

Townsend Life Care Ltd

Dumpton Lodge

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

Dumpton Lodge is a residential care home providing personal care to up to 28 older people who may be living with dementia. At the time of our inspection there were 27 people being supported in one large adapted building.

People's experience of using this service and what we found

People told us they felt safe living at the service. However, the provider and registered manager had not acted to mitigate risks to people to keep them as safe as possible. There was a new registered manager since the last inspection; the service had not improved.

Potential risks to people's health and welfare had been assessed but when people's needs changed risk assessments had not been changed to reflect this. Information in people's care plans was not always consistent or accurate. Staff knew people well and were able to explain how they supported people.

There had been a large number of falls recorded in the year before the inspection, these had not been analysed for patterns or trends and this put people at risk of further falls. Though some action had been taken on an individual level, this had not been reviewed to check if the action had been effective.

Staff had not always been recruited safely. There was not always enough staff to support people when needed. People complained they had to wait to be assisted at night.

Checks and audits had not been effective in identifying the shortfalls found at this inspection. The provider visited the service regularly but had limited oversight of the quality of the service. People, relatives and staff had been given the opportunity to express their opinion of the quality of the service. The responses to quality assurance surveys had not been analysed to identify patterns and trends.

Opinions on the culture within the service varied. Some relatives were not comfortable to raise concerns and felt staff were defensive in their attitude when concerns were raised.

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

Medicines were managed safely. The service worked with other health professionals to support people to access the support they need. The registered manager and staff understood their responsibilities to report concerns to the local safeguarding authority.

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 8 February 2020) and there was a 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 we found the provider remained in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected

This inspection was prompted by a review of the information we held about this service and the previous rating.

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 carried out an unannounced comprehensive inspection of this service on 9 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations

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

We have identified breaches in relation to safe care and treatment, good governance, staffing and fit and proper persons employed at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement 

Is the service well-led?

The service was not well-led.
Details are in our well-led findings below.

Inadequate 

Dumpton Lodge

Detailed findings

Background to this inspection

The inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was completed by one inspector.

Service and service type

Dumpton Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dumpton Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 7 April 2022 and ended on 12 April 2022. We visited the location's office/service

on 7 April 2022.

What we did before the 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with three people about their experience of living at the service and three relatives. We observed staff interactions with people in the communal areas. We spoke with five members of staff including the registered manager, the nominated individual, a senior carer and carer. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care plans and all the medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits, were also reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Learning lessons when things go wrong

- Accidents and incidents had been recorded; however, these had not been analysed for any trends or patterns. Following each fall staff had completed an accident form, and these had been put in a file. Since April 2021 there had been approximately 100 accident forms completed, the majority of these were unwitnessed falls. There was no record the registered manager had reviewed the accident forms or action had been taken to mitigate risks. The lack of analysis to identify patterns and trends put people at risk of further falls and incidents.
- The registered manager told us they had taken action when one person kept falling. They had been moved to a ground floor room and the furniture had been moved. This action had not been recorded or reviewed to check it had been effective in reducing the person's falls.

The registered persons had failed to do all that is reasonably practicable to mitigate risks. This is a breach of regulation 12 (2)(b) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There was not always enough staff to meet people's needs. The registered manager used a dependency tool to calculate the staff required. The tool calculates how many care hours are required. People, relatives and staff told us there was enough staff during the day. However, people told us and mentioned at residents' meetings, they had to wait for over 15 minutes for assistance at night, which had worried them.
- There were two staff available at night for 27 people at the time of the inspection. There were two people who required the assistance of two staff with all their care needs. When staff were supporting these people there were no staff available to assist others. People told us they had to wait for staff and there was a risk people would not wait for staff and mobilise independently without staff increasing the risk of them falling.

The registered persons failed to have enough numbers of staff to support people's needs. This is a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had not always been recruited safely. Checks had been made prior to staff being employed. These included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. When staff had declared convictions there was no risk assessment in place. There was no information about why the decision had been made to employ them and what actions had been taken to keep people safe.

- References had been obtained for staff, but these had not always been from former employers. One applicant had the required two references but neither had been obtained from previous social care employment. We discussed this with the registered manager, and they confirmed they had not contacted the former employers.

The registered persons had failed to establish effective recruitment procedures. This is a breach of regulation 19(2) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Potential risks to people's health and wellbeing had been assessed, however, the guidance provided to mitigate risk was not consistent. One person required assistance to move around the service. There was contradictory guidance about how to do this safely. One assessment stated they required a sling hoist while another assessment stated they could stand if supported by two staff and a walking frame. Staff told us the person had to be assessed each time to know if they could stand. This was not recorded within the care plan. When people required the hoist to move safely, there was no information about the size of the sling and how this should be positioned.
- When people had lost weight, they had been referred to the dietician. However, care plans did not always contain up to date information about the nutritional supplements prescribed. One person's care plan had not been updated; the plan stated the person had two supplements a day. However, this had been reduced to one supplement and currently they were not prescribed any supplements as their weight had increased.
- Some people had behaviours that may be challenging to staff and others. Care plans did not provide staff with strategies to de-escalate and calm situations. Staff told us how they supported and reassured people when they became distressed. We observed staff reassure people during the inspection. People told us they felt safe living at the service.

The registered persons had failed to assess, monitor and mitigate risks to people's health, safety and welfare. This is a breach of regulation 17 (2)(b) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks had been completed on the environment and equipment to make sure people were as safe as possible.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

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

Using medicines safely

- Medicines were managed safely; people received their medicines as prescribed. Staff had completed the

medicines administration record (MAR) accurately to confirm medicines had been given. The number of tablets available were correct. When prescriptions were handwritten, two staff had signed to confirm the instruction was correct.

- Medicines were stored correctly. Room and fridge temperatures had been recorded to make sure they were within the recommended ranges for medicines to remain effective.
- Some people required insulin to manage their sugar levels. Staff had received training and been competency assessed to give people their insulin when prescribed.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

We observed, and relatives confirmed they were able to visit their loved ones in the service. Visitors were required to book and let the service know when they wanted to visit. One relative told us they spent an afternoon with their loved one each week, which they enjoyed.

Systems and processes to safeguard people from the risk of abuse

- Staff and the registered manager understood their responsibilities to keep people safe from abuse and discrimination. Staff were aware of how to recognise signs of abuse and how to report these. They were confident the registered manager would take the required action. Staff were able to explain the whistle blowing policy and how to report concerns to outside agencies.
- The registered manager had reported concerns to the local safeguarding authority when required. They had worked with them to take appropriate action and reduce the risk of them happening again.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. The rating for this key question has changed 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; Continuous learning and improving care

- There was no effective system to check the quality of the service. Though the provider visited the service frequently, they had not recorded any checks on the quality of the service. The registered manager had been in post since April 2021, and they were responsible for the general audits of the service.
- The audits completed by the registered manager had not identified the shortfalls found at this inspection. The care plans had been reviewed each month but changes to people's care had not been recorded. Accidents had not been reviewed and analysed to identify patterns and trends to identify any improvements required to keep people safe. Staff had not always been recruited safely and there was not always enough staff to meet people's needs.
- The service has not improved since the last inspection, there were new breaches of regulations identified at this inspection. This is the third consecutive inspection where the service has been rated requires improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to seek and act on feedback from relevant persons on the service provided. This was a breach of regulation 17(2)(e) (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 this part of regulation 17.

- At our previous two inspections, the service had not sent out quality assurance surveys to stakeholders such as people and staff. At this inspection, quality assurance surveys had been sent to relatives and visitors. However, though the results were mainly positive, these had not been analysed to identify any pattern or trends.
- People had attended meetings; relatives had been invited to give their input. Topics discussed included activities and COVID-19 updates. People were asked about different elements of the service and their opinions. People felt comfortable to raise concerns such as having to wait for support at night, however, there is no evidence these concerns were addressed.
- Staff attended regular meetings to discuss their practice and improving documentation and

communication with relatives.

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

- There was mixed feedback from people and relatives about the culture within the service. Some people and relatives thought there was an open culture and were comfortable to raise concerns. However, one relative told us, they had raised concerns about the standard of care their relative received, and these had not been well received. They stated, "I am concerned staff take it personally and I am having a go at them and my expectations are high."
- There were mixed comments about how approachable the registered manager was. Comments included, "I have had no update about issues I raised." "I don't see them around the service much." However, other relatives had confidence in the registered manager, and they had previously been very helpful when issues had been raised. Another relative told us, they had always been contacted if their relative had a fall.
- People told us, staff knew them well and they were encouraged to be as independent as possible. One person told us, "Once I am up, they leave me to get on with things but help if I need it." Another person told us, "The staff know what I like and make sure I am helped in the way I like."

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to assess, monitor and mitigate the risks. The provider had failed to act on feedback from people. This is a continued breach of regulation 17(2)(a)(b)(e) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The service worked with other agencies to support people to receive holistic care. The registered manager kept up to date with local and national forums as a source of information about changes within adult social care.

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 The registered persons had failed to do all that is reasonably practicable to mitigate risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to establish effective recruitment procedures.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons failed to have enough numbers of staff to support people's needs.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered persons had failed to assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to assess, monitor and improve the quality and safety of the service.</p>

The enforcement action we took:

We imposed on condition on the provider's registration