The Fremantle Trust

Carey Lodge

Inspection report

Church Street
Wing
Buckinghamshire
LU7 0NY

Tel: 01296689870
Website: www.fremantletrust.org

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced inspection of Carey Lodge on 18 March 2017. We let the manager know we were coming so that they could be in attendance.

Carey Lodge provides care for up to 75 older people, some of whom may have dementia. On the day of our visit there were 70 people using the service.

At the last inspection on 16 and 22 February 2016 the provider was in breach of one regulation of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements within the Safe domain. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carey Lodge on our website at 'www.cqc.org.uk'.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social l Care Act 2008 and associated Regulations about how the service is run.

People, families and staff told us that at times there were not enough staff to meet people's needs. Staff rotas confirmed that the planned staffing levels were not always maintained. Comments were "Three staff are not always maintained on the floors" and "I know one lady needs two people to assist her, but there is not always enough to do this".

People and their families told us they felt safe at Carey Lodge. Staff understood their responsibilities in relation to safeguarding people. The service had systems in place to notify the authorities when concerns were identified. People received their medicines as prescribed.

The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role. Where risks to people were identified, risk assessments were mainly in place. We found some reviews of these risks had not clearly been recorded.

Accidents and incidents were well managed. We found there were checks in place to ensure people were safe.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There were not always sufficient staff deployed to meet people's needs and keep them safe.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns. Checks were in place to promote the safety of people.

Risks to people were identified and in some cases, risk assessments were in place to manage the risks. Safe recruitment practices were in place. People had their medicines as prescribed.

We could not improve the rating for Safe from Requires Improvement because we found a further breach in Staffing.

Carey Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 March 2017 and was announced. The inspection was carried out by one inspector.

We reviewed the information we held about the service. During the inspection we spoke with 12 people who used the service and two relatives of people who lived at Carey Lodge.

We looked at two people's care records, medicine administration records, two staff records and records relating to the general management of the service. We spoke with the registered manager, deputy manager and three care staff.

We observed how care was provided to people, how they reacted and interacted with staff and their environment.

Requires Improvement

Is the service safe?

Our findings

This inspection was a focused inspection carried out to follow up on the previous breach at our inspection in February 2016. At the inspection in February 2016 we found the provider was in breach of Regulation 12 of Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. This was because the provider was not recording fridge temperatures to ensure people's medicine was kept safe in line with manufacturer's instructions and controlled drugs waiting to be returned to the pharmacy for destruction were not recorded in a controlled drug record book. We asked the provider to send us an action plan outlining what actions they were going to take.

At this inspection we found improvements had been made and the provider had met the requirements of the regulation. They had introduced a clear record of fridge temperatures and a new controlled drugs cupboard had been put in place to ensure and records were maintained of returns of controlled drugs.

People told us there were not always enough staff on duty to meet people's needs. Comments from people included "There is a shortage of staff, there was only two on duty yesterday"; "No not enough staff and they have to use agency a lot"; "Staff everywhere today, but that is not usual"; "My medicine was late due to staff shortage"; "Weekends are the worse, especially Sundays"; "One staff member had to go to several different units as there was no one who could give out the medicine"; "Rushed off their feet, only two sometimes"; "There was only one staff member giving out lunch which meant it was cold by the time we got it" and "Yes I am kept waiting sometimes".

However, there were some positive comments from people. They said "I am not left waiting for staff, they come when I need them to"; "Not kept waiting really, not for any length of time anyway"; "If I need help, they would come, feel at home, I am happy here"; "It's lovely here, really nice"; "Staff come when needed" and "All very pleasant, care staff and people".

Two relatives we spoke with told us there was a shortage of staff. One said "Staff are rushed, but do chat and keep us updated with how [name] is. Staff are very helpful, but have to go as they are so busy".

Staff told us "Sometimes staff are called in at short notice (due to staff shortage)"; "Staffing is a problem here, it has got worse, we are here for the residents and we do our best"; "Have to get more staff, some day's there are only two staff on duty in one area of the home"; "On one day there was only two staff who could administer medicine"; "Some days only two staff on shift and we do try to work as a team, but cannot guarantee staff will come in!"; "There is not enough staff, on our own sometimes"; "Quite often only one staff on shift"; "They use a lot of agency, some have not been here before so don't know the people" "They are trying to recruit more staff"; "I know we have two more staff coming on board"; "No one has come to any harm because of staff shortages" and "The manager does her best sometimes but I know they are trying to recruit more staff".

We were told by the manager that the number of staff required to look after people was 13 per shift am and pm at Carey Lodge. We were supplied with a copy of staff rotas from 1 February to 18 March 2017 on the day

of the inspection. We analysed the rotas to see if there were 13 staff on shift both am and pm. We found there was consistently shortfalls of staff on shift, both am and pm. Following our inspection the manager provided us with a second copy of the same rotas. However, these differed from the first copy. Amendments had been made as staff names had been added which were not originally included. We were told this was because agency staff had not accurately been recorded. It was also not made clear on the day of the inspection that relief staff were counted as care workers. Although the second copy mainly showed there were 13 staff on duty, the staff rotas were very difficult to follow as they still did not provide a clear and accurate picture of the actual number of staff on duty at any one time due to the number of amendments made. Whilst we appreciate this showed staff numbers did at times, total the expected number, people, relatives and staff told us this was not the case and the care provided suffered as a consequence. We also saw that agency staff names were recorded at the bottom of the rota and did not show where each agency staff member was deployed, for example in which of the five houses at Carey Lodge. This therefore made it difficult to confirm staff had been deployed appropriately and safely to ensure people's needs were met.

We also looked at the number of agency staff used at the home. We found there was ten occasions when the staff complement was made up of 50% agency in February and in March 2017 there was already six times where agency had made up 50% of the staff complement. We were told where possible, the same agency staff were used, but this was not always met. People may be at risk due to the high number of agency staff used as it was not always possible to ensure continuity of care for people.

We saw the manager had assessed people's dependency needs on a regular basis. However, these dependencies were not clearly linked to the number of staff allocated at the home. The manager told us they were given an allocation of 13 staff by head office (this was going to be increased to 14 in April 2017). They said that agency staff were arranged by head office and there was little flexibility or autonomy for the manager to arrange staff cover which meant, at times, staffing numbers were not maintained.

We discussed these concerns with the manager. They told us that sometimes staff shortages was down to short notice of sickness by staff and agency letting them down. They also said they had difficulty in recruiting staff due to the homes location and poor public transport links. They said they were aware from comments in a recent staff survey that staff were 'fed up with working with agency staff'. They said that recruitment was arranged by head office and felt it would be better if they could do the recruitment process as it may speed things up. Following the inspection we were informed that a recruitment company had been appointed to work in partnership with Fremantle to provide staff and temporary cover staff to assist recruitment. They told us that they had six further staff members who had received training to administer medicine. However, following the inspection, the manager told us there was now nine staff who had received medicine administration training. They were in the process of checking the staff members' competence to ensure they were able and confident to administer people's medicine. This would ensure that there were enough staff competent to administer medicines to people.

The manager also told us they felt the incident with people not getting their lunch on time and it being cold was down to a misunderstanding with the chef as they should be putting terrines on the tables to enable people to help themselves at lunchtime Therefore people were not kept waiting for staff to serve their food.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained risk assessments and included risks associated with; falls, nutrition, and medicines. However, where risks were identified, care plans were not always in place to ensure risks were managed. For example, one person was identified as having a pressure sore. Although staff were aware of

how to manage this condition, the person's care plan did not contain a risk assessment for the management of the pressure sore. This was a concern as the home used a high number of agency staff which meant the person may be at risk of not receiving the correct treatment. We raised this with the manager and deputy manager. The deputy manager immediately reviewed the file and on the day started to make changes to ensure all details were up to date and records contained guidance on how to manage this person's risks. The risk assessments we saw were generic and not person centred. The manager showed us the proposed new care plan that was going to be introduced at the home in April 2017. This provided more detail and was more person centred.

Safe systems were in place to manage people's medicines. We observed the medicine round with one of the care staff at Carey Lodge. The care staff member was diligent and approached the person in a calm manner. They wore a tabard so that people and staff knew they were not to be disturbed as they were carrying out the administration of people's medicine. The staff member was clear of their responsibility and explained the storage of people's medicine. We saw the person's medication administration records (MAR) were completed appropriately. The medicine trolley was stored in a locked room and was secured to a wall. The medicine room had a temperature check and a secure controlled drugs (CD) cupboard. We looked at two people's records that were prescribed a CD. Both were recorded in detail. We saw daily temperature checks were undertaken of the medicine room and the fridge to ensure people's medicine was stored at the right temperature to keep these effective. This meant the provider had robust systems in place to manage people's medicine. People mainly told us they had their medicine when needed. However, one person told us they had to wait 45 minutes as there was not a member of staff on duty who could administer medicine.

We saw people had appropriate equipment to keep them safe when moving around the home. We saw staff were aware of what equipment people needed and when this equipment should be used.

People and their relatives told us they were safe. Comments included, "Absolutely safe, never any concerns"; "I have no concerns re my safety"; "I would start shouting if there was any concerns, staff are beyond reproach, nice and it's quiet here"; "I am safe, no problems, nothing untoward regarding my safety"; "I have not concerns about my safety" and "I know at night I am safe".

Safeguarding incidents had been recorded and reported to the local safeguarding authority. There were systems in place to record safeguarding concerns at Carey Lodge.

Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. One member of staff said, "It's about protecting people and to protect them (people) from abuse". We saw the home was calm and people were relaxed in the company of staff and there was a good 'banter' between people and staff. This enhanced people's experience of living at Carey Lodge.

Accidents and incidents were recorded and the manager told us how they regularly checked these. For example, if anyone had a fall the manager investigated the reason for this to ensure where possible, processes were put in place to help mitigate this person falling again.

Arrangements for emergencies were in place. People had their own personal emergency evacuation plan (PEEP) in place. These detailed the person's individual needs in case of an emergency, for example, their mobility needs. The details were held in the person's care plan and a central copy was kept in the office by the fire board so that emergency services had access to the details.

Records relating to recruitment of staff contained relevant checks that were completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

We saw checks were in place to protect people's safety, for example, regular fire alarm test, fire doors check, key pad test (entry to areas) and 'dorgard' checks (shutters released when the fire alarm sounded).

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 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough staff on duty to meet people's care needs.