West Bank Residential Home Limited

Dunmore Residential Home

Inspection report

30 Courtenay Road
Newton Abbot
Devon
TQ12 1HE

Tel: 01626352470
Website: www.bucklandcare.co.uk

Date of inspection visit:
17 September 2020
23 September 2020

Date of publication:
12 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dunmore Residential Care Home is a residential care home providing personal care and accommodation to 20 people aged 65 and over at the time of the inspection. The service can support up to 32 people in one adapted building, with bedrooms located over four floors accessed by a passenger lift.

People's experience of using this service and what we found
People who were able to comment on their experiences of living at the home told us they were satisfied with their care. Other people living with dementia responded positively to individual staff members. They showed through their actions and facial expressions they felt at ease with staff.

A new manager started working at the service in at the end of June 2020. They became the registered manager in September 2020 after being interviewed by the Care Quality Commission. Since their appointment they have shown a strong commitment to improve the quality of care at the home and ensure staff have access to appropriate training and supervision. This was work in progress and will be reviewed again at our next inspection.

Some aspects of risks to people's health and safety needed further improvement. This specifically related to the care of frail people living with dementia who required staff to be vigilant to risks to their health and safety. Work continued to help the staff group understand the importance of accurate records, improve their understanding of person centred care and address unmet training needs and supervision. During the inspection, improvements were made by the registered manager and staff in response to CQC feedback.

Work was on-going to establish effective quality assurance systems to monitor and review the quality of care at the home, and the competency of the staff team.

The current staff group have praised the leadership of the registered manager. They recognised the importance of changing the culture of the home to make it a safe and caring home for people to live. Health and social care professionals have also commented on improved communication between staff and external agencies, which has been beneficial to people living at the home. The providers continued to invest in the service with environmental improvements, additional staff posts and have reviewed their own roles and the effectiveness of their quality assurance systems.

Rating at last inspection and update
The last rating for this service was Requires Improvement (Published September 2020) with three breaches of regulation. After the last inspection, the provider completed an improvement action plan to show what they would do and by when. At this inspection, we saw how some of these changes had been implemented. However, there was still further improvement needed to monitor risks to the health and well-being of some individuals. There were two breaches of regulations. Changes to how the quality of the care was monitored needed to be embedded and sustained. On this inspection, the service remained Requires Improvement.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about people's safety. These incidents were subject to individual safeguarding investigations. A decision was made for us to inspect and focus on people's health and well-being, suitability of staff and quality assurance. We inspected and found there had been an improvement in the recruitment process. However, we remained concerned about the management of risk, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe and Well-led.

Enforcement
We have identified two on-going breaches in relation to keeping people safe and managing and running the service. Following our inspection in July 2020, we issued a warning notice in relation to the running of the home. This provides a timescale for the registered manager and providers to make improvements, and sustain them, otherwise further enforcement action will be considered. The timescale for compliance was 1 December 2020.

Follow up
The provider has sent us a regular updated service improvement plan listing the action taken to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

We will carry out another inspection to check if the warning notice timescales have been complied with. If we receive any concerning information we may inspect sooner. We will have a meeting with the provider to discuss the outcome of this inspection.

You can see what action we have asked the provider to take at the end of this full report. For more details, please see the full report which is on the CQC website at www.cqc.org.uk You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dunmore on our website at www.cqc.org.uk.

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 always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

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
Two inspectors completed the inspection.

Service and service type
Dunmore 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.

Notice of inspection
We gave a short period notice of the inspection so we could arrange infection control measures because of the COVID 19 pandemic.

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, including the most recent service improvement plan. We attended safeguarding meetings led by the local authority. We sought

feedback from the local authority and health professionals who work with the service. We met with the providers and the nominated individual as part of our monitoring role of the provider's ten care homes.

During the inspection
We spoke with five people living at the home to explain our role and observed how staff supported them. During the inspection, we spoke with 12 staff including the registered manager, area manager, care staff and ancillary staff. We reviewed four care records, two recruitment files, induction and training records, accidents/ incidents forms, quality assurance records and audits. We also checked people's medicine administration records. Two health professionals provided feedback following the first day of inspection on behalf of their teams, and a social care professional updated us on recent reviews of people's care needs.

After the inspection
As part of the inspection, we requested and received copies of audits, an action plan, care plans, staff rotas and monitoring checks connected to the running of the home and people's welfare. We provided written feedback after the first day. We also met with the providers and the registered manager to provide detailed verbal feedback following the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks for some individuals continued to be poorly assessed and monitored. Records for people's meals and fluid intake continued to be poorly completed, which potentially put people at risk. During the first day of the inspection we shared with the management team our serious concerns regarding how one individual was supported with pressure care, food and drink. In response, the registered manager and other staff worked additional hours to address the potential risks around well-being and safety for this individual and others with similar needs. Community nurses visited the home over the following weekend and confirmed the person's physical care needs were being met.

● No information was available to guide staff on how much each person with a fluid chart should drink to maintain their health. Fluid recording charts were in place but were not reviewed. This meant an identified risk of dehydration was not being monitored. During the inspection, the registered manager addressed this issue.

● Food charts were ineffective as they were not reviewed to ensure people were being supported to eat adequate amounts. According to the daily entries for one person, on some occasions they were only offered one meal a day. The registered manager said this was not accurate; we saw staff were regularly reminded on handovers to complete records in a timely and accurate manner. There was no record of these charts being reviewed, which meant an identified risk of malnutrition was not being monitored. By the second day, this had been addressed and systems were in place for a review at the end of each shift, which was then reviewed again by the deputy or registered manager.

● Equipment was available to weigh people and records kept; staff said there was no one at the home with significant weight loss. However, one person's health had significantly declined. They were too frail to use the seated scales and an alternative method to assess their weight had not been sought. This meant their weight was not being effectively monitored. Staff could not show if the person's pressure mattress setting was correct as they had no recent record of the person's weight. However, there was no evidence of harm to the individual who smiled at staff and looked well cared for; staff could describe the care they needed to provide to them.

● Following our last inspection, significant work to create meaningful care plans for each person had taken place. However, for one person whose care needs had significantly increased in the last four weeks, the information was contradictory and had not been effectively reviewed. They now needed staff to assist them with meals while they were being cared for in bed. Following our feedback, the registered manager amended the care plan to reflect the person's high care needs. This included positioning them correctly when they were supported with food and drink.

● Measures to manage pressure damage were not monitored effectively. For one person with a pressure sore, there was contradictory information about how often they should be turned. Guidance for staff was not clear how to reduce the risk of further damage. We met with the person and the registered manager said

staff had not positioned the person correctly. They immediately began work on the person's care plan to update it and ensure staff had clear instructions about how often to move the person and how to position them.
● One person living at the home had received an injury after falling out of bed. This incident is being investigated under local safeguarding procedures.
● Fire training had not been provided for 17 staff of the 29 staff currently working at the home. Fire equipment records showed there were gaps in safety checks. There had been delays in addressing high priority work in a fire risk assessment completed in July 2020.

These examples are an on-going breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to effectively mitigate risks to people which placed them at risk of harm.

● By the second day of our inspection, work had started to address the above concerns, including contacting health professionals for advice. Additional care guidance had been put in place for staff, with clearer instructions. We met again with an individual who needed increased support, whose care records we had reviewed on the first day. They looked relaxed as a staff member supported them with breakfast. The staff member showed good person centred practice, for example tone of voice, positioning and eye contact. The person smiled at them and there was a positive connection between them, which resulted in the person eating more than usual.
● Following the inspection, we met with the providers and the registered manager to give formal feedback. Fire training for all staff was being arranged and work was starting to make changes to the environment in response to the fire risk assessment recommendations. The registered manager said work was now being taken in response to the risks identified in the fire risk assessment. On our last inspection, hot water temperatures were checked but action was not taken to address unsafe water temperatures. Thermostats have now been fitted which regulate the temperature of the hot water to keep people safe and staff know to report changes.
● Staff were able to outline the key points of people's care needs and knew them as individuals.
Since our last inspection, work to improve the quality of information for staff had begun regarding people's individual care needs. This was still work in progress. Following advice from an external quality assurance company who audited the service's care plans, information was being reviewed again to provide practical and personalised guidance for each person.
● Where people showed distressed or anxious behaviours there were now plans to guide staff on how to support the person. Following feedback, the registered manager was making further improvements to guidance to help staff respond in a consistent manner.

Staffing and recruitment
● Enough improvement had been made at this inspection and the provider was no longer in breach of the regulation linked to recruitment. Following their appointment in July 2020, the registered manager had tightened the recruitment process. Each individual staff member's file had been audited to ensure they contained the necessary documents to prove applicants were suitable to work in care. Previous employers were being contacted again, where necessary.
● There were staff vacancies across different roles within the home. The registered manager used observation as part of their interview process to see how candidates interacted with others. A staff member commented the registered manager was recruiting staff better suited to the job.
● Since the last inspection, there had been further staff resignations and dismissals. Six new staff had been recruited, with more staff being interviewed.
● A new member of staff was trying to get to know people but said they would have benefited from a written

summary, for example with people's names, care needs and room. By the second day, a comprehensive written summary of people's needs had been produced, which included key information. The registered manager said the summary sheet would be shared with new staff and agency staff.

● Agency staff were also part of the staff team, most of whom regularly worked at the home. After the first day of inspection, improvements had been made to the handover sheet to provide pertinent information to staff starting each shift; the quality of written information was improving.

● Since the last inspection, staff deployment had been reviewed using a dependency tool to calculate staffing levels on each shift. We reviewed the outcome with staff and found discrepancies regarding people's level of need; we were told the tool was now under review. Since the inspection, the registered manager told us, "Staffing levels are higher than the dependency tool so not short staffed in the home." A safeguarding alert was made to the local authority when a person had fallen out of their chair and was found under a table by a member of the maintenance team as care staff were elsewhere in the building. They had been identified at risk of falling. Since this incident, changes have been to help keep them safe. Following the inspection, the registered manager told us, "We have not changed the staffing levels since the incident, just better time management is being carried out."

● The registered manager clarified the current staffing levels for 20 people living at the home, which had been reinstated after the fall. The day shift was five care staff, which included a senior. At night, there were three care staff, which included a senior. They were supported by housekeeping, laundry and domestic staff, as well as the management team.

● The registered manager and deputy manager had worked additional shifts over a weekend in September 2020 to cover staff sickness and boost staff confidence. Staff reported they were positive role models, showing how a shift could be run, which had created a positive impact on the atmosphere of the home and staff morale.

Systems and processes to safeguard people from the risk of abuse

● The registered manager had reported safeguarding concerns in a timely manner to appropriate agencies and continued to work with staff to remind them of their safeguarding responsibilities. Staff were aware of their responsibility to report poor and abusive practice.

● This inspection was in response to a safeguarding incident where a person was injured. Moving and handling training was being prioritised to address staff training needs and to reduce the risk of further incidents. A new company trainer started on 12 October 2020. The registered manager was also trained to deliver moving and handling training so had informally assessed staff members' practice.

● Since the last inspection, there have been further concerns raised about the quality and safety of individual people's care. The local authority safeguarding team was overseeing the investigation of these individual concerns but some care records relating to specific incidents were missing. This was being investigated.

Learning lessons when things go wrong

● Changes to the staff culture in the home were on-going. There was a commitment led by the registered manager to ensure the staff group recognised they were working in people's home rather than a work place. And therefore, needed to adapt their approach to be more person centred and respectful about the way information was shared and care provided. Infection control measures were being reviewed on how to respond to people with suspected Covid-19.

● There was acknowledgement from the management team and the provider work was on-going to create a positive person centred culture. Their aim was to create a positive and supportive working environment within the home where all staff felt equal and able to express concerns. Staff told us they felt confident to report concerns.

Using medicines safely

● A new electronic system was being introduced as part of an action plan to improve the running of the service. The registered manager continued to make improvements to the current medicines system. Staff spoke positively about a new colour coding system for medicines, which made them easier to identify.

● Staff were trained by shadowing a more experienced team member. The registered manager described how they informally observed staff administering medicines to check their practice was safe. There were plans to ensure all staff completed medicines awareness training, and for competency checks to be recorded.

Preventing and controlling infection

● In September 2020, a visiting health professional made a safeguarding alert regarding infection control practice at the home. Staff had attended external training on Covid-19 and the use of PPE. Staff had access to personal protective equipment such as aprons and gloves (PPE) to stop the spread of any potential infection and some had received training in managing infections. Some staff were not routinely wearing masks when they worked together in the home's office; this has now been addressed. We have also signposted the provider to resources to develop their approach.

● The service had invested in systems to measure people's temperature before entering the building. A system had been created to monitor tests for COVID-19 and the outcomes for staff and people living at the home.

● The registered manager requested written confirmation regarding a negative Covid-19 result before people returned from hospital.

● There were no on-going unpleasant odours in communal areas. The newly registered manager had revised the cleaning schedules to make them more effective. Staff understood infection control with regards to laundry.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as Inadequate. At this inspection this key question was rated as Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Following our inspection in July 2020, we issued a warning notice in relation to the running of the home. This provides a timescale for the registered manager and providers to make improvements, and sustain them, otherwise further enforcement action will be considered. The date for completion has not yet been reached. We will carry out another inspection to check if the warning notice timescales have been complied with.
- The service remained in whole home safeguarding which was overseen by the local authority, who were also investigating new individual safeguarding concerns. New admissions had been suspended.
- Work was progressing to make care plans and care records meaningful, but these improvements needed to be sustained. Following our last inspection, care records were reviewed for each person living at the home. On this inspection, one person's care needs had changed significantly but their new care plan had not been comprehensively reviewed to reflect the increased risks to their health and well-being. Staff guidance had not been updated. During the inspection, a new care plan was written which gave staff improved guidance and reflected the person's current care needs.
- The provider's previous management and governance processes had not been effective to ensure the safety and quality of the service. Before this inspection, feedback during a meeting gave assurances of improved recording in care records. However, we saw this was not the case for an individual who was at high risk of pressure sores, dehydration and malnutrition. Staff had not recognised the importance of reviewing charts to ensure people had been turned at regular intervals or eaten and drunk regularly. This was fed back following our first day of inspection, and by our second day of inspection we saw improvements in the quality of recording. For example, the registered manager improved the systems to review the individual's health. They also provided improved guidance, for example how to position the person, including when they were being supported to eat and drink.
- To enhance the quality of training, the providers had created a new role within the company by recruiting a fulltime trainer for their care homes who started on 12 October 2020. Formal inductions, safeguarding and moving and handling training were being prioritised. Some staff said they did not feel confident in delivering some aspects of care, such as catheter care or using equipment, which the registered manager said would be addressed. Staff gave positive feedback on recent epilepsy awareness training, which was delivered to a group of staff rather than on-line.
- As on our previous inspection, new staff and some permanent staff had not received a robust induction. Their competency was not being formally assessed and much learning was based on shadowing other staff members. As a temporary measure, the registered manager completed an induction session with new staff

and paired them with staff who were more experienced. Since the inspection, the registered manager has confirmed staff inductions and supervisions were being prioritised by the new trainer and the management team.
● The high number of staff changes meant the majority of current staff had not received fire training or attended a fire practice. The providers explained some of the delays had been linked to external trainers and contractors not being available during the pandemic. However, they had not ensured fire practices had taken place in the meantime. The providers said this was being addressed by employing an external trainer and would now be prioritised.

This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to ensure the governance of the service was effective.

● The new manager has now registered with CQC. They have been in post since July 2020; staff were positive about their impact on the running of the home. For example, their approachability and role modelling. They advocated for the people living at the home by promoting good working practices, which aimed to put people living at the home central to the changes in the way the home was run. People's rights were better protected as applications for deprivation of liberties assessments were now in place.
● Staff were motivated and positive. Staff praised the support of the registered manager and the deputy manager describing them as being 'hands on' , making time to assist and support them. A staff member summed up many of their colleagues' comments by saying they were starting to be a good team, "We are learning from each other… We need to do everything properly and follow the rules. We are putting into practice something new and need more time. The priority is the residents."

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 registered manager and the providers have provided requested information in a timely manner; they have been open to advice and making improvements to the service, including increased investment, recruiting new staff and creating a new training role. A service action plan was reviewed monthly and showed action had been taken to address multiple areas of improvement including people's safety, staff training, environment and quality assurance.
● There was recognition that these changes had to be embedded and sustained to give commissioners, other agencies and the regulator confidence that people's health and well-being were consistently met.

Continuous learning and improving care; Working in partnership with others
● Community healthcare professionals and the local authority quality improvement team continued to work with the service to monitor people's safety and well-being. The registered manager had spent time building positive relationships with health and social care professionals, they said appropriate referrals were being made in a timely manner and their advice was followed. There was also improved records of these calls and the advice given.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Work was taking place to build improved communication with people using the service and their families. The registered manager explained how they had consulted with people about the environmental changes to the home and re-introduced meetings to gather feedback. People's families had been sent photographs to show the changes, which included new accessible outdoor space, new lounge chairs and carpets, and a change to the layout of communal rooms. The impact of living with dementia was considered in the choice

of colours, changes to lighting, the layout of the home and signage.

● The providers had spent more time at the home, including talking to staff individually to gain their feedback; staff valued this opportunity which they found beneficial. The registered manager had regular contact with the providers and said they were open to making improvements and were supportive.

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

● Some people enjoyed activities in the new lounge, they were laughing and singing. Some staff connected particularly well with individuals; people looked relaxed with them and responded positively. The re-positioning of the dining room made for more space for people and staff to move around. The atmosphere was calmer than at our previous inspection with less call bells ringing, no loud walkie talkie conversations and staff not talking loudly with each other in corridors.

● The management team acknowledged there was still further work to embed an improved staff culture. where they recognised Dunmore was the home of the people who lived there and not just a place of work. Most staff were positive about future training opportunities and recognised the benefits the changes had made to their practice and the lives of people living at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to effectively mitigate risks to people which placed them at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure the governance of the service was effective.

The enforcement action we took:

We issued a warning notice which provided a timescale for the provider to make improvements.