Care Unlimited Group Ltd

Chipstead Lodge Residential Care Home

Inspection report

Care unlimited Group Limited
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Ratings

Overall rating for this service	**Good**
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Chipstead Lodge is a care home that provides accommodation and support for up to 36 people. The home specialises in providing care for people with a past or present mental health illness, people living with dementia and older people. Accommodation is arranged over two floors part of which is an extension of the original house.

Summary of findings

The home did not have a registered manager in post on the day of our inspection. 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 and associated Regulations about how the service is run. There manager had an application in progress with us and since the inspection have become the registered manager.

People told us they were treated well by staff who were kind and caring. People's privacy and dignity was maintained. We saw staff knocked on people's doors before they entered, and personal care was undertaken in privacy.

Staff had undertaken training regarding safeguarding adults and were aware of what procedures to follow if they suspected abuse was taking place. There was a copy of Surrey County Council's multi-agency safeguarding procedures available in the home for information and staff told us this was located in the office for reference.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The manager and staff explained their understanding of their responsibilities of the Mental Capacity Act (MCA) 2005 and Dols and what they needed to do should someone lack capacity or needed to be kept safe.

Staff had a good understanding of the Mental Capacity Act 2005 and appropriate procedures were in place relating to Deprivation of Liberty (DoLS).

Assessments were in place where people had an identified risk. For example a person was required to have a soft diet because they were at risk of choking, and people who smoked had assessments in place to protect them from being burnt.

Care plans were well maintained, easy to follow and information was reviewed monthly or more frequently if needs changed. For example someone was having ongoing diagnostic treatment which was clearly documented.

People's health care needs were being met. People were registered with a local GP who visited the home weekly. Visits from other health care professionals for example care managers, and district nurses also took place.

People had sufficient food and drink to keep them healthy. We saw lunch was well organised and people had the choice of three dining areas. There was ample staff support available for people who required help to eat.

We looked at the medicine policy and found all staff gave medicine to people in accordance with this policy. Medicines were managed safely and people received their medicine in a safe and timely way.

There were enough staff working in the home to meet people's needs. People said the staff were very good and they never had to wait when they rang their bell. We saw several examples of staff responding to call bells in a timely way throughout the day.

Staff recruitment procedures were safe and the employment files contained all the relevant checks to help ensure only the appropriate people were employed to work in the home.

People were engaged in activities that staff facilitated as there was no activity person in post during our inspection. People had been provided with a complaints procedure and knew how to make a complaint. They told us they knew who to talk to if they had any issues or concerns.

Adequate systems were in place to monitor the service being provided, for example reviews of care plans, risk assessments, and health and safety audits.

The home was being well managed. People said they found the manager approachable and available. The standard of record keeping was good and records relating to the care of people were stored securely.

Summary of findings

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 safe.

There were enough staff available to safely meet people's needs.

Risks to people were managed well and staff were aware of the assessments in place to help prevent avoidable harm.

Staff had a clear understanding of how to protect people from the risk of abuse and the procedures to follow if abuse was suspected.

Medicines protocols were effective and people received their medicines safely and according to their medicines plan.

Good

Is the service effective?
The service was effective.

The provider and staff had a good understanding of the Mental Capacity Act 2005.

Staff had the appropriate training to meet people's needs and received adequate supervision.

People received adequate nutrition and hydration.

Good

Is the service caring?
The service was caring.

People were involved and encouraged in decision making.

People were treated with dignity and respect and were responded to promptly when they needed help.

Privacy and dignity was maintained.

Staff spoke with people in a polite and kind way and they were looked after by a staff team who were caring and kind.

Good

Is the service responsive?
The service was responsive.

People received personalised care that was responsive to their needs.

People's concerns and complaints were listened to and responded to according to the complaints procedure in place.

Some people were encouraged to participate in activities. However the activity coordinator post was vacant but had been recruited to. .

Good

Is the service well-led?
The management team had a good understanding of the service's aims and objectives and the needs of the people who lived there.

Good

Summary of findings

Staff felt supported by the manager and were encouraged to develop their skills further.

There were quality assurance processes in place to monitor the service.

Chipstead Lodge Residential Care Home

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 was an unannounced inspection, which took place on 17 July 2015. The inspection team was made up of two inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the service is required to send to us by law.

We spoke with 10 people who used the service eight staff, three relatives the acting and deputy managers, the chef, three health care professionals and the operations manager. We looked at six care plans, six risk assessments, four staff employment files and records relating to the management of the home including audits and policies.

Not everyone was able to communicate with us so we spent time observing the interactions between people and staff. We also spent time in the three lounge areas and three dining areas observing how care and support was provided.

The last inspection of this home was on 12 February 2014 where there were no concerns identified.

Good

Is the service safe?

Our findings

People said they felt safe. One person said “I came here because I was unsafe at home and staff here take good care of me”. Another person said “Because I lived alone I found it hard to manage, now I have peace of mind as staff here keep me safe”.

Staff told us they would recognise the signs of abuse and were aware of the various types of abuse. They said the if they felt uncomfortable about how someone was being treated or if they suspected that abuse was taking place they would talk to the manager immediately and were confident that the manager would act on their concerns.

There was a safeguarding policy in place that provided staff with guidance to follow and all staff had read this policy. They told us they had undertaking training on safeguarding people from abuse and had access to contact numbers displayed on the notice of people to contact if they needed to. We spoke with staff individually during our visit and they were all aware of their roles and responsibilities to keep the people they cared for safe.

People told us that there were enough staff available to safely meet their needs. One person said "There are always enough staff here and they are good to me”. Another person said when they used their call bell staff always came to see what they wanted. A relative said there was always enough staff on duty when they visited and their family member would say if they were kept waiting for anything. A health care professional told us they thought that the service was well staffed and that people looked comfortable and well cared for when they visited. We saw several examples of good practice throughout the day when call bells were answered to promptly. This meant people did not have to wait for assistance.

The duty rota showed the allocated number of staff on duty was six care staff during the day and three care staff during the night. Both the manager and deputy manager worked in an administration and supervisory role. The manager told us they had created new posts for two cleaners and a laundry assistant. They said the arrangement was working well as it meant the care staff had more time for caring.

There was a safe recruitment process in place and the required checks were undertaken before staff started work. We looked at staff employment files and noted that staff had been recruited safely. This included two written references, a past employment history, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People had risk assessments in place for identified risks. Plans were drawn up with guidance for staff to follow in order to keep people safe. For example one person was at risk of the person choking and had a management plan in place to reduce the risk. This included soft food and thickeners in their drinks. Staff understood and told us how important the plan was to minimise the risk of choking. Another person was at risk of developing pressure ulcers due to the poor condition of their skin. We saw they had a Waterlow score risk assessment which is a tool used to assess people’s skin integrity in place and guidance for staff to help prevent this occurring. We saw risk assessments in place for people who smoked and guidance for people and staff to follow to keep them safe.

People’s risk assessments were reviewed monthly or more frequently if an additional risk was presented or people’s needs changed. Updated information was recorded and shared with staff and health care professionals to promote good practice.

People received their medicines safely. There was a policy in place for medicines administration. Staff who had responsibility for the administration of medicines had signed this policy indicating they had read and understood this. Staff had received training in medicines safety awareness which was updated annually. Medicines were stored safely and securely in the medicines room on the ground floor. A fridge was available for medicines that had to be stored below room temperature, for example insulin, eye drops and creams.

Appropriate arrangements were in place in relation to the recording of medicines. The service used the medication administration record (MAR) chart to record medicines taken by people. We noted appropriate codes were used to denote when people did not take their medicines.

For example if they refused, if they were on leave or in hospital. The MAR charts included information about people’s allergies, if they required PRN (when required) medicines and a photograph for identification. The

Good

Is the service safe?

majority of medicines were administered using the monitored dose system (MDS) which were supplied by a local chemist that also undertook audits of medicines in the home.

Good

Is the service effective?

Our findings

People were supported by staff with the skills and training required to meet their needs. A relative said "The staff are so good they know exactly what Mum wants and needs". People told us the staff "Knew their job" and were "Spot on" when it came to undertaking their roles.

Staff told us they had undertaken induction training and were mentored by a senior staff member until they were assessed as competent to undertake duties alone. We looks at training records in place and saw that mandatory training which included manual handling, first aid, food hygiene, fire safety awareness, health and safety, dementia awareness and infraction control was undertake by staff as part of their ongoing development. Staff were supported to undertake further training for example a certificate or diploma in social care.

Staff had also undertaken specialist training in the management of aggressive behaviour and de-escalation management to support people living in the home with behaviours that challenge. The training records we saw accounted for all the training provided. This meant the provider was proactive in identifying the training staff needed to adequately prepare them for the roles and responsibilities. We observed people becoming agitated during the inspection. We saw staff respond in a kind and calm manner. Staff explained to people when they could not understand them, and asked them to repeat slowly what they wanted to say. We saw the person responded to this approach in a positive manner, calming them sufficiently to be able to express their needs.

Staff told us they were having more regular supervision since the new manager was appointed. They said during supervision with their line manager their strengths and weaknesses were discussed and were given the opportunity to address issues or concerns as a result.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager was aware of the changes in DoLS practices and had policies and procedures regarding the Mental Capacity Act (MCA) 2005 and DoLS. We saw in care files application for DoLS had been made appropriately. We also saw mental capacity and best interest assessments had been undertaken prior to a DoLS request being applied for. For example when it was in the person's best interest to be cared at Chipstead Lodge as they did not have the capacity to care for themselves at home. This demonstrated the service took appropriate measures to ensure they did not restrict people unnecessarily. We saw examples when some staff asked people's consent before they undertook everyday tasks such as "Would you like to sit to the table for lunch" or "How many spoons of sugar would you like in your tea".

People said they liked the food and said the standard of catering was good. They said the chef gave them a choice and if they did not like this there was always an alternative they could have if they wished. We saw staff asked people each day what they would like for their meal and the information was recorded and given to the chef who then prepared the food. We saw people were provided with drinks and snacks throughout the day.

We observed lunch being served and people had the choice of three dining areas to choose form. One person said "I am going to eat here today (small dining area) as I don't feel like walking down to the main dining room, I do that sometimes". Tables were nicely laid with table cloths, drinking glasses, condiments and cutlery. A selection of juice and water was also available.

Food was served by the chef in the main kitchen through a food hatch to the dining area. We observed the chef carrying out good practice regarding the hot holding of food where we saw regular temperature probes were carried out ensuring food was served at the appropriate temperature. Special diets for example soft or pureed food was presented well and we saw people who required support with eating was given this by staff who sat with then in the dining room. One person said "I had a second portion of fish and chips today with tomato sauce on the first and brown sauce on the second".

Some people were at risk of losing weight and as a result there were Malnutrition Universal Screening Tools (MUST) in place so that the risk to people could be managed. People's weight was monitored regularly and the results recorded so that appropriate action could be taken should people lose weight. The service had access to a dietician and speech and language therapist for further guidance when this was required.

People's healthcare needs were managed well. People had regular access to chiropody, dental care and eye care and people could either access this in the community or home

Good

Is the service effective?

visits were arranged. Staff told us that everyone was registered with a local GP who visited the service weekly or more frequently if required to do so. People told us they could see the doctor when they needed to and if they required additional support for example consultant intervention or psychiatric support this was arranged by their GP. One person told us they had significant health issues and the staff supported them throughout. “They understood how I was feeling and gave me time to talk”. A health care professional said they were encouraged by the by the significant improvement in the home and felt people well cared for.

Good

Is the service caring?

Our findings

People told us they were very happy living in the service and that staff were kind and compassionate. One person "I love it here and the staff are my friends". Another person said "It's a good place to live". A relative said "It's an amazing place and my relative is really well cared for". We have good quality staff here."

We were able to see from observations and from our interactions with people that they were content living in the service. People were interacting with staff and in a trusting and confident manner and staff responded in a kind and caring way. We saw staff speak with people at a pace and manner which was appropriate to their levels of understanding, and staff gave people time to respond to questions. For example when they were choosing what to eat or where they wanted to sit.

Staff provided care and support in a kind and caring way and had time to spend with people individually helping them with specific needs. One person wanted to set up their easel for painting and a staff member was able to support them. Another person was having an anxious time and we saw staff provide one to one support to sit and talk their problem through and provide reassurance. A health care professional told us they were generally "very satisfied" with the level of care and support provided by the service.

We saw people were well cared for and wore appropriate clothing that was clean. One person said "Staff help me have a shave every morning", and another person said "Look at my painted nails what do think of the colour". We saw people wore the appropriate footwear and we heard a staff member remind someone who was going to have a cigarette in the garden that the grass was damp and suggested they should change their footwear.

People's privacy and dignity was respected. We saw staff knock on people's doors and wait for a reply before they entered which helped maintain people's dignity. Some people had their own door keys to further promote privacy. People were encouraged to bring ornaments and photographs into the home to make their bedrooms more personal to them. Staff supported people who did not have relatives to personalise their individual space. A staff member said" I like taking people shopping for nice things for their room and they appreciate this".

Relatives told us they were welcome in the home at any time and encouraged to participate in organised events and care reviews. They said there were private areas where they could visit their family member and speak without being overheard.

Staff understood the wishes of the people they cared for. For example one person liked to have gender specific staff to undertake personal care, and staff confirmed this happened.

People were encouraged to make choices about their daily routines. Some people chose to spend time alone and participate in activities they liked. One person said "I can sit in the garden to have a cigarette and admire the flowers, which is relaxing in the summer. During the winter I use the smoking room". We spoke with a person who had to move rooms after a hospital admission. They told us staff explained to them it was for their own safety and to help prevent them from falling. They said they were happy about being included it the decision and said "They really do care".

Good

Is the service responsive?

Our findings

People had assessments undertaken before they were admitted to the service in order to ensure there were the resources and expertise to meet people's needs. People were involved in their assessment as much as possible and were supported by their care manager or a family member if appropriate. The manager told us these had recently been reviewed and updated. They said as a result some people had now moved to more appropriate placements which were able to meet their changing needs. Relatives told us they had been involved in part of the assessment especially with their family member's life history which helped build a picture of what the person was like. The assessments we looked at were informative and explained the needs of the person which included areas such as communication, personal background, likes and dislikes, their physical health needs, cognitive ability, their personality when unwell, how they engaged with others, their dietary needs and information about their family and friends.

People had care plans in place which were written on information gained from the needs assessments. Each care need was supported with a plan of care and objectives to be achieved. The reviews of care were undertaken monthly or more frequently if needs changed. One person's care plan identified that they were at risk of choking and written guidance for staff was provided for staff to manage this risk. Another person had an interrupted sleep pattern and they also had guidelines in place to manage this and to minimise disturbance to others. Staff recorded daily entries in the care plans about how care was delivered on each day and how that person was feeling and if they had any visitors either family or health care professionals. Care plans were reviewed with people monthly of more frequently if people's needs changed. Staff also had daily handovers to discuss relevant information regarding people they looked after.

On the day of our visit the activities coordinator post was vacant. The manager told us this had been recruited to and they were waiting on the relevant security checks to be in place before the staff member could commence work. Staff were undertaking activities for example one to one or group talking. People were also supported to walk in the garden, play music and join in a group game. People in the small lounge were watching a film of choice on television. We heard a staff member discuss with people what they wanted to do that afternoon, and were planning a trip to the local shops. People told us that generally there was enough to do and they were looking forward to the new activity staff starting work.

People's spiritual needs were observed and visits form various clergy were arranged on request. A church service was organised regularly which also included Holy Communion for people who wished to attend.

People knew how to make a complaint or comment on issues they were not happy about. People and their relatives were provided with a copy of the complaints procedure when they moved into the home. There was also a copy of this displayed in the main entrance. People said they were happy and did not have any issues to complain about, and would know who to talk to if they needed to. We looked at the complaints record and saw the last formal complaint was made on 20/12/2014 and was resolved using the service complaints procedure.

Good

Is the service well-led?

Our findings

The home was being managed well by a manager who had an application in progress with us to become the registered manager. They are now registered with us. They had recently employed a deputy manager who had commenced their role the week of our visit. People were happy about the management arrangements in the home. One person said "I am well supported and things get done now." People said they could talk with the manager every day and they were listened to. Relatives told us the manager kept them informed regarding any changed in their family members care or treatment and they were able to ring the home and visit at any time. A health care professional said the manager was proactive and worked well with other health care professionals.

Staff felt supported by the management arrangements that were in place and said the manager was approachable and listened to any concerns or suggestions they had. For example an additional cleaner and laundry assistant were employed which meant care staff had more time to spend providing support to people. This decision impacted on good practice with less accidents and episode of challenging behaviour recorded.

The provider had adequate systems in place to monitor the quality of the service. Regular service meetings took place to monitor and review the standard of care provision and make improvements or amendments when required. For example when someone had an appointment and required an escort preparations were made in advance in order not to impact on the provision of care for other people in the service.

House meetings took place and people told us they were able to give their views on how the home was run. We saw people looking at pattern books and being asked to give their opinion regarding flooring which was going to be changed which had been discussed at a meeting.

Relative meetings took place every three months. The manager told us she had moved these to a Saturday for convenience to enable more relatives to attend.

Monthly visits from the quality assurance coordinator took place which was based on CQC's five domains of safety, effectiveness, caring, responsive and well led and reports retained in the home for information. There are also annual meetings when the business plan for the forthcoming year is discussed.

The standard of record keeping was good and up to date. Records were kept securely. Care plans and medication records were kept locked when not in use and to maintain confidentially. Reviews of care plans and risk assessments were undertaken in a timely way which meant staff had the most recent information and guidance in relation to individual's care. Medication audits were completed and any errors and discrepancies noted for discussion and improvement.

Health and safety audits were undertaken to promote the health and welfare for people and visitors to the service and to maintain a safe working environment. Audits of infection control, housekeeping audits, catering audits, and audits of accidents and incidents were undertaken and evaluated to measure the service being provided. Issues identified were discussed at service meetings.

People and their relatives were asked to complete customer service satisfaction questionnaires to give feedback to the provider regarding the service.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider continued to inform the CQC of all significant events that happened in the service in a timely way. This meant we are able to check that the provider took appropriate action.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.