West Bank Residential Home Limited

Dunmore Residential Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Dunmore Care Home is registered for 32 older people, including people living with dementia. There were 13 people at the service at the time of the inspection. Bedrooms are located over four floors. There is a small passenger lift to access all floors. There is accessible outside space.

People's experience of using this service and what we found
People continued to be at risk of harm because risks to people's safety were not consistently identified or action taken to mitigate them. Documentation did not show people were routinely having their care needs met or provide the information staff needed to provide safe care. There was a lack of oversight which meant one person, living with dementia, was at risk of falls because they were wearing their reading glasses when mobilising. Another person, living with dementia, had been assisted to bed wearing a pendant alarm, which was found wrapped around their neck in the morning. Systems to keep staff informed about changes in people's needs were not always effective. People were at risk due to failings in pressure area care and bowel management. There had been some improvement in the management of risks related to malnutrition and dehydration. People had gained weight and there was an improvement in the amounts of fluids being offered and drunk. A new kitchen manager was in post. Further improvements were required however, in relation to recording and the increased monitoring of people at high risk.

There had been some improvements in the training, support and supervision of staff, but further improvements were needed. Training was being delivered online and face to face, however the management team advised staff did not always want to engage and so had not always completed the training. There had been issues with the timing of the training; staff not being informed it was taking place; the only available room being double booked, and the trainer being unwell. The training matrix continued to show significant gaps in key areas of training.

During the inspection we raised concerns about aspects of staff practice. The management team advised they would be addressed through the introduction of staff competencies for all of the staff team. A new induction programme was being introduced with competencies assessed alongside. Newly recruited staff were receiving enhanced mentoring and monitoring due to gaps in their knowledge. Staff were receiving supervision but told us they did not find this supportive, because it was only being completed to raise concerns about their practice rather than discussing their development and experience. Supervision records showed where concerns had been identified in staff practice, but they had not always been effectively addressed.

We found people continued to be exposed to the risk of harm and poor care due to ineffective systems to check the quality and safety of the service. The local authority quality assurance and improvement team (QAIT) had been working with the service to develop governance processes. However, the tools developed were not yet embedded or effective. The concerns we identified during the inspection had not been identified, or action taken to minimise risk in relation to aspects of pressure area care; medicines

administration; support with personal care; skin integrity and oral care; accidents and incidents; environmental safety and the quality of manager walk arounds and staff handovers. The provider continued to rely on external professionals to identify failings rather than internal governance processes.

The provider and management team were confident the quality and safety of the service was improving. The management team was in the process of being strengthened, and there was now a stable staff team in place. We received positive feedback from people and relatives about the kindness of the current staff team. A new computerised care planning system had been introduced to improve staff practice and oversight of the care being provided. The provider had increased their oversight of the service, receiving weekly progress reports from the nominated individual. However, despite these developments we were not reassured by their assessment of improvement, given the on-going concerns linked to this service and the findings from this inspection. The service had been in a local authority whole home safeguarding process since 10 November 2021. This was still in progress at the time of this inspection.

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 inadequate (published 3 February 2022) and there were multiple breaches of regulation. We found evidence the provider needed to make a number of improvements, some of which were urgent. Urgent conditions were therefore placed on the providers registration following that inspection. The urgent conditions addressed the management of risks linked to nutrition, bowel management, pressure care and access to call bells. They included ensuring staff had the guidance they needed to manage those risks and were competent to do so. Also, that there was daily oversight and checks of how the risks were managed by the registered provider.

Why we inspected
We undertook this targeted inspection to check whether the provider had met the urgent conditions imposed on their registration. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement and recommendations
We have found evidence the provider had failed to meet the urgent conditions imposed on their registration. People remained at risk of harm, and the provider was given short timescales to rectify immediate risks. We checked these had been addressed following our inspection and were told they had been.

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

Special measures
The overall rating for this service remains 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dunmore Residential Home 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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection

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 Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the urgent conditions imposed on their registration following the inspection in November 2021

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Dunmore Residential Home 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. Dunmore is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

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 all this information to plan our inspection.

During the inspection
We spoke with eight staff, including the manager; deputy manager; care staff; kitchen staff and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed everybody living at the service and spoke with four people. We also spoke with a visiting relative. We viewed a range of records including risk assessments; care plans; daily records; handover sheets and audits.

After the inspection
Following the inspection, we spoke to one person living at the service by telephone and eight friends and relatives. We also had feedback from four external health professionals. We emailed seven members of staff to request additional feedback but had no response. We requested and reviewed additional care plans and other documentation related to the management of the service.

Inspected but not rated

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 this key question was rated inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the urgent conditions placed on their registration. We will assess the whole key question at the next comprehensive inspection of the service.

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 repeated breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was the fourth time the provider has been in breach of this regulation since January 2020.

We imposed an urgent condition on the provider's registration requiring them to make immediate improvements to the assessment, monitoring and management of risk. At this inspection we found this condition had not been met. Risks to people's safety were not consistently being identified or action taken to mitigate them.

● At the last inspection we found failings in documentation and recording which placed people at risk of not having their care needs met. This was still the case. Handwritten charts did not show people were routinely receiving full assistance with oral care, washing or having their skin checked. Care plans and documentation kept in people's rooms were still missing key pieces of information for some people. For example, information to ensure a person was sitting appropriately when being assisted with food and fluids in bed, potentially putting the person at risk of choking. This information was particularly relevant to new staff and to alert all staff to changes in people's care needs.
● People were at risk due to a lack of oversight of their care. A relative told us their family member who was at high risk of falls, was wearing their reading glasses when moving around which put them at risk of harm. The person was living with dementia and was reliant on staff to assist them to wear the correct glasses. Another relative told us how their family member had been without their hearing aid for a considerable amount of time, until the hearing aid was found by the relative in the person's room. Without their hearing aid there had been a detrimental impact on the person's well-being as they had become withdrawn. Staff said there was a noticeable positive difference in their mood since wearing their hearing-aid. The person's relative told us the person was completely isolated without their hearing aid saying, "At home she would be in a terrible state if she couldn't hear." Since the relative had found the hearing aid the person was interacting again and had been out of their room in their wheelchair, which had not happened for a long time.
● People were at risk because systems to keep staff informed about any changes to people's needs were not always effective. Staff told us the member of staff doing the handover on the day of the inspection said there

was no information to share. They reported they were sometimes unaware of what was going on if they had been off for a couple of days as there was no information in handovers. Some handover records contained no information, including on the day of the inspection, which meant staff were not always kept up to date with any changes in people's needs. We raised these concerns with the management team. Following the inspection, the area manager advised us staff could now access handovers on the new computerised care planning system; a more complex handover sheet was going to be introduced and a communication book was going to be trialled.

● At the last inspection we found ineffective pressure care provided by staff increased the risk of harm to people who were vulnerable to skin damage through immobility, incontinence and poor health. This was still the case. One person assessed as at high risk of pressure damage had been supported on the incorrect mattress for at least 20 days. This placed the person at increased risk of harm of pressure sores. The issue had not been identified by staff or governance processes. We raised our concern with the management team who acknowledged this should have been picked up in the manager's daily walk arounds. Following the inspection, they advised the correct mattress had now been put in place and daily mattress checks were being introduced.

● Creams were not always being applied as prescribed to prevent skin breakdown. For example, one cream was prescribed to be applied three times daily, however records showed it was only applied twice daily and there were gaps in records. This had not been identified by governance processes, and daily records repeatedly documented sore and red skin on pressure areas. We raised this concern with the management team. They advised us that a new computerised care planning system, introduced four days previously, would now prompt staff to apply creams as required.

● Information had not been sent to external health professionals regarding concerns about one person's skin integrity. The manager was not aware of this until we identified the concern during the inspection. Following the inspection, they advised the information had been sent to external health professionals.

● At the last inspection we found people were not always able to summon staff in an emergency, although call bells were now in communal areas, and people had pendant alarms, this was still the case. Staff were observed carrying on with tasks rather than investigating why the call bell was continually ringing during the inspection, which put people at risk of harm.

● During the inspection we noted the call bell system was not working correctly on the ground floor. This had not been raised by staff. We highlighted this to the management team, and requested they came with us to address the problem as they had not investigated why the call bell was constantly ringing.

● Risk assessments had not been completed regarding people's safety when wearing pendant alarms. Records showed one person living with dementia had been found by staff with the call bell wrapped around their neck. Staff had not removed the pendant when they assisted the person to bed. We raised this during the inspection, as it had not been picked up by the management team. We were subsequently advised staff had assessed the person did not to have capacity to understand or know how to use the call bell and it had therefore been removed. This meant the provider's risk assessments had not been completed properly nor followed appropriately to keep people safe.

● At the last inspection we found people were at risk of harm due to constipation, because there was no oversight of how often they opened their bowels. This was still the case at this inspection. Documentation indicated one person had not opened their bowels for several days. There was no guidance in the care plan to prompt staff about what action to take. We raised this with the management team who advised they would prompt staff to provide more effective bowel care for this person. This would be documented on the new computerised care planning system and checked daily by the manager.

● At the last inspection we found people were at risk of malnutrition and hydration. Food and fluid charts had been poorly completed and people had lost significant amounts of weight. At this inspection we found there had been some improvement, although further improvements were required. For example, there had been increases in weight for people in the last month, although no indication of people's weight being

regularly monitored. For example, people had been assessed by staff as being at high risk of malnutrition using the Malnutrition Universal Screening Tool, but they had not been weighed for two months according to records, which did not follow best practice recommendations. There was no evidence to show food charts were being monitored, or people had been offered food after 5pm. Following the inspection, the manager advised this had been reviewed. Cakes, fruit and other snacks were being offered after 5pm. This meant the provider's risk assessments had not been completed properly nor followed appropriately to keep people safe. A night owl menu would be developed by the new kitchen manager who had started on 28 February 2022. We had been told previously a 'hostess' role would provide additional support with snacks, but this role had not yet been recruited to.

● Most fluid charts had improved in their completion and there was an improvement in the amounts of fluid people were offered and drinking.

Inspected but not rated

Is the service effective?

Our findings

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

At our last inspection this key question was rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check if the provider had met the urgent conditions placed on their registration. We will assess the whole key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience

● At the last inspection we found staff did not have the training, support and supervision they needed to provide safe and effective care. At this inspection we found there had been some improvements, however, further improvements were needed.

● The management team informed us training was being delivered both online and face to face. They advised it was going well but was a work in progress. Three senior staff were due to complete a 'train the trainer' course, so they could teach other staff in manual handling. However, the staff training matrix continued to show significant gaps in key areas of training for care staff. For example, the training 'Falls: Managing risk', had been completed by just two staff namely one night carer and a cook.

● During this inspection we raised concerns about aspects of staff practice, for example related to recording, the application of topical creams and the checking of skin integrity. In addition, the chef had provided diabetic and dairy free foods to all residents, rather than understanding the importance of meeting individual dietary needs. This potentially undermined the ability of a number of people to increase their weight, due to previous unplanned weight loss. The management team said these dietary concerns had been addressed after the issue was discussed with an external dietician. In addition, new staff competency checks were due to be implemented for all staff but had not yet been completed. The competencies had been developed using feedback from the local authority quality assurance and improvement team (QAIT).

● The management team told us staff did not always want to engage with the training and therefore would not attend. Minutes of a staff meeting showed this was discussed and staff were advised the training was mandatory and a legal requirement. However, there had been issues with training being booked after a night shift, cancellations because the trainer was unwell, or a room not being available for training, despite a number of empty bedrooms that could have been used instead.

● During the inspection an external dietician was delivering training. A previous session had been cancelled because the room was double booked. Attendance was low at this session. We ensured the kitchen staff were aware of the dietician's training and encouraged them to attend, as none of them had been made aware by the management team that this training was taking place.

●The management team advised us that some newly recruited staff, although nurse trained, had gaps in their knowledge related to the provision of person-centred care and supporting people with dignity. They therefore required training, which had not yet been provided. The management team said they also needed mentoring by other members of the staff team, particularly around providing personal care to people living

at Dunmore.

● Some new staff did not have English as their first language, which was a barrier to learning. They were being supported by their colleagues who were more fluent in English.

● Staff felt the induction in place was poor, and new staff were not being adequately supported. One person told us, "Whenever a new carer came in they used to have someone with them for the first day. Now they are just let loose. You have to tell them how to go about things." The area manager told us a tick box induction programme was being introduced for each role, with staff competencies assessed alongside but this had not yet commenced. The competencies would be reviewed annually.

● The provider's service improvement plan documented that individual supervision was now in place to 'review level of knowledge and understanding about role; expectations about standards of care. Plan individual training needs'. Staff confirmed they were receiving supervision but did not find this supportive. It was used to raise concerns about aspects of their practice rather than discussing their development and listening to their experiences. This was evidenced in supervision records.

● Where concerns had been identified in staff practice, they had not been effectively addressed. For example, supervision records showed repeated concerns about the poor practice of one member of staff, but no further action had been taken.

● We observed some effective person-centred practice when staff were supporting people. A relative commented, "There is a more stable staff team. The staff I meet now are kind." One person told us, "They treat me ok and give me what I need. They look after me very well. It's the management that needs seeing to."

Inspected but not rated

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 this key question was rated 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. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the urgent conditions placed on their registration. We will assess the whole key question at the next comprehensive inspection of the service.

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

- At our last inspection we found systems and processes to monitor and check the quality of care were not established and/or did not operate effectively to ensure compliance with the regulations. This was still the case. As a result, people continued to be exposed to the risk of harm and poor care.
- Since the last inspection the management team had been supported by the local authority quality assurance improvement team (QAIT), to develop governance processes and improve the quality and safety of the service. The provider had commissioned an external consultant to audit and assist with quality monitoring. The management team advised tools were now being developed to improve governance but were not yet embedded or effective.
- QAIT had assisted with the introduction of a manager's monthly checklist; a 'high-risk monitoring form' and a service improvement plan, which had been implemented with the aim of improving quality monitoring. However, the provider had not actioned all of QAIT's recommendations.
- The high-risk monitoring report completed by the provider on 19 January 2022 stated the daily manager walk arounds would also include the checking of fridge temperatures, cleanliness and the measuring of dignity and respect. This had not been put into practice. It also stated documentation kept in people's rooms was to be checked daily, but we found this documentation was missing key pieces of information for some people.
- Daily manager walk arounds were being completed by senior staff. However, the information in them was frequently not detailed enough to allow meaningful follow up. For example, it was documented diet and fluid charts had "missing entries" but did not specify for which residents. Staff were to "encourage more fluids", but the people at risk of dehydration had not been identified. It was not evident that any action had been taken.
- At the last inspection we raised concerns about failings in the oversight and management of environmental risks. This was still the case at this inspection. There was no audit for environmental health and safety, and this was not part of the manager's walk around. A relative told us they had tripped over equipment in a communal area and sustained bruising. There was a door on the top floor to flight of stairs, which the manager told us should be kept shut for people's safety. There was no sign to alert people to shut the door. In response to feedback during the inspection a sign was put on the door to alert people. The

nominated individual told us environmental health and safety audit was going to be put into place, and the environment checked for safety hazards, as part of the managers walk around.

● Accidents and incidents were not always accurately documented or reviewed by the management team. During the inspection we found an incident report on the new computerised care planning system, which the manager was unaware of. The management team reviewed the incident in response to our feedback and concluded the member of staff had not recorded the issue correctly.

● Senior staff had the task of checking that all documentation had been completed accurately at the end of their shift. However, time had not been put aside for them to do this and they told us they needed to prioritise the care of residents. We found examples of care documentation which were poorly or inaccurately completed which the service had not identified.

● One person, and several relatives, told us they were not kept well informed about what was happening at the service, or the welfare of their family member. This had been exacerbated by isolation and visiting restrictions during a recent COVID-19 outbreak. Relatives were not aware they could be an essential care giver and continue to visit their family member as part of the staff team in line with national guidance. One relative said, "I wasn't allowed to see [them]" and told us this had had a detrimental impact on their family member's welfare. Following the inspection, the manager advised they had requested senior staff keep relatives informed about the welfare of their family member.

● Some audits had been carried out since the last inspection, including infection prevention, health and safety, mattresses and call bells. However, governance processes did not identify the concerns we found during the inspection, or ensure action was taken to minimise risks, for example in relation to pressure area care; medicines administration; support with personal care; skin integrity and oral care; accidents and incidents; environmental safety and the quality of manager walk arounds and staff handovers. This, and the provider's service improvement plan developed with QAIT, demonstrated the continued reliance on external professionals to identify failings rather than internal governance processes.

● The provider and management team said they were confident current and planned developments would improve the quality and safety of the service. However, we were not confident in their assessment of improvement given the on-going concerns linked to this service and the findings from this inspection. The service had been in a local authority whole home safeguarding process since 10 November 2021. This was still in progress at the time of this inspection.

● The management team was in the process of being strengthened. This included a new deputy manager who had been in post for three weeks, and a peripatetic crisis manager had been appointed to start on 7 March 2022.

● The provider had increased oversight of the service, meeting weekly with the nominated individual for updates. Issues discussed included staffing, management arrangements and the progress being made.

● There was now a more stable staff team in place, with only one agency member of staff. Key roles were still being recruited to including the head housekeeper; kitchen manager; activities co-ordinator, 'hostess' and administrator, with advertising for a further two team leaders, and senior care workers.

● The management team advised the new computerised care planning system, implemented on 21 February 2022, would ensure people's needs were met, and facilitate effective oversight of the support provided.

● A 'resident of the day' system had been recently introduced, with a monthly review of each person's needs and support, with the person and their representatives.

● A residents' meeting held on 21 January 2022 provided people with an opportunity to express their views about aspects of the service. People had commented they would like more activities, as there was too much sitting around, as well as excursions and trips to the pub and shops. However, the newly appointed activities person had left, which meant the suggestions could not be actioned until the new activities co-ordinator was in post.