West Bank Residential Home Limited

Dunmore Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dunmore Residential Care Home is a residential care home providing personal care to 23 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.

People's experience of using this service and what we found
People who were able to comment on their experiences on living at the home described staff as kind and caring. Other people living with dementia responded positively to the staff group. They showed through their actions and facial expressions they felt at ease with staff. However, a number of people said they were bored and under stimulated. Relatives who gave us feedback were reassured and positive about the care provided at the home, although others expressed how they had lost confidence following a safeguarding incident which triggered this inspection.

During the inspection, improvements were made by the new manager in response to feedback and their own findings. They had begun working with the staff group to help them identify areas where they needed support, further training and where necessary undertaken disciplinary action. However, ineffective monitoring of the service had resulted in a number of areas for improvement, some of which had been previously identified by CQC and other agencies, such as the management of risk to people's health and safety. Improvements noted in the previous CQC inspection had not been sustained, and there had been significant changes within the staff and management group.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.
Rating at last inspection and update The last rating for this service was Requires Improvement (Published 21 April 2020) with one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulation. The service remains rated Requires Improvement with a rating of Inadequate for the key question Well Led.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about people's privacy and dignity. A decision was made for us to inspect and examine those risks.

We inspected and found there were a number of other areas for improvement, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

The information CQC received about the incident indicated concerns about the management of people's

privacy and dignity; following which several staff were dismissed. This incident was subject to a safeguarding investigation. As a result, this inspection did not examine the circumstances of the incident. Instead, we focussed on people's health and well-being, suitability of staff and quality assurance.

Enforcement
We have identified three breaches in relation to keeping people safe, recruiting staff, managing and running the service.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will have a meeting with the provider.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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.

Inspection team
Two inspectors and a medicines inspector 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.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service

During the inspection
We spoke with ten people living at the home to explain our role and observed how staff supported them. We

used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not comment directly on their care. We spoke with 11 staff, both during the inspection and by making phone calls to them, including the new manager, area manager, the nominated individual, care staff and ancillary staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Four relatives shared their views on the service with us.

We reviewed five care records, three recruitment files, induction and training records, accidents/ incidents forms, quality assurance records and audits. We also checked seven people's medicine administration records in detail. We checked storage arrangements, policies and procedures, medicines audits and records. A health professional provided feedback following the first day of inspection.

After the inspection
As part of the inspection, we requested and received copies of audits and monitoring checks connected to the running of the home and people's welfare.

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 people were not always 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 provider was still in breach of regulation 12.

- Risks were poorly assessed and monitored. During the first day of the inspection we shared our serious concerns over the management of risks to people with the management team, nominated individual and the provider. In response, the area manager and new manager worked additional hours over the weekend to monitor people's well-being and safety. We also shared our concerns with external professionals who arranged for a community nurse to visit the home over the weekend. Following their visit to several people living at the home, they advised their physical care needs were being met.
- Risks linked with people's health and mental well-being were poorly managed. For example, there was no guidance for staff on how to support individuals effectively, such as how to care for a person with an invasive catheter. Records showed the person had been in discomfort around their catheter area; staff said they had not been trained to provide catheter care.
- Risk assessments had not been reviewed and updated following significant events. For example, an incident between people living at the home, resulting in one person being hit by another.
- Plans and records did not support staff to identify and mitigate risks associated with people's health, such as pressure damage to their skin. For example, the records for a person, whose physical health was declining and who was at risk of pressure damage. They had not been updated to highlight how the risks to their health had increased and how the risks could be reduced.
- When risks had been identified, such as how food should be prepared to prevent choking, food was not prepared appropriately. Despite an incident at the home in 2019 regarding choking, staff had no current list of people's special diets in the kitchen. For example, preparing food to reduce the risk of choking and adapting the presentation of food to suit people with few or no teeth. We met a person, whose meal had not been appropriately presented and had not been provided with equipment, such as a spoon and a straw, to aid their independence. By the end of the first day, the new manager had ensured kitchen staff had a written list of how people's food should be prepared and served.
- Some people were at high risk of falls. There were no falls risk assessments in place and no guidance to staff. For example, one person had 12 recorded unwitnessed falls but there were no monitoring forms or a falls care plan to reduce the risks to their safety.

● Records for people's meals and fluid intake were poorly completed. Fluid recording charts were in place but not reviewed. No information was available to guide staff on how much each person should be drinking to maintain their health. This meant the records were ineffective as they were not reviewed to ensure people were being supported to drink adequate amounts.
● Where people showed distressed or anxious behaviours there were no plans to guide staff on how to support the person. For example, guidance and support provided by the Older Person's Mental Health Team had not been incorporated into people's care plans. People's reactions to events which led to behaviour that put themselves or others at risk of harm were poorly recorded and not reviewed.
● At the last inspection, we identified hot water temperatures needed to be monitored to reduce the risk of scalding. Records continued to show hot water temperatures in some people's rooms were consistently unsafe with no action taken to address the risk.

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.

● The first day of inspection took place in the new manager's first week. They had already identified the quality of care records and assessments was poor. They had produced a prototype care plan for a person living at the home to demonstrate to staff what information an effective care plan should contain. Following our feedback, by the second day the new manager and staff had begun to collate a 'pen' picture of each person living at the home to ensure all staff had access to key pieces of information about each individual's care and life history.
● By the second day of inspection, the new manager had begun to review other people's care plans, and make amendments, to identify risks to people's health and safety. They prioritised people with the most complex or unstable care needs. Care plans were better organised making them more accessible. Staff said they had not previously been encouraged to read care plans and did not always recognise their purpose.
● Work had started to improve the completion and reviewing of food and fluid charts. The new manager had taken action to arrange training to support staff to understand the experiences of people living with dementia. The new manager was also addressing the tracking of falls and the completion of incident/accident forms.
● During the inspection, a plumber visited the home to fit equipment to control hot water temperatures.

Staffing and recruitment
● The system to request references was poor, previous employers were not requested to provide confirmation of the applicant's good character. For example, for one staff member who had worked in care before there had been no verification of the reasons why they had left another care provider's employment. There was an over reliance on references from friends of the applicant. The importance of references to judge people's suitability for their role had not been recognised, which put people at risk of unsuitable staff working at the home.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to ensure fit and proper person were employed.

● However, identification documents and police checks were completed. The new manager and new area manager said recruitment procedures would be tightened and recognised the potential for people unsuited to care work being recruited under the current practice.
● There continued to be a high turnover of staff, which meant over half of the staff team had been in post for less than six months. Inductions for new staff were poor or had not happened. For example, one staff

member said they nearly left at the end of their first shift because of the lack of support. They said information was not shared with them about the running of the home and the needs of people living there. They were persuaded to stay and learnt from colleagues but had no formal structured induction. Their competency had not been assessed, despite moving frail people using equipment. There was the potential for new staff to learn poor practice from other staff members, who had also not completed an induction or practical training in moving and handling.

● During the inspection, we shared our concerns regarding the lack of competency checks around moving and handling practice and the potential risks this posed to people's safety. By the second day, the new manager, who said they were a qualified moving and handling trainer, had started addressing staff practice. We saw examples of improved moving and handling on the second day of inspection.

● Risks from poorly completed records or from a lack of information were compounded by the number of new and inexperienced staff working at the service. Staff explained they had not completed training to fulfil some of their duties, which was confirmed by training records. For example, some staff did not feel confident in completing tasks allocated to them, such as catheter care. Several described how they had learnt as they went along. However, we saw how several staff had been recruited from a non-care background, then not provided with an induction or training and then were paired with newer staff.

● Following disciplinary actions, there were vacancies across different roles within the home which the new manager was addressing through a recruitment campaign. In the meantime, agency staff were used to cover shifts at night. The agency ensured it was the same two staff members who provided this cover, so the new manager was reassured they knew the people living at the home well. The new manager had assessed the deployment of staff on each shift in light of the vacancies at the home. They said it was work in progress to improve how staff worked as a team so they could meet people's social and care needs in a more person-centred way.

● Due to bedrooms being located over four floors, staff had been issued with walkie-talkies to ensure they could respond quickly when assistance was needed. Records documented staff had been reminded to respect people's privacy in the way they shared information when using the equipment. On the first day, the use of this equipment was intrusive as the volume was loud which we fed back, and this had improved by the second day of inspection.

● People told us they felt safe, some people understood the purpose of call bells and said staff responded quickly when called. Records showed staff had been reminded to ensure people had accessible call bells. This followed an incident when a person became distressed at not being able to call for help. On the first day of the inspection, we saw there was not a system in place to check on the well-being of people who could not understand the purpose of a call bell. The new manager addressed this by introducing a formal system for staff to record people's well-being on a regular basis.

Preventing and controlling infection

● There were no on-going unpleasant odours in communal areas and people said they were happy with the cleanliness of the home, for example their bedroom. The new manager had introduced new cleaning schedules as part of the service improvement plan.

● 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. However, during the inspection, we saw some staff did not follow best practice guidelines, which we fed back during the inspection.

Systems and processes to safeguard people from the risk of abuse

● On our previous inspection in January 2020, Dunmore had been the subject of concerns being raised about the quality and safety of people's care. These had been reviewed by the local safeguarding team. Community healthcare professionals and the local authority quality improvement team had supported the

management team to address the concerns.
● This inspection was in response to a safeguarding incident involving some staff which undermined two people's dignity. As soon as the area manager was made aware of the incident, they took appropriate action with the support of the new manager who had just started working at the home. However, the incident highlighted a culture where some staff did not recognise their responsibility to report poor or abusive practice. This was despite most staff completing on-line safeguarding training. The new manager said they were qualified to provide internal safeguarding training and had met with the staff group to discuss learning from the incident. They planned to review the training available to staff to ensure it was effective and meaningful.

Using medicines safely
● We saw that there had been some improvements to the way medicines were managed since our previous inspection.
● People's medicine administration record (MAR) charts were completed when doses of medicines were given. However, we found a few occasions where a dose had not been signed for or the quantity was not recorded where a variable dose had been prescribed.
● When medicines were prescribed to be given 'when required' we saw that clear, detailed and person-centred protocols had been written to guide staff when it would be appropriate to give doses of these medicines. However, improvements could be made to the way these were recorded on the MAR charts to make it easier to check how often doses were given when reviewing medicine use.
● There were systems in place to record the application of creams and other external preparations. Recent audits had highlighted that these were not always being recorded and a new system had been put in place to try to improve this. We saw that clear directions and body maps were available to guide staff how to apply these products. Records had improved; however, we saw some gaps in two people's records where it was not clear if preparations had been applied in the way prescribed.
● Medicines were stored securely. Storage temperatures were recorded and monitored, however the maximum and minimum temperature range in the refrigerator was not being recorded.
● Staff told us that they received medicines training and had competency checks to make sure they could give medicines safely. The new manager informed us that these competency checks were about to be updated for all senior staff who gave medicines. We saw that regular medicines audits were undertaken and areas for improvement had been identified and actions taken.

Learning lessons when things go wrong
● As identified on the last inspection, accident and incident reporting forms continued to be poorly completed and lacked detail. They did not prompt or guide staff on immediate actions to take. For example, if there had been altercation between people, what action to take to reduce a reoccurrence.
● The new manager and area manager had been proactive in responding to a recent safeguarding event in the home and staff had been dismissed. They both acknowledged the need to review the staff culture in the home and 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.
● Within the safeguarding process, there was acknowledgement from the management team and the provider that on-going work was needed to create a positive and supportive working environment within the home where all staff felt equal and able to express concerns.

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.

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

- The service did not have a registered manager in post, but a new manager had been appointed and planned to make an application to register with CQC. At the time of the first day of inspection they had been in post for less than a week and had arrived at a time of staff changes and vacancies following a safeguarding event at the home.
- When we last inspected in January 2020, there had been a different manager in post; they had left the service in June 2020. Prior to their appointment, there had been another period of uncertainty for the staff group, including changes of home manager, area manager and a new nominated individual. These periods of change had significantly impacted on the quality and safety of the service as the systems to monitor the service were ineffective.

Continuous learning and improving care; Working in partnership with others

- The organisation's quality assurance methods had not been successful as improvements had not been embedded to increase the safety and well-being of people living at the home. Checks had not been effective to ensure staff were effectively trained and supported. The provider said they usually visited once a month to monitor the quality of care at Dunmore, although no records were kept of their actions during their visits. Following the beginning of the Covid-19 pandemic, the provider monitored the quality of care remotely through calls by liaising with the nominated individual, area manager and staff at Dunmore.
- The provider's management and governance processes had not been effective to ensure the safety and quality of the service. Our inspection highlighted multiple areas for improvement, some of which had been previously raised as areas to address by the local authority in 2019. These included poor practice in staff recruitment and induction, poor management of staff conduct, poor quality care recording, ineffective risk assessments and lack of reviews, and delays to address physical risks, such as hot water temperatures. People were still at risk of choking despite this being identified at the previous inspection and a previous incident. The failure to act on these and other concerns put people's safety and well-being at risk.
- An internal six-monthly audit in December 2019 was ineffective as it did not give targets for when work should be completed or provide a rating to indicate the level of risk to help staff prioritise their actions.
- The local authority's quality assurance and improvement team had been supporting the service and after a review in March 2020 had made further recommendations. But improvements to ways of working identified in their report had not been embedded and sustained. For example, there was still poor documentation of oral health care and fluid charts.
- Audits were completed but were ineffective. Records, such as the daily manager walkarounds in May 2020,

were completed in different handwriting but were not routinely signed, making it difficult to judge who was responsible for addressing issues. Identified areas of concern were not followed up on subsequent days to show if they had been addressed, for example maintenance work. 'Resident of the Day' records completed by care staff in May 2020 did not identify the poor quality of people's care plans and did not record actions to address medication errors identified as part of this audit. A weekly manager form (completed before the new manager started at the home) did not identify issues relating to a lack of induction for new staff, which we judged as having a significant impact on staff practice and the well-being of residents.

This was a 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.

● Following the first day of our inspection, the new manager began to address the quality of care planning by contacting relatives and speaking to people living at the home. As well as drawing on staff knowledge to create a summary of people's needs with the aim to make information more accessible to staff and to ensure risks were reviewed and updated. They had also made contact with relatives to introduce themselves and reassure them.
● The new manager showed a proactive attitude to concerns and complaints. For example, making changes to the way laundry was managed as well as employing an additional staff member for this task, in response to concerns.
● With the area manager, the new manager had created a service improvement plan which they reviewed regularly and updated, which they shared with CQC, safeguarding and commissioning teams to provide reassurance about the improvements being made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had engaged an external care organisation to audit the quality of care at the home. A report in February 2020 raised, amongst other areas of concern, the inconsistency of how people's rights were upheld. We saw records were still unclear as to how people's mental health had been assessed, and how decisions had been made to submit a deprivation of liberties assessment for individuals. We have other examples where recommendations had not been addressed.
● Feedback from some people living at the home and relatives indicated on occasions communication about changes at the home, for example in management, had not been conveyed in a timely way which had not reassured them. However, they praised individual staff members with updating them on day to day issues.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The management team acknowledged there was need for a culture change at the home and recognised there was the potential for staff to learn poor practice or bad habits from each other. For example, referring to people who needed two staff to help them move as 'doubles'. This is not respectful as it labels people and objectifies them.
● However, people who were able to comment on their experiences on living at the home described all the staff as kind and caring. Other people responded positively to the staff group, through their actions, body language or singing to them, although they were not able to comment directly on their care. However, a number of people said they were bored and under stimulated. They told us they had interests, which weren't being met. The new manager had re-introduced meetings with people living at the home to gain their feedback.
● Relatives who provided feedback on the service praised the quality of the care and said they were

reassured. For example, "Mum loves Dunmore, is happier than I've seen her in years and that makes me happy. The staff are all very kind and wonderful. Thank you all for keeping Mum safe during the last few months in this very stressful time."

● We received mixed feedback from the staff group about recent changes in the running of the home. Some staff recognised improvements to care plans, recording, handovers and care practice would benefit people living at the home and create a better working environment. They were positive about future opportunities to advance their professional knowledge, which were being promoted by the new manager. For example, a staff member said the new manager had made a massive difference, and said, "I'm glad she is here." The new manager had taken steps to improve the handover of information between shifts and met with staff to explain why practice needed to change and improve.

● However, some other staff felt unsettled and were concerned some of the changes in staffing and ways of working would negatively impact on the atmosphere of the home. There were elements of staff practice which showed routines of the home were based on the social needs of some of the staff group, including eating lunch together and loud exchanges of personal information. A culture had developed which did not recognise that Dunmore was the home of the people who lived there.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a failure to ensure fit and proper person were employed.

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.