were not familiar with people's needs. This meant records were inaccurate, contradictory and could potentially put people at risk of harm of practice which was no longer appropriate and potentially unsafe.

● There was a failure to ensure effective monitoring of the day to day care provided at the service. Manager 'walkaround records' had been introduced but were poorly completed with sections left blank. It was unclear, what action, if any, had been taken to reduce the risks identified in records completed by a variety of staff, for example where there were gaps in records, or where records indicating people had not had anything to eat or drink. This meant people were at risk of harm because poor practice was not identified, and action taken to ensure it did not happen again. People's lives were impacted by a poorly run home; they were not protected from poor care.

Continuous learning and improving care

●There were ineffective systems to identify that people had their own clothes and possessions, received timely personal care and were treated in a respectful and dignified manner. A lack of oversight relating to the experience of people meant shortcomings were not identified. As a result, people were not treated with dignity and respect in a way that ensured their privacy and supported their autonomy and independence.

● There were inadequate systems and processes in place to ensure fire safety concerns identified by the previous Nominated Individual were addressed in a timely manner to keep people safe. In November 2020, the Nominated Individual assessed there were 15 areas rated as high priority, including fire safety in the home. In May 2021, six months later there were still nine areas rated as high priority, including two further points in connection to fire safety. During the inspection, we were told work was in still in progress to update people's individual fire evacuation plans. Thirteen days later these were still incomplete.

● There were inadequate systems to regularly monitor staff skills and training. For example, there was not a system to monitor staff inductions to ensure staff were made aware of relevant policies, as well as ensuring they had access to training suitable to their role. Staff did not routinely receive supervision or competency checks to ensure their practice was safe and to support them to meet people's needs.

● The current staffing arrangements at the home were unclear as rotas and training records were not kept up to date. Despite many people living with dementia, staff training in dementia awareness was not prioritised. This meant people were at risk of inappropriate care causing unnecessary distress, which put staff and other people at potential risk of harm.

● Environmental quality assurance processes were poorly completed. For example, empty rooms, which were accessible to people living with dementia, contained trip hazards and potential hazards, such as a

heavy door propped against a wall. These risks have not been recorded or acted upon.
● Quality assurance processes failed to identify action had not been taken to prevent the risk of dehydration with poor fluid intake. Nor had these processes addressed the risk of people becoming malnourished and dehydrated and experiencing significant unplanned weight loss.
● There were no systems or processes in place to monitor the standard of care delivered by care staff. For example, to ensure all people received appropriate oral care on a regular basis in line with their individual needs.
● There were no systems or processes in place to ensure all people received regular and person-centred support with personal care to ensure they were clean; their skin was undamaged, and their dignity respected.
● Quality assurance processes had failed to address the fact that there was a lack of stimulation for people at the home, including for those cared for in bed or people living with dementia. There was a high risk of people becoming withdrawn due to lack of social stimulation.
●There were no effective systems or processes in place to ensure all staff understood people should wear their own clothes and no system to ensure this was happening, to maintain people's dignity and self-respect.
● The management of medicines was not effectively audited. For example, medicines were being stored at an inappropriate temperature. This had not been identified through the audit system. Issues with the storing and recording of medicines needing enhanced security had not been identified through the audit system. The audit system had not identified that medicines to be given as required were not accompanied by sufficient guidance for staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; 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
● People told us, "There's something wrong at the moment". They described how there had been a lot of changes since the previous registered manager had resigned. They said they weren't informed about changes or introduced to new managers. They said, "No communication at all, we don't get told anything at all." This meant people were left feeling unvalued and not treated as equals with opinions and views that counted despite them living at the home longer than many of the staff who worked there.
● There were no systems or processes in place to ensure all people had input in devising their care plans which would have made them more person centred and shown their consent to the contents of the plans ensuring they reflected their needs and preferences.
● The previous registered manager had ensured a monthly newsletter kept people and their relatives up to date with life at the home and plans for change. People praised this form of engagement. However, they said this was no longer the case. A group of people said there were no residents' meetings and one said, "We would like to know more, to be kept in the loop."
● There were no systems or processes in place to ensure all people's care was reviewed at least monthly or sooner, if needed, and where appropriate their families involved in this action. Some care plans had not been reviewed since March 2021and were therefore out of date. This was confirmed by relatives who had requested to see care plans because of their concerns about the poor care at the home.
● People had complained about missing clothing when it was sent to the laundry, which was recorded in a residents' meeting. Conversations with people and relatives during this inspection showed the provider had failed to resolve these issues. Quality assurance processes failed to ensure complaints were managed effectively. The provider failed to act on the feedback of relevant persons, including people living at the home, in order to drive improvement in the service.

Poor governance placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care People using the service did not receive care which was appropriate, met their needs or reflected their preferences.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People using the service were not treated with dignity and respect.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not consistently delivered with peoples consent and in their best interests.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not well managed to keep the safe. People using the service were not protected from risks associated with the management of medicines; the spread of infection; and deteriorating physical and mental health.

Systems were either not in place or robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

Notice of Proposal to cancel location

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 Poor safeguarding systems, processes and practices at the service, placed people at risk of harm.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were placed at risk because their nutritional and hydration needs were not met.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People were at risk because complaints were not acknowledged or action taken to address them.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were at risk because there was a lack of oversight by the provider. The systems in place to assess and monitor the quality and safety of the service were ineffective.

The enforcement action we took:

Notice of Proposal to cancel location

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not suitably qualified, competent and skilled to meet people's needs.
Staff were not deployed effectively.

The enforcement action we took:

Notice of Proposal to cancel location