Care Quality Commission

Squirrel Lodge Limited

Squirrel Lodge

Inspection report

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Lowestoft
Suffolk
NR330PD
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Date of inspection visit: 9 October 2014
Date of publication: 27/03/2015

Ratings

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

Overall summary

Squirrel Lodge provides accommodation and personal care for up to 24 older people who require 24 hour support and care. Some people using the service were living with dementia. There were 20 people using the service when we visited on 9 October 2014. This was an unannounced inspection.

There were two registered managers in post, and they jointly managed the service. 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.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider needed to make improvements to ensure people received care that was safe, effective and responsive to their individual needs.

Summary of findings

People's needs were not always met in a safe way because there were not enough staff available to meet their needs. We saw that this left people alone when they needed help to move or when they needed reassurance and support.

Staff training was not detailed or effective enough to ensure staff understood the needs of people and how they needed their care to be delivered. Although staff had training to support people living with dementia, their practice was out of date and the plans of care did not reflect how individuals should be cared for.

Staff were recruited safely and had checks carried out to ensure they were suitable for their roles. They were caring, respectful and knew people well. People or their advocates were given the opportunity to participate in reviews of care which made them feel involved and listened to. Relatives, health professionals and people using the service were complimentary about the staff.

Care records for people did not document enough specific information about people's needs in order for staff to be able to deliver people safe and appropriate care. Care staff could not tell us how they would support people with specific and complex health needs. People did not have enough opportunities to be engaged and stimulated during their day. Some people were bored or became agitated with nothing to distract their attention. People, including those with more complex needs, did not have their interests explored as part of care planning to ensure their welfare.

There was a lack of proactive leadership and oversight to ensure the service was being run in people's best interests. Systems in place to monitor the quality of the service were not robust enough to independently identify issues and take action to improve. Where people, staff and relatives had made suggestions about how to improve things, they felt they had not been listened to.

You can see what action we told the provider to take at the back of the full version of the report.

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?
This service was not consistently safe.

Although staff were recruited safely, the roles and responsibilities of staff meant there were not enough to meet people's needs.

People were provided with their medication when they needed them and in a safe manner.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff did not receive adequate and appropriate training to meet the needs of people. Staff were not appropriately supported to carry out their roles effectively.

Requires Improvement

Is the service caring?
The service was caring.

The relationships between staff and people using the service were caring. People and their representatives were involved in making decisions about their care.

Good

Is the service responsive?
The service was not consistently responsive.

There were no formal care plans for people using the service showing how their individual care should be provided.

Care was task focused and not personalised to the individual. People were limited in their options to keep them stimulated and engaged in their daily lives.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

The service was not always run in the best interests of people living there. People, staff and relative's input was not always listened to or explored to help the service improve.

Quality assurance systems were not robust enough to identify, monitor and address shortfalls in the service.

Requires Improvement

Squirrel 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 9 October 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people who were able to express their views verbally and the relatives for one person. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three health and social care professionals about their views of the care provided. Feedback received was complimentary about the service, the management and the staff team.

We looked at the care records for seven people. We spoke with five members of care staff and the two registered managers. We looked at records relating to the management of the service, staff personnel and training records, and the systems in place for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

There were not consistently enough staff available to ensure that people were kept safe. For example, people who were dependent on staff to move were left in a communal area with no staff present for 30 minutes. People had no way to call for staff assistance as call bells were out of reach. When one person said they wanted to go to the toilet we had to find a member of staff to support them. One other person showed signs of distress and continually called out, "I don't know what to do, I don't know what to do." We had to intervene to keep someone safe who was identified as at risk of falling. Staff were not following the risk assessment for this person, which stated they should not be left alone with no staff present to assist them. Care staff were tasked with cleaning the service, and this took their focus away from delivering care or spending time with people. They told us that people are often left alone whilst they complete cleaning tasks in the mornings and that they felt this was a risk to people being safe.

During another observation, we saw that people were left in a communal area of the service for 40 minutes with no staff present. Four people seated in this area needed full assistance to mobilise, and two had complex needs which meant they required more support from staff to safeguard their health, safety and welfare. Four members of care staff told us there were not enough staff to support people, and raised concerns about not being able to meet people's needs or offer a “personal touch”. A health professional told us that there were not always enough staff to assist people, and said that on occasions they struggled to find an available member of care staff to speak with. Another health professional commented “There is not enough staff on the floor. You can just see they’re stretched and people don’t get a lot of time devoted to them individually.” One person using the service told us “The staff are always rushed off their feet.” One other person said “I can go ages with no one coming to my room to see me, mind you; they’re all so busy that I can understand why.” A relative told us “The staff work hard but there’s never enough bodies to get everything done. They’re all rushing around.”

The management acknowledged that cleaning tasks did take staff away from providing direct care but had not identified that this put people at potential risk. Therefore no action had been taken to increase staffing. They told us they would now look at ensuring there were enough staff to keep people safe.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they received their medication when they needed it. However, we saw that for one person, the dose stated as needed on their boxed medication differed from the dose recorded on the medication administration record (MAR). This had not led to any mistakes in administration, but there was a risk that the person could have been administered a higher dose than was prescribed. The managers changed the records at the time of inspection to ensure this did not cause any further confusion.

People we spoke with told us they felt safe, one person said “Yes, I feel very safe here” and commented “I definitely would feel comfortable telling someone here if I didn’t feel safe.” Another person said "The staff really make me feel safe, I couldn't feel safer.” Staff told us about their responsibilities with regard to protecting people from abuse. They were able to describe the action taken to protect people when concerns were raised, and this included action planning to minimise the risks to people using the service.

Staff told us that they encouraged people to keep themselves safe, by ensuring they used mobility aids where they were needed and by seeking help from them rather than struggling to complete tasks alone. Staff demonstrated an awareness of what the risks to people were, and what reasonable steps they could take to minimise the risks. One person told us, "The staff really make me feel safe, I couldn't feel safer" and said “The staff encourage me to keep safe by using my frame, even though I don’t always like to.”

We observed staff using equipment safely during our inspection, and one staff member demonstrated how they checked equipment over before use. We looked at a number of hoists and wheelchairs and saw that they were free from flaws that could cause harm to people. A relative told us “I’ve no concerns about the safety of the home, everything is well maintained and the gardens are adapted so that [relative] can walk outside without falling over.”

Plans in place for emergencies helped to minimise potential risk for people. Staff told us what action they

Requires Improvement

Is the service safe?

would take to respond to an untoward incident or emergency such as a fire, and the understanding of these procedures was consistent among the staff team. Staff were also able to tell us what plans were in place to respond to unforeseen circumstances such as poor weather conditions which may prevent staff getting to work.

The management of the service operated a robust recruitment procedure which checked that new staff had the appropriate skills, background and qualifications for the role. This is because appropriate references and Disclosure and Barring (DBS) checks were sought prior to staff beginning work.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff who did not always have the skills, competence and support to ensure their needs were met consistently. Training was delivered by the management of the service, and did not always reflect changes to guidance or best practice. Three members of care staff told us the training they received wasn't adequate enough for them to feel confident that they were effectively meeting the needs of people. They said that they had no formal training in caring for people with dementia, and that this meant they found it difficult to deliver care to people with advanced dementia. This was demonstrated by their lack of action to effectively support a person who was distressed and calling out for their relative who was not there. We observed that this led the person to become very distressed as staff were unable to console them.

Because staff were inexperienced and lacked training in dementia care, this also meant that their knowledge about how to ensure people's choices and freedoms were protected was also minimal. For example, we observed staff carrying out tasks such as moving and handling without first asking for their consent. Staff told us that where people couldn't make decisions, they thought it was up to them to make decisions on their behalf about what they ate, where they spent their time and what they wore. They did not understand how to promote people's independence and protect their rights in relation to day to day living. Although staff had undertaken training in the principles of the Mental Capacity Act (2005) and how it affected the people they cared for, they were not clear on how they should obtain consent in situations where people lacked capacity, and did not know when it might be appropriate to make a best interest decision on a person's behalf.

Staff received regular supervision and appraisal from the management of the service, but this was ineffective as it was not used to identify training and development needs, and did not address poor practice. Staff meetings were held infrequently, but the minutes of these meetings did not demonstrate that they were used as a way to communicate best practice, gain feedback from staff or identify how they could develop the skills of the staff team. Staff told us they did not find these meetings useful or learn from them. The managers told us that staff supervision, appraisal and staff meetings were not used as an opportunity to communicate learning and offer development opportunities to staff.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us certain people did not have capacity, but were unable to explain how they had come to that conclusion and whether the person's capacity had been formally assessed. There were no records of formal MCA assessments for the people staff identified, and there was no clear care planning to inform staff practice when supporting the person with everyday tasks. The management of the service showed us Deprivation of Liberty (DoLs) applications they had made to the Local Authority, which had been authorised. This is a process to ensure that people do not have their freedom restricted unnecessarily.

People were able to make choices about what they wanted to eat at meal times from a menu. We observed that people were supported by staff to eat and drink sufficient amounts. One person told us "If I don't like what's on the menu they'll make me something else." We observed positive interactions between staff and people using the service during the meal, and people we spoke with were positive about their meals. One person told us "It was tasty and enjoyable." Another person said "It was appetising." We observed that people had access to drinks and snacks outside of meal times to boost their nutritional intake. Staff told us they regularly offered snacks and drinks to people who were unable to verbally request these, to ensure that they had enough.

We saw that people were provided with the equipment they needed to eat their meals, such as plate guards and adapted cutlery. Where people required assistance to eat their meals, we observed that staff upheld their dignity by supporting them on a one to one basis, enabling them to eat at their own pace. We observed that people who needed support were not rushed by staff, and staff encouraged them to eat sufficient amounts of food. Staff were responsive to the needs of people who sometimes required support or encouragement to eat, and staff observed those at risk of poor nutrition to ensure they were eating sufficient amounts. We observed that where one person was pushing food around their plate, a staff member identified this and asked the person if they

Requires Improvement

Is the service effective?

wanted their food cut up. After the staff member had cut the food up, the person proceeded to eat most of their meal. People's nutritional needs were assessed by the service and their weight monitored for changes. Where people required support to maintain good nutrition or to eat their meals, this was identified in these assessments, and our observations demonstrated that staff were aware of people's support needs.

People were supported to have appropriate input from other health professionals such as GP's, dentists and podiatrists. We observed during our visit that a GP was visiting several people, and they told us they had been asked by the management to see these people. Records were kept of when people were referred to other professionals.

Good

Is the service caring?

Our findings

The interactions between staff and people using the service were positive. Observations demonstrated that most staff treated people with kindness and respect. One person told us “They’re caring people and they take it upon themselves to get to know me.” Another person told us “They are kind, nothing’s too much trouble and they do the best they can.” At lunch time we observed that one person was supported to change their clothing after it had become soiled with food. This was done respectfully and promoted the persons dignity. We also observed a staff member assisting a person to arrange their clothing in a way which upheld their dignity. We observed that all personal care was delivered in private, and staff discreetly offered people support to use the toilet.

A relative told us the staff were caring, they said “The staff are all just brilliant, they really care about people and even give up their free time outside of work to volunteer to spend time with people when they aren’t getting paid. That really is going the extra mile and shows how much they really do care for them and enjoy spending time with them. Couldn’t really ask for more.” Three health professionals we spoke with told us that the staff displayed a caring and respectful attitude towards people using the service.

We found people, their family and friends, were involved in the reviews and discussion about their care. Records confirmed that where possible, people using the service had indicated whether or not they wanted their relatives involved in care planning and decision making. We saw that a care review taking place involved everyone in the person’s care and personal life they wanted. This included health professionals and family. Their relative told us “We're involved in every step of their care. The staff communicate really well with us."

People felt they were involved in making decisions about their home, and were consulted on things such as changes to menu’s and décor. For example, we saw staff giving people choices about how they wanted their personal care to be provided. This empowered people who were able to make decisions to have choice and control about their lives.

People told us that staff treated them with dignity and respect, and encouraged their independence. One person told us “They’re very respectful, they know I’m entitled to my privacy.” Another person said “They do treat me in a dignified way. Everything is done with my blessing and they’re respectful of that.” A relative commented “They do treat people here with respect, I have no concerns that my relatives dignity is ever compromised by the staff, they’re very respectful of us and my [relative].

Relatives told us they could visit their relatives any time, and were always welcomed by staff. One said, “I can come around any time, day or night. I always feel welcome.” Another said, “I come by every day and I’ve never been turned away.”

Requires Improvement

Is the service responsive?

Our findings

People's care needs were not assessed and planned in such a way as to provide sufficient information to enable staff to meet their individual needs and ensure care was delivered in a way which protected their safety and welfare. For example, there were no care planning documents in existence for people using the service which set out what their needs were and how staff should deliver their care. Care staff indicated on a task sheet when they had delivered personal care such as bathing or taking someone to the toilet but could not demonstrate knowledge of people's individual care needs.

One person using the service was a diabetic, but there was no care plan for this person to inform staff of how they should support the person to remain healthy. Staff could not tell us what type of diabetes the person had and whether this was diet or insulin controlled. Staff couldn't tell us what symptoms they should look for which may indicate the person needed contact with a doctor or other health professionals. This placed the person at risk of receiving inappropriate care by staff who did not have the knowledge to be responsive to their needs.

Another person had in place a long term catheter, but there was no care planning setting out how staff should support this person with catheter care, such as how often they should change the catheter bag. There was no information for staff setting out if they had any responsibilities in supporting the person with their catheter, or if these responsibilities lay with the district nurse. In addition, there was no information for staff as to what signs they should be aware of which may indicate a problem with the catheter which required input from another health professional. Staff were unable to tell us how they checked the persons catheter to ensure its integrity and identify any possible problems, and they were unable to tell us how they would recognise if the person had a urinary infection, which can be common with long term catheters.

One person was at risk of developing a pressure ulcer, but there was no care planning stating how staff should support the person to reduce this risk, and what equipment was in place to minimise the risk further. The management told us that the person required regular repositioning, but the repositioning charts didn't identify the frequency and staff could not tell us this information. The records of repositioning contained large gaps and with staff unable to confirm when or if it was done we were not assured that their care was being delivered effectively.

A referral to the dietician had been made for one person, but there were no records of what advice or guidance had been given to staff and they were unable to tell us. We were told by the kitchen staff that this person required a food supplement, but care staff we asked could not tell us what supplement the person had or how it was intended to be used.

Reviews of people's care needs were carried out, but changes did not feed into the planning of care, and there was a lack of clarity about how staff would know what they needed to do differently. Care staff told us that they relied on another staff member to tell them when something had changed, and said they wouldn't read the care review document for this information. There was a system for staff to be updated, but we found it was ineffective as staff could not tell about people's up to date care needs. This left people at potential risk of receiving inappropriate or unsafe care.

There was no documented information for staff with regard to people's preferences for how they would like their care delivered for them as an individual. There was a lack of information about people living with dementia, such as information about their past history, likes, dislikes, hobbies and significant events in their life. One staff member told us that they found providing care to people with complex needs difficult, as they didn't have the information needed to fully understand the person.

There were no care plans to demonstrate how people had been assessed to ensure they were stimulated and spent their time in a meaningful way. Staff were unable to show us how people were supported to explore hobbies or interests. One person told us "I'm going to sit here and do nothing." We asked what they wanted to do, and they told us "It's not what I want to do, but it doesn't matter, it's all I can do."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their representatives were given the opportunity to feed back their views as part of an annual survey. The last survey identified trends in negative feedback. However, the management had not yet taken

Requires Improvement

Is the service responsive?

action to address people's dissatisfaction in areas such as food and how they spent their time. The management had not yet used people's comments to inform learning and to implement changes in the service delivered as a result. This meant that people felt that their views were not always considered, listened to and acted on in a timely manner.

Changes were not made as a result of what people told the management. One person told us "We can go to residents meetings every now and then, but to be honest, they don't often change anything." Another person told us "We can go to meetings. Nothing has ever come of things I've suggested though." A relative told us "We go to the meetings but there's not always much point as nothing has ever changed as a result. I think they're set in their ways and haven't changed with the times."

People and their relatives told us that they knew how to make a complaint if they wanted to. One said "I'd just go and tell the managers and they'd sort it right away." A relative said "I've seen a copy of the complaints process so I know what to do if I'm not happy, but so far, no complaints." Although people had raised concerns via a survey, no formal complaints had been made.

People were supported to maintain relationships with the people that mattered to them. A relative said "I live in another county, but the staff help [relative] give me a telephone call every week so I can see how [relative] is doing in between visits." A person using the service commented "They always welcome [my relatives] whenever they visit." Another person told us "My [relatives] can come to see me any time and it is no problem. I can phone them whenever I want to." One other person said "I write letters to my friends and the staff kindly pop them in the post box for me when they finish their shifts." Staff told us they thought it was important to help people keep in touch with their family so they didn't become isolated or feel alone.

Requires Improvement

Is the service well-led?

Our findings

The service was unable to deliver a consistent service overall. Although the two registered managers were clear that they wanted to ensure the best care for people, they had not independently recognised potential risks and there was no overall plan to drive improvement. In addition there was a lack of up to date knowledge about best practice to support the needs of those that they cared for, particularly those with dementia. Systems to regularly assess and monitor the quality of the service provided were not always in existence. The management recognised that the shortfalls we found needed to be addressed, such as inaccurate records, staffing levels and staff duties. They also recognised that without access to comprehensive information about the people they cared for, staff were limited in their understanding and may not provide a consistent approach which helped those they cared for.

There was no system for monitoring the content of incident, accident and safeguarding records to identify trends and possible changes that may need to be implemented in order to protect people in future. For example we found that some people had falls but there was no analysis to see if changes in staff practice or routines could limit further risk. In turn, any learning from this could have been applied to the whole service.

The service did not have links with external organisations or other care services to share best practice and ideas for improvement within the service. The management did not have a system in place to keep up to date with changes in practice, such as changes in the care of people living with dementia.

Staff told us that they felt there was a disconnect between them and the management team and that they did not feel comfortable questioning practice or raising concerns about the way the service was run

Staff meetings were not used as an opportunity for staff to be open and honest about their concerns and views of the service. Staff told us they did not feel listened to, and that when they had made suggestions in the past, such as extra training they'd benefit from, these suggestions had not been actioned by the management or reasons given as to why this had not happened. Care staff told us they were not aware of what values the management would like them to adhere to. Whilst they were clearly committed to those they cared for, they felt disconnected to the running of the service overall.

There was not an emphasis on encouraging an open, honest and transparent culture within the service. Management confirmed discussions of shortfalls in staff practice were not shared with all staff members for learning and development purposes. The management team couldn't evidence that investigations as a result of mistakes, safeguarding concerns or complaints were used as a way to drive improvement within the service.

Comments and suggestions made by people using the service during a survey of their views and during residents meetings were not actioned by the management, and people told us they did not think that the management would take account of their views and make changes to the service. The management of the service could not evidence that an action plan had been put in place following comments from people and their relatives, and could not tell us what changes had been implemented as a result of people's feedback.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Notifications were submitted to CQC and other bodies such as the Local Authority appropriately, and the managers were aware of their legal obligations with regard to making these notifications.

The service tried to promote relationships between the service and the community. Relatives of people using the service and visiting health professionals told us about being invited to a meal at the service. One relative told us, "It was a really nice gesture." A health professional told us, "Being invited to a meal with the service users, staff and families was invaluable in getting to know everyone a bit better. The service really engages with the outside world and that is nice to see."

When we fed back the findings of our inspection to the management of the service, these were well received. They were positive about making improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff (1) (a) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their

This section is primarily information for the provider

Action we have told the provider to take

responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 - (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.