Mr David Krishnalall Jangali

Priory Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 1 September 2016 and 07 September 2016. Priory Lodge provides accommodation and care for up to 20 people. At the time of our inspection 19 people were being accommodated.

The service had a registered manager. 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 Care Act 2008 and associated Regulations about how the service is run.

Staff understood the principles of keeping people safe, but in practice these had not been followed. We found some risk assessments in place to meet their needs, but for some people relevant risk assessments were not found or up to date. This meant there were risks associated with people's care which staff were not aware of.

The environment had not always been maintained to a safe standard.

Sufficient recruitment checks had not been carried out before staff started work to ensure that they were suitable to work in a care setting.

Medicines were administered and stored safely. People were supported with their medicines but correct guidance was not in place when people were given medicines as needed (as and when required).

Staff had a basic knowledge of the Mental Capacity Act 2005 but this had not been properly followed or put into practice. This meant people did not have their mental capacity assessed and restrictions had been placed on people without their agreement or being in their best interests as authorised by proper processes.

There was a training programme in place for staff but this did not cover all the areas needed, which meant staff did not always have the knowledge to meet people's needs.

People enjoyed their meals and were offered a choice at meal times. People were supported to access a range of health professionals.

People did not always have their needs planned in a personalised way which reflected that their choices and preferences had been considered. This meant staff may not always have the best information on how to meet an individual's needs and preferences.

People were not always supported to engage in activities and individual interests were not always accommodated.

There were systems employed to monitor the quality of the service, but they had not effectively identified concerns which impacted on the quality of care that people received.

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 safe.

Some people's risk assessments were not reflective of their current risks and did not guide staff on how to care for people.

People were supported with their medicines but correct guidance was not in place when people were given medicines as needed.

The environment had not always been maintained to a safe standard.

Accidents and incidents had not been analysed.

The provider operated recruitment practices which were not robust.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a training programme in place for staff but this did not cover all the areas needed, which meant staff did not always have the knowledge to meet people's needs.

People were supported by staff who were not supervised or appraised.

Staff had a basic knowledge of the Mental Capacity Act 2005 but this had not been properly followed or put into practice.

People enjoyed their meals and were offered a choice at meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in making decisions about their care and support.

People had developed positive caring relationships with staff.

People's privacy and dignity were respected. Although the absence of locks on doors was not explored or explained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff demonstrated their knowledge about people's needs and wishes, but the care plans did not always have sufficient information to guide staff.

People did not always receive personalised care, which was in line with their needs or preferences.

People were not always supported to engage in activities and individual interests were not always accommodated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People's records were not always accurate and complete.

The service was not always well-led because there were no effective systems to manage risks across the service.

There were systems employed to monitor the quality of the service, but they had not effectively identified concerns which impacted on the quality of care that people received.

Staff knew how to question practice and system were in place to support staff to whistleblowing.

Priory 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. The inspection took place over two days and was unannounced.

The inspection team consisted of one inspector on the first day and two inspectors on the second day. The provider had kept us updated of events by sending us relevant notifications. Notifications are reports of accidents, incidents and deaths of service users that the provider is required to send to us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with the registered manager, the deputy manager and three care care staff. We spoke with 7 people who used the service. We observed the care and support people received in the home. This included looking in detail at five people's care plans in detail to ascertain if the care and support they received matched the contents in the plans. We also looked at these people's daily care records and records of their medication.

Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service.

We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and wellbeing were not consistently identified, managed and reviewed. Peoples' risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. Some care plans contained some risk assessments specific to health needs such as environment, behaviour, mobility and a person's overall dependency. However not everyone's health, safety and wellbeing had been assessed and protected.

The measures to minimise the risk in relation to mobility were recorded but there was no information about the specific equipment the person needed or where the specific transfer instructions could be found. The registered manager did tell us that newer staff would only transfer people with the support of experienced staff that knew people well. During the inspection we did observed a transfer from wheelchair to chair that was completed safely.

We saw that two people had bed rails in place but there were no risk assessments found within their care plans. One of these people had no current weights recorded so the service could not be assured that their pressure relieving mattress was at the correct setting. We also identified that they were at risk of skin breakdown and had previously had a pressure sore but we found no skin integrity risk assessment or detailed guidance in place for staff.

Risks associated with the use of bed rails with pressure relieving mattresses had not been assessed or recorded to ensure that they complied with safety guidelines. These were discussed with the management team who were unaware of this guidance.

We also identified one person at risk of choking, the risk assessment was out of date and just advised staff to cut food up small. There was no evidence found in any of the current or historical notes about a referral to speech and language Therapists (SALT) to undertake an assessment, although staff told us the person was seen a long time ago. There was a risk assessment found for choking on medication from May 2016 that stated 'give tablet one at a time in yogurt or custard'. When we spoke to staff they told us this person was not at risk of choking on medications because a risk of choking on food was identified the person may also be at risk of choking on medication. However, we found no evidence that the service had explored whether medications can be given in liquid, crushed or dissolved.

There were other incidents of identified risks to people where there was no detailed guidance for staff on how to manage the risks particularly around people's behaviours. One person had a history of behaviours that included that they may put themselves or other people at risk. Their care plan stated that staff needed to be aware of person's triggers and signs of low mood, but did not always include any information about what these triggers might be or guidance for staff about how to manage these behaviours.

Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us "I would report any concerns to my manager or CQC if I needed to." Staff had received training on protecting

people from harm and records we saw confirmed this. However, on one completed incident form a person who used the service had made an allegation of abuse, a risk assessment identified that the person had a history of making allegations, the risk assessment was dated the same day as the incident. When we spoke to the registered manager and other staff they confirmed that they were aware of this. However, when we looked at the person's care plan we could not find any other recorded incidents of this nature or detailed guidance for staff about how to manage this behaviour.

Accidents and incidents were recorded and escalated to the manager but we did not find any evidence that the information had been reviewed or analysed to support identification of trends or learning from accidents or incidents. There was no information to identify people's physical health needs and how this correlated to the number of falls they experienced. There was no evidence of any lessons learnt through analysis, or any changes in practice. The registered manager and staff were able to tell us about additional controls they had introduced but this information was not recorded. For example, they told us that they had put an alert mat in place for one person to reduce their risk of falling.

We completed a tour of the premises as part of our inspection. We looked at people's bedrooms, bathrooms, communal living spaces, the kitchen and the garden area. We found the garden was untidy and overgrown in areas. There was rubbish at the back wall on a raised flowerbed. The rubbish included an empty milk carton, food wrappers and cans. Around the outside of the garden was broken sofas piled up, broken chairs and other broken furniture. The clinical waste bin had lots of waste bags in but was unlocked. The staff told us that this was because they had just used it, but this should be kept locked.

A cupboard that was situated in the hall was found not to be attached to the wall but contained evidence it was once, a screw was still attached to top of cupboard and the hole was still apparent in the wall. Inside the cupboard various stock creams and chemicals were stored, the cupboard was unlocked. We brought this to the attention of the registered manager and deputy manager. When we checked this cupboard over an hour later the cupboard remained unlocked. We also found that wardrobes were not secured to the walls in the bedrooms. The provider had not carried out risk assessments to identify whether these wardrobes being unsecured may pose a hazard to people using the service.

We identified a fire door kept open with a large can of paint. The fire door had a sticker to inform staff to keep it closed at night. When we tested the fire door, the magnetic opener was broken and the fire door would not remain open without the can of paint.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that appropriate checks had been regularly undertaken by the deputy manager or by other external professional's, in order to provide people with a safe environment in other areas. For example, various fire safety checks were carried out on a weekly or monthly basis. Records showed that staff had attended fire safety training and staff and people that used the service were involved in regular fire drills. Other safety tests included up to date electricity and gas checks and bathroom and mobile hoist checks.

There were suitable arrangements for the safe storage, management and disposal of people's medicines. Each person had a completed medicine administration record (MAR) which recorded the medicines that people were prescribed and when to administer. There were no gaps or omissions in the MAR, and staff maintained an accurate stock count of medicines. The temperature of both the medicines room and fridges was monitored which ensured that people's medicine were stored within safe temperature limits. Where stocks were received and disposed of, accurate records were maintained. People's MAR's were complete

with an up to date photograph which ensured staff could identify the person correctly prior to administering their medicine.

However, where people had been prescribed 'as needed' medication (PRN) such as pain relief or medicines to control behaviour, guidance was not available to staff to determine when to use these medicines. For example, one person was prescribed a medication to reduce anxiety, there was not a personalised guidance document contained in the medicine record that instructed staff when to use these medications. When we spoke to senior staff that administered medication they were able to describe situations where this medication might be administered, but told us it had not been given for a long time as person's behaviour was stable.

We looked at the recruitment records for four members of staff. We found relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded. However, for two staff members only one reference was available. This meant the provider could not be assured that staff members they have employed are suitable and safe to carry out their role and work with vulnerable adults.

People told us there were sufficient numbers of staff available to provide their care and support, and these views were shared by the staff we spoke with. One person said, "There are enough staff and they are very helpful." Another person told us, "There are too many staff."
One staff member we spoke with told us, "It is currently holiday time but we do have enough staff."

People we spoke with told us they felt safe living at the service. One person told us, "I feel very safe." Another person told us, "I am safe and comfortable."

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was not fully following the MCA code of practice. A mental capacity assessment should be carried out to assess people's capacity to make certain decisions. People who do not have capacity to consent to any area of their care and treatment should be supported by relatives, health or social care professionals in their best interest.

Some people had not had their mental capacity assessed. This might lead to people losing the right to make their own decisions in respect of their care and treatment.

Despite training in the MCA and DoLS, we found instances where people's liberty and rights were restricted and relevant assessments of mental capacity had not been undertaken. For example, we identified that certain decisions about where one person spent their time had not been asked, considered or referred for a best interest meeting. There was no supporting documentation that explained the reasons why the person was in bed and whether any other option had been considered. We also saw that two people that staff told us did not have capacity had bed rails in place and again we did not see this decision had been considered or referred to in the person's best interest.

Whilst these actions may have been in people's best interests and represent the least restrictive option available to keep people safe we found that mental capacity assessments and subsequently DoLS applications had not been completed which were necessary in order to deprive a person of their liberty lawfully in accordance with the legislation.

We spoke with staff about their understanding of the principles of the MCA and how they supported people with decision-making and giving consent. Staff were able to demonstrate how they helped people make decisions in their day to day lives. For example, one member of staff told us, "We see if clients can make a decision, and give them time to make that decision." Another member of staff told us, "I would check care plan if I was unsure and ask the manager." However the care plans did not contain all of the relevant information to guide staff on people's capacity.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We manager told us about staff training and support, showing us a training matrix that detailed the training staff had received, training included first aid, infection control, fire safety, safeguarding, moving and positioning, food hygiene, equality and diversity, care planning and medication. One staff member said, "I've done all the mandatory, first aid, food hygiene, fire safety." We checked records of people who had recently been employed by the provider and found they were either working toward or had completed an induction and had started to complete the care certificate with support from the in house trainer. The Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge, and behaviours to provide compassionate, safe, and high quality care and support.

Staff we spoke to did have a good understanding of people's needs and how to support them. However, although we were provided with evidence that training for one specific health condition had been undertaken and staff spoken to demonstrated the required knowledge. Some other people who used the service had diagnosed mental health conditions and staff had not received appropriate training to enable them to support people with their mental health needs effectively.

Despite not always receiving regular formal one to one supervision or appraisals staff felt supported. One member of staff told us, "I can talk to the manager whenever I want." Another member of staff told us, "We do sometimes have supervisions and meetings and I can talk to [Named manager] at any time." Staff we spoke to were not clear on the frequency of supervisions. We checked seven staff files and could only find one appraisal and that had not been dated. Staff meetings were held regularly and staff told us that handover meetings were detailed and held twice daily.

These failings are a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records. However, we identified one person that had been assessed at risk of choking and had not been referred to the speech and language team (SALT) for an assessment. The registered home manager told us this would be done following the inspection.

The cook ensured people were provided with meals that met their nutritional and cultural needs. We saw that they prepared meals to suit each person's individual needs, such as pureed food; they had access to information about people's dietary needs, their likes and dislikes. One person told us "I am vegetarian and I always receive a vegetarian meal." Another person said "The food is good, and I choose what I want."

Staff were aware of the people who needed assistance and who needed prompting to eat; most people chose to eat together in two dining rooms which were both set out so people could eat sociably. People were offered two alternatives, but could also choose something else if they did not like the two choices available. The cook told us she planned to make some more changes to the menu's based on people's choices and preferences. On the day of inspection we noted that two people were provided with an alternative to the two choices offered. Menus were displayed for people to see. Food looked appetising and people ate well.

We discussed the presentation of the pureed meal with the cook as it had been blended together which did not make it look very appetising, the cook told us she would investigate best practice in this area.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that staff respected their privacy and knocked on the door prior to entering. We observed this on the day of our visit. A staff member we spoke to told us how they would respect people's dignity. They told us "I knock on doors and close curtains or blinds.". However, we found people's privacy and dignity had been compromised by the absence of locks on doors. One person told us, "They do knock but I would like a lock." The care plans did not contain any information about why people could not lock their doors or any risks associated with this.

Two of the bedrooms still accommodated people in shared rooms, although we checked with people using these rooms and they were happy with this arrangement.

We asked people if the staff team were caring. People told us, "They are helpful and kind " and, "They are helpful, but there are a lot of new staff." Another person told us, [Named] my keyworker is very kind helps me a lot."

We saw some good examples of how staff had responded to people's individual needs. For example a person that required prompting with personal care needs confirmed that staff did this.
The person said, "The staff always prompt me to have a bath."

Staff knew people's routines well, we spoke with staff about people's daily routines, their likes and dislikes. From these discussions it was clear that staff knew people well. For example, staff could describe what time a person liked to get up and how they chose to spend their day.

During the meal we saw people helping to lay the tables to prepare for lunch. The tables were nicely laid with placemats, serviettes, cutlery and condiments. The cook supported staff with the meal time, and staff chatted to people while they ate. Staff supported people to eat in a kind and caring way. One person had a plate guard in place to support them to eat independently.

We were not always able to see that people were involved in their care planning. The registered manager and staff told us that they were, but there was no consistency in the care plans that showed people were involved. In paper care plans we did see some evidence that people had signed their care plans but these consents were out of date, on the electronic care plan there was no evidence found that people were involved in their review process.

Most people's rooms were personalised and did contain personal items such as photographs, personal music and televisions. The registered manager told us some bedrooms had been redecorated and some were still to be done.

Requires Improvement

Is the service responsive?

Our findings

Most people had lived in the service for a long time and people were assessed before they moved into the home. From these assessments people had care plans developed. It was not possible, from the way care plans had been written, to establish people had always been involved in the development of their care plans. The provider had recently introduced electronic care plans but had not completed these in detail. Paper care plans remained in the service but unfortunately had not been kept up to date. Care plans had the same format and tended to include information in the same areas, rather than being individual to each person's needs and preferences.

Some people's care plans had information that was out of date, which meant staff would not be able to respond to people's needs in a positive and appropriate way. For example, we found recordings about a person's catheter but when we checked, the person now had a different catheter. We did see evidence of district nurse notes that did record the correct catheter but this was not detailed on the care plan. Most care plans reviews were not up to date.

There was some information in people's care plans about their lives and their preferences but these did not contain much detail. Consequently care plans were not significantly personalised. In one person's care plan it recorded in the occupation and entertainment section that the person liked to watch television, this person was cared for in bed and when we visited the person the television was off. We checked the person's notes and found no recordings of what the person had been offered or provided with in terms of their preferences.

People had mixed feelings about the activities on offer. People felt they did not receive much in the way of social stimulation. One person said, "We don't have activities. I try and get to town if there are staff available." Another person told us, " We have done some model making." Activities for the day were recorded on a white board highlighting the morning and afternoon activities, the board was not dated so it was unclear if this was for today or had been like this for a while. The morning activity stated adult colouring, and the afternoon activity stated bingo or scrabble cards. There was a statement written to invite people to write what activities they might like, but the board is out of reach of people with disabilities, and located in the conservatory where people were not sat. There was also no pen to write suggestion's down with, in spite of inviting people to use the pen provided.

One person told us that they were struggling to access the community, when we spoke to the registered manager they told us this person is able to walk to the shops, but in a different section of the care plan it had recorded a recent increase in the persons pain due to a previous injury. The care plan did not record or evidence how the person might be supported. When we spoke to staff they told us that they had been driving the person to the shops. This indicated that care plans were not clear about the care and support people actually need.

Some people we spoke to were able to access the community independently. One person told us, "I go out on my own, I go to the park, I go to church and I go out on Thursday's." Another person told us, "We go to the

park." Staff we spoke to told us people were given the opportunity to go out most days but not everyone wanted to go out. One staff member told us, "We do try to motivate people to go out but they are not always willing."

In a previous quality assurance audit for 2015 we noted that recruiting an activity organiser was one of the actions outstanding. We discussed this with the registered manager who told us they had recruited a person but they had left and this action now remains outstanding.

There was a complaints procedure in place for people to access. The registered manager told us that he had not received any complaints. However during our inspection one person told us about a concern they had. When we asked the staff about this we were told the detail and reasons behind this concern. However when we checked the person's care plan and the complaint file we could find nothing recorded. This did not reassure us that people's complaints were being taken seriously and investigated, so the findings and outcomes could be recorded.

Requires Improvement

Is the service well-led?

Our findings

Records were not accurately maintained and needed to improve. Care records needed to be improved; we discussed the two systems with the manager who told us that they had nearly completed all the electronic care plans. However the paper care plans were out of date and did not reflect people's actual care, this evidenced that the transition to electronic care plans was slow and therefore accurate up to date information was not always available.

Accidents and incident were recorded but there was no evidence that the information had been reviewed or analysed to support identification of trends or learning

The registered manager completed monthly audits in areas such as meals, fire procedures, complaints, medicines, accidents and the environment. However, we found these audits did not contain any detail and were mainly tick sheets. The previous five months had been ticked and recorded no action.

Given the concerns noted during our inspection, this meant that the registered manager was not always proactive in identifying and resolving shortcomings in the service. For example, Some people's risk assessments were not reflective of their current risks and did not guide staff on how to care for people. The service had failed to ensure the environment was maintained to a safe standard and that recruitment processes were robust. There was no evidence of individual mental capacity assessments for people living at the service on how their freedom may be restricted or what least restrictive practice could be implemented.

The registered manager told us that a service user survey was undertaken in 2015, however when we asked to see evidence of this survey the registered manager was unable to locate the information or findings from the survey. We looked at meetings held with people who used the service and could only find one meeting dated January 2016, when we looked for previous meetings these were from 2014. Through these processes the provider had not sought the views of people or their representatives in relation to improving the service.

This inspection highlighted shortfalls in the service that had not been resolved by the monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were positive and said that the registered manager was very approachable and knew what was happening in the service. One staff member told us, "They are very approachable and on some days works on the floor." Staff also said they felt supported by the registered manager. One staff member said, "[Registered manager's] and [HR manager] are both very supportive, I can talk to either of them." Another staff member said, "I can talk to the manager whenever I want."

The registered manager oversaw the home on a day to day basis and had a good understanding of people's individual needs. People knew who the registered manager was by their name and said they could approach

them. A person said, "I know who the manager is, their name is [Registered manager]." There was a clear management structure in place and staff knew who to go to if they had any issues. People received care from a consistent staff group which meant that people were familiar with them and staff knew people well. Staff we spoke to told they liked working at the service and teamwork was good. One staff member said, "We all work really well with each other," and another staff member said, "Everyone gets on well and teamwork is really good."

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff were acting in accordance with the requirements of the Mental Capacity Act 2005 where a person was deemed to lack capacity to give consent Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use this service were not provided with safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were systems employed to monitor the quality of the service, but they had not effectively identified concerns which impacted on the quality of care that people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide staff with appropriate training and supervision to enable them to carry out their duties.