Care Quality Commission

Quantum Care Limited

Dukeminster Court

Inspection report

Dukeminster Estate
Church Street
Dunstable
Bedfordshire
LU5 4FF

Tel: 01582474700

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22 January 2021

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18 February 2021

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

About the service
Dukeminster Court is a residential care home providing personal care to people aged 65 and over, some of whom live with dementia. At the time of the inspection 53 people were living in the home. The service can support up to 75 people. The home is purpose-built over five units accommodating three floors. Some units specialise in providing care to people living with dementia.

People's experience of using this service and what we found
The individual risks to some people had not been identified, assessed or fully managed. This had resulted in harm to some people and put others at risk of harm. The service's current quality monitoring systems had failed to identify and rectify this although a new system was being introduced at the time of this inspection. Not everyone we spoke with felt there were consistently enough staff to meet people's needs promptly which meant there was sometimes a delay in people receiving assistance.

People received their medicines as prescribed and good processes were in place to help protect them against the risk of infection. Safe recruitment practices were followed and regular maintenance and servicing meant the environment and equipment remained safe.

People told us they were happy living in the service and relatives spoke positively about the home, it's management and staff. There was a positive culture amongst the staff and team work was effective and supportive. People were involved in their care and support and relatives were kept updated in relation to the health and wellbeing of their family members. People told us they would recommend the home. One person who used the service told us, "I like living here. Everyone is so nice to me."

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 (report published on 18 February 2020) and there were two breaches 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 regulations. The service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to the management of falls. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service remains as requires improvement.

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.

We have identified breaches in relation to the safe care and treatment of people and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from, and meet with, 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.

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 always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

Dukeminster Court

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
The inspection team was made up of three inspectors, two of which visited the home. The third lead the inspection remotely. An Expert by Experience sought feedback from people who used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Dukeminster Court 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 had a manager registered with the Care Quality Commission. However, an application had been received to cancel this registration and the registered manager was no longer working in the home. A new manager had been appointed although they were absent from the service on the day of our inspection. It is this person we will refer to as manager throughout this report. This means that the registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 90 minutes notice prior to our inspection. This was because there was a COVID-19

outbreak in the home and we wanted to ascertain the risks and work with the service to effectively manage them during the inspection.

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 viewed the action plan the provider sent following the last 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 used all of this information to plan our inspection.

During the inspection
We spoke with the head of clinical governance and the regional manager. We reviewed a range of records; this included the care records for five people who used the service and the medication records for 10 people. We looked at two staff files in relation to recruitment and staff supervision. We assessed the infection prevention and control measures in place.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and a variety of records relating to the management of the service were reviewed.

We spoke with a further 11 staff including seven care assistants, three housekeepers and one care team manager. We spoke with three people who used the service and eight relatives. We received written feedback from one additional relative.

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

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

Enough improvement had not been made at this inspection and the provider was still in breach of this regulation.

● The service had failed to fully identify, assess, mitigate and record the individual risks to some people. This put them at risk of potential harm.
● For example, two people who used the service had been harmed by other service users living with dementia. There were no care plans or risk assessments in place to assist staff in managing these behaviours and help keep people safe.
● A third person had self-harmed due to their behaviour associated with their dementia. No guidance was available to staff to help them support this person and keep them safe.
● For people with specific health conditions such as seizures, diabetes or a sight impairment, no care plans were in place to guide staff on how to support these conditions. Staff had not received specialist training.
● Some people were at high risk of falls and, to help manage that risk, the service had assessed that some people required regular visual checks to ensure their safety. For one person who had experienced a fall resulting in serious injury, these had not been regularly completed.

The above concerns constitute a continued breach to Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had themselves identified shortfalls with care plans prior to our inspection and, at the time of the site visit, were training staff in their completion.
● The environment and equipment were well maintained and regular servicing and maintenance was undertaken to ensure it remained safe.
● A business continuity plan was in place specifically for COVID-19 which provided information and solutions for associated emergency situations.

Staffing and recruitment
● Most people we spoke with felt there were enough staff to meet people's needs in a person-centred

manner. However, some staff told us shifts were sometimes short staffed and that this had some impact on the people who used the service.
● Out of the 11 staff we spoke with, seven felt there were enough staff to meet people's needs. Those that disagreed told us there was sometimes only two staff on a unit meaning when both were assisting a person, this left nobody available to assist anybody else. They told us this meant people sometimes had to wait for assistance.
● We checked the personnel records for two staff and saw that safe recruitment practices were in place such as obtaining references and a DBS (Disclosure and Barring Service) check which helps providers make safer recruitment decisions.

Learning lessons when things go wrong
● We were not fully assured that the provider had learned lessons when things had gone wrong.
● At our last inspection, completed in December 2019, we identified that the service had failed to fully assess the individual risks to some people who used the service. These concerns continued at this inspection.
● Whilst some individual analysis was completed when people experienced falls, the service had not considered such potential contributing factors as time of day or staffing levels for example.

Systems and processes to safeguard people from the risk of abuse
● Whilst the service was able to identify incidents of potential abuse and report it as appropriate, effective systems were not always in place to help protect people from the risk of abuse. For example, some service users had come to harm after being assaulted by other service users living with dementia.
● Staff had received training in safeguarding and through discussion were able to demonstrate they had the knowledge to identify and report potential abuse both inside, and outside, of their organisation.
● Potential incidents of abuse had been reported to the local authority safeguarding team as required.

Using medicines safely
● People received their medicines as prescribed. One person who used the service told us, "Yes, of course I get my tablets each day. I am due them at about 8 o'clock and it's very rare staff are late with them."
● Medication administration record (MAR) charts showed people received their medicines as prescribed and that administration followed good practice guidance.
● Idenitfication cover sheets recorded people's preferences for receiving their medicines and contained photographs to help reduce the risk of medicines administration errors.
● Medicines storage was seen to be clean, ordered and secure.

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 personal protective equipment (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 could be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date. However, this was not being adhered to in relation to staff changing into a uniform on site to prevent cross infection. The provider had identified this shortfall themselves and was awaiting uniforms. Following our inspection, the

provider took immediate interim measures to rectify the situation whilst awaiting uniforms.

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 requires improvement. At this inspection this key question has remained the same. 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; Continuous learning and improving care

At our last inspection the provider had failed to have effective quality monitoring systems in place to identify shortfalls in the quality of care provided. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of this regulation.

● In October 2020, the service identified that people were experiencing a high number of falls and that further investigation was required in each unit to establish cause. This had not been completed at the time of inspection and people were continuing to experience a high number of falls often resulting in injury.
● The service had assessed falls that occurred in early January 2021, but this did not investigate possible causes or trends or come to any conclusions around actions required to mitigate future occurrence.
● The service had failed to have a system in place that identified that care records, such as observation charts or care plans for people living with dementia, had not been completed in order to mitigate risk.
● Following our inspection in December 2019, the provider sent us an action plan setting out what action they would take to make improvements. This recorded that systems were in place to identify risks to people and ensure risk assessments were in place. At this inspection, evidence showed risks had continued not to be fully identified, assessed or mitigated.
● Whilst the provider had a service improvement plan in place, this had failed to identify some of the concerns ascertained at this inspection.

The above concerns constitute a continued breach to Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We could not be confident the provider would make us aware of all safety incidents that needed to be reported by law. This was because, on some occasions, the provider had to be prompted to report safety incidents. However, once identified, the provider had taken immediate action to rectify this by changing systems and providing senior staff with associated training.

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

- The home had had recent changes in management at the time of this inspection. However, the people we spoke with talked positively about the new manager and the ethos of the home.
- All of the three service users we spoke with told us they had positive experiences living in Dukeminster Court. One said, "I like it here because I know I have all I need and I am looked after properly; it's also lovely and warm all the time."
- One relative we spoke with told us of a situation where the manager showed compassion and awareness of a sensitive situation and acted accordingly.
- Staff agreed that the manager was supportive, visible and listened. One said, "[Manager] is good, you can talk to them and they are bringing a good vibe to the home. [Manager] takes time to talk to you and the [people who use the service]."
- All the staff we spoke with agreed that the home promoted team work and that, even during the difficult times of the pandemic, staff worked well together to meet people's needs. Staff told us they felt supported and valued.

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 service understood their responsibilities under the duty of candour requirement.
- The relatives we spoke with told us the service made them aware of safety incidents that involved their family members and were open in their approach. One relative told us they felt the service, "Told the truth at all times."
- The relatives we spoke with talked positively about how the service had engaged with them during the COVID-19 pandemic. They told us staff kept them updated in relation to the health and wellbing of their family members and that the home had made them aware of any virus outbreak.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Although formal opportunities to provide feedback on the service had not been completed, people told us they had informal opportunities to discuss the service.
- The relatives we spoke with told us they felt involved in the care and support of their family members. They told us that, prior to the pandemic, care reviews had taken place regularly and face to face but that these had now, understandably, taken place by telephone.
- One relative we spoke with told us staff were, "Very sympathetic" whenever they rang the home to seek updates on their family member. They said, "I am certain the care [family member] is getting is the best it can be."
- Staff told us they felt engaged through regular supervision sessions and felt supported to voice their views and opinions.

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 provider had failed to do all that was reasonably practicable to mitigate the risks to the health and safety of service users receiving care or treatment Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had failed to effectively assess, monitor and improve the quality and safety of the service provided Regulation 17(1)(2)(a)(b)(c)(f)