

Cheybassa Caring Limited

Cheybassa Lodge Rest Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Cheybassa Lodge Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cheybassa Lodge Rest Home accommodates up to 18 people in one building. At the time of our inspection 15 people were living at the home.

This inspection took place on 8 and 12 December 2017 and was unannounced.

There was a registered manager in post at 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 and associated Regulations about how the service is run.

People who use the service and one person's relative were positive about the care they received and praised the approach of the staff and how the service was managed. Comments from people included, "Staff are good as gold, not a bad egg", "Staff are kind" and "The staff are very nice, all of them". One person's relative told us, "Staff are brilliant". We observed staff interacting with people in a friendly and respectful way.

People told us they felt safe living at Cheybassa Lodge Rest Home. However risks to people were not consistently monitored and managed to ensure they received safe care. The provider did not have effective systems in place to learn from safety incidents and concerns. The provider told us they took action following our inspection to manage these risks.

Staff knew how to identify abuse and they told us they would raise any concerns with the registered manager. Not all concerns had been shared with the local authority. The provider took action to report these concerns during our inspection. We have made a recommendation about the reporting of safeguarding concerns in line with safeguarding protocols.

People did not receive all of their medicines when required and some improvements were required to the recording of prescribed creams. All staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines.

The home was clean and staff understood their responsibilities for infection control.

Care plans lacked detailed information about people's needs and preferences. The registered manager had identified improvements required to ensure all care plans were detailed and relevant. We have made a recommendation about involving people and their representatives in care planning.

People's preferences and choices for their end of life care were not discussed with them or recorded in their care plans.

People received support to ensure they had enough food and drink.

The provider had identified improvements to the systems to monitor the quality of the service provided however these improvements had not been implemented. Improvements were needed to make sure quality monitoring processes were effective in identifying and addressing shortfalls in the service and improving the service people received. The provider did not have systems in place to learn from safety incidents and concerns.

People told us they felt the service was well managed.

People were supported by staff who had been through checks on their suitability to work in the home but improvements were required to ensure staff's full employment history was checked.

Staff required additional training to ensure they had the necessary knowledge and skills to meet people's needs. We have made a recommendation about staff training on the subject of dementia.

People had access to health care professionals and were supported to maintain their health by staff.

The provider had arrangements in place to respond to complaints and a complaints procedure. Improvements were required to how complaints were responded to.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People's identified risks were not consistently managed.

Some improvements were required to how medicines were managed.

There were not sufficient numbers of suitable staff on duty to keep people safe.

Improvements were required to recruitment procedures to ensure staff's full employment history was checked.

Is the service effective?

Good ●

The service was effective.

Staff were knowledgeable about the physical care needs of the people they cared for but required more support to understand the needs of people living with dementia.

Decisions were made for people who lacked capacity, involving people with legal authority.

People were supported to maintain a balanced diet.

People had access to health and social care professionals when required.

Is the service caring?

Requires Improvement ●

The service was caring but some improvements were required to how people's rights and information were protected.

People received care from staff that were kind.

Staff communicated with people in a friendly and warm manner.

Staff respected people's independence.

People were treated with dignity but improvements were required to how people's privacy was protected and rights upheld.

People were listened to and involved in making decisions about their care.

Is the service responsive?

The service was not always responsive.

People were supported to participate in activities in the home.

People received care that was not always responsive to their needs because staff required further support to meet their needs.

There were systems in place to collate concerns and complaints. Improvements were required to ensure they were dealt with promptly and action taken to resolve all concerns.

Improvements were required to support people to express what they wanted at the end of their life.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Improvements were required to how the service was monitored and systems reviewed.

Improvements were required to the records relating to the management of the home and people's needs.

People told us they felt the service was well managed.

Staff told us they were not involved in identifying improvements to the service.

The provider had been identified additional resources to support the improvements required and this was on-going.

Requires Improvement ●

Cheybassa Lodge Rest 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 checked 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.

Cheybassa Lodge Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cheybassa Lodge Rest Home accommodates up to 18 people in one purpose built building.

This inspection took place on 8 and 12 December 2017 and was unannounced. The inspection was completed by one social care inspector.

Before the inspection we reviewed other information we had received about the home, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We gathered this information during the inspection. This was the first inspection of this service.

During the inspection we spoke with four people and one relative about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home

because they were living with dementia, and were unable to communicate their thoughts. We therefore 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 the registered manager, one of the directors and five members of staff. We also spoke with five health and social care professionals.

We looked at care documentation relating to four people, seven people's medicines administration records, four staff personnel files, 15 members of staff training records and records relating to the management of the service including quality audits.



Our findings

People told us they felt safe living at Cheybassa Lodge Rest Home. One person told us they felt safe said, "I do not have any concerns". One relative told us their relative had put on weight and their health had improved since living at Cheybassa Lodge Rest Home. They said, "I do not have any worries or concerns" and "the staff are brilliant". Staff told us they were aware of the signs of abuse or neglect to look out for. Staff told us they would report any concerns to the registered manager. The majority of staff told us they felt people were safe living at Cheybassa Lodge Rest Home.

Not all safeguarding concerns had been reported as required. We identified some safeguarding concerns following incidents between people from reviewing incident records and asked the registered manager to share this information with the safeguarding authority. The registered manager did this the same day. The concerns were in relation to putting safeguards in place to manage the risks people presented to others. The home had a safeguarding policy in place but it did not detail who staff should contact to report any concerns. The registered manager told us they would ensure the policy was updated so staff knew who to contact to raise any safeguarding concerns in their absence. Staff had received safeguarding training regarding what signs to look out to identify any signs of abuse or neglect and they would report any concerns to the registered manager. The registered manager had reported a safeguarding concern in May 2017 regarding a medicine error and action had been taken to address the concern.

We recommend that the provider reviews its systems to ensure safeguarding concerns are reported promptly to the safeguarding authority.

Risks to people were not consistently monitored and managed to ensure they received safe care. People at risk of pressure sores had equipment to reduce the risk of developing pressure sores, such as pressure relief cushions. However they were not always being used and care plans lacked sufficient detail. For example, one person who was at risk of developing a pressure sore had been prescribed cream for the area and a pressure relieving cushion by the community nursing team as part of their treatment plan. On the first day of our inspection the person was unwell, and had sat in a chair in their room in one position not on their prescribed cushion. There was no care plan in place to advise staff how to support this person to prevent skin damage and there was no information in the handover notes on the first day of inspection.

The provider did not have effective systems in place to learn from safety incidents and concerns. For example, on two occasions a person left the building and was found by staff in the garden. The registered manager confirmed these people needed support to access the garden safely. However this support was not

provided on these occasions. There was no risk management plan in place for these people. The registered manager and the provider were aware the external doors' alarms were faulty. However no action had been taken to manage the increased risks this presented to people whilst they were waiting for remedial work to take place to the doors. We discussed this with one of the company directors who told us they would put in additional staff with immediate effect to manage these risks. The provider told us these improvements had been completed following our inspection to secure the building by fitting coded locks on all exit doors.

We observed other people's risks were being managed. For example, another person was supported to prevent pressure sores and actions had been taken to manage the risks identified for another person who was at risk of falling. Actions had to been taken to manage the risk to the person and the person had been moved to the ground floor. Staff were aware how to support the person to manage this risk.

The management of medicines was not consistently safe. People may be put at risk through not having their prescribed medicines and medicines administered were not always recorded. Medicine Administration Records (MAR) had a current photograph of the person but were not accurately completed. We found gaps in the records of prescribed creams for two people and found two people's medicines had not been administered on one morning and there were gaps in records for two other people. We raised our concerns with the registered manager during the course of our inspection. We asked the registered manager to seek advice from the people's GP who had not received their medicine on one morning as prescribed.

Arrangements were in place for the safe storage of medicines including those that require additional security. However we found medicines in the hallway waiting to be disposed of that were not secure. The registered manager told us they did not realise there were medicines remaining in the packs. There were arrangements for the storage of medicines that required storage in a fridge at a certain temperature. The temperature of the fridge was monitored to ensure it was at safe levels. However the temperature of the room that the other medicines were stored in was not being monitored. This meant there was risk that medicines were not being stored at the correct temperature. There were a large amount of medicines being stored in the home. The registered manager said that they were trying to resolve the amounts of medicine being reordered with the pharmacy and GP. The registered manager told us they would take action to return surplus stock to the pharmacy.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean and staff understood their responsibilities for infection control. Staff had access to gloves and aprons to provide personal care.

There were arrangements in place for fire equipment and hoisting equipment to be serviced to keep people safe. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment and lift maintenance.

There were not enough staff at times to meet some people's needs. Two people told us they thought more staff were needed at times. People looked well care for, had access to food and drink and people told us staff would respond their needs. Four staff told us they thought more staff were required in the afternoon, evening and weekends as the home now supported more people living with dementia. In the afternoon there were only two staff on duty who were responsible for administering medicines, preparing food in the kitchen as well as responding to people's needs. Some people living with dementia required support and supervision to keep them safe and meet their needs. We observed staff were not always able to do this as they were attending to other tasks. We raised our concerns with the registered manager and one of the

directors at the end of our inspection. One of the directors wrote to us at the end of our inspection and told us that an additional member of staff was being put in place with immediate effect for the afternoon/evening shift in order to meet people's needs

Recruitment checks were carried out however some improvements were required. For example, checks for new staff included feedback from previous employers, criminal records checks and identification documents had been obtained before people were permitted to begin their employment. However staff's full employment history was not checked as required in each file we reviewed. We raised this with the registered manager who told us they would take action to address this.



Our findings

People told us they had been involved with planning their care. One person told us, "They respect what I can do". Another person told us, "My [relative] helps me. My [relative] gets involved with my care". Healthcare professionals told us the home was responsive to people's changing needs or any health concerns. A healthcare professional told us, "Any advice you give them they do follow through". However two healthcare professionals told us staff required more support and training to meet their needs of people with dementia.

Staff were not fully supported to give them the skills to meet the needs of people living with dementia. For example for one person, staff took a differing approach to support the person when they became distressed. Two health care professionals told us staff needed training on how to support people with dementia in order to improve how they met people's needs. Staff did not always understand whether a person had capacity to make a specific decision and the process they would follow if the person lacked capacity. Staff had not received training on understanding dementia, positive behaviour support for people with challenging behaviour and the Mental Capacity Act 2005. The registered manager told us they had planned additional training for staff on safeguarding adults, the Mental Capacity act 2005 and dementia awareness.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

Staff told us they received other training and support to give them the skills to meet people's needs, including infection control, supporting people to move safely and administering medicines. New staff were supported to understand some of aspects of their role by working with an experienced care assistant until they were assessed as being competent. Staff told us that they had received training in the administration of medicines and their competency had been checked. The registered manager told us one member of staff was receiving additional support and training in administering medicines. The member of staff confirmed this was happening. Staff told us they received supervision but some staff told us they did not always feel supported to carry out their role. For example, some staff told us that some concerns they had raised, including how staff worked together had not been addressed.

People said they were able to see health professionals when necessary, such as their GP or community nurse. One person told us, "I see my doctor when I need to". One person's relative told us, "[The manager] had the doctor in yesterday". The majority of health care professionals told us the home followed the advice they gave them to meet people's needs.

People were supported to eat and drink enough to maintain a balanced diet. People told us that the food was generally good but there was only one choice at lunchtime. The menus only detailed one choice. We discussed this with one of the directors who told us they planned to redesign the menu with residents to offer an alternative lunchtime meal. Lunchtime was a calm and social event for those that wanted to eat together. Tables were set with cloths and condiments were available for those who wanted them. People chatted with each other and to staff. People who required a modified diet received this in line with advice from Speech and Language Therapists. Advice was sought from healthcare professionals for people losing weight.

People told us they were involved in decisions about their care. We observed staff working in this way, checking with people before providing any care or support. One person told us, "They respect what I can do". The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA.

Where people did not have capacity to give consent, decisions were made in their best interest. However this was not always recorded. Decisions had been made for people who lacked capacity regarding the use of bed rails and being assisted with medicines. The registered manager told us those families who had power of attorney for health and welfare for had been consulted about specific decisions but this had not been recorded. The registered manager told us they would take action to improve the recording of these best interest decisions. One person relative told us they were involved in decisions relating to the relative's care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Applications to authorise restrictions for some people had not been made by the service as they had recently moved into the service. The registered manager told us they would take action to submit these required applications.

There were daily handover meetings to advise staff of people's changing needs and any actions required. Two staff told us that handover meetings did not always fully update them about people's changing needs.

The home had outside space that was accessible and staff told us people enjoyed using it in the good weather. People had personalised their rooms and looked comfortable. The service was on two levels and there was a stair lift in place for the two rooms upstairs. Handrails were in place to enable people to move around independently and adequate space for people to move around with walking aids. There was space within the home for people to spend time together and alone.



Our findings

People told us staff were caring. However staff did not always respect people's right to privacy, including personal information. Further improvements were also required to identify how people liked to be supported, where people could not express their views. One person told us, "Staff are good as gold, not a bad egg". Another person told us, "Staff are kind". Other comments from people described staff as, "The staff are very nice, all of them" and "The staff are brilliant, you can have a laugh with them". One person's relative told us, "Staff are brilliant". For example we heard people and staff talking and laughing together throughout our inspection. We observed staff providing support to a person who was distressed, talking to them and providing reassurance.

People were supported to express their views and were involved in making decisions about their care. Staff had recorded some important information about people; for example, personal history and important people. Staff told us what was important to people, people's personal histories and how they liked their support to be provided. People told us staff consulted them about their care plans and their preferences. There was no information to guide staff to how people liked to be supported where people were unable to express their views.

The service was meeting the requirements of The Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff communicated with people in accessible ways that took into account any sensory impairment which affected their communication such as hearing loss.

Staff did not always respect people's privacy and rights. We observed that staff meetings to discuss people's needs were not held in a private area. This meant that discussion about people's personal information could be heard by other people and was not treated confidentially. Staff did not always respect people's right to a private space. Staff used one person's room for a meeting without their consent. We raised our concerns with the registered manager during the course of our inspection.

People who required support with washing and dressing were dressed in clean, warm clothing and their personal hygiene needs appeared to be met. Staff took time to talk to people and comfort people who at times became distressed. We observed staff responding to requests for assistance. One person told us staff respected their independence and provided the amount of care they wanted.



Our findings

People told us they felt well cared for and staff responded to their needs. One person who had been unwell told us, "They [staff] come and check on me". Other comments from people included, "I have everything I need" and "You have only got to ask and staff will help". Care provided to people was not always consistent in responding to people's needs, where people were not able to express their views. People were not always supported to make decisions about their preferences for end of life care.

Staff provided care that respected people's independence and wellbeing. One person told us they were able to access the community independently to visit friends and family. People were supported to maintain contacts with friends and family and a relative told us they always felt welcome in the home. Activities were arranged in the home including visiting singers, bingo and quizzes that people told us they enjoyed. One person told us, "We have lots of activity, all sorts like quizzes". Another person told us, "They [the singer] is very good". Activities were not arranged to support people to go out into the community. Two staff told us they felt improvements to activities were required to plan different activities and to support people to go out.

People did not always receive personalised care that was responsive to their needs. People's care plans did not always contain sufficient detail to guide staff and there were gaps in assessments of people's needs. Where people were able to express their views, these were respected by staff and care provided was responsive to their needs. Where people were not able to express their views, due to the effects of their dementia, staff were inconsistent in the way they responded to them. For three people living with dementia, their care plan did not detail how to support them when they became distressed or disorientated. For example, staff were not consistent in their responses when one person became distressed and disorientated at times. An agreed approach based on good practice had not been recorded. There were gaps in personal information and preferences recorded for people living with dementia. The registered manager told us care plans were being updated.

We recommend that care plans are developed with people and their representatives to identify people's needs and preferences and staff are supported to meet these needs.

The provider had arrangements in place to respond to complaints and a complaints procedure. However not all complaints had been responded to promptly and action taken to resolve concerns. For example actions had not been taken to respond to complaints made on the 16 October 2017 and 27 November 2017. The registered manager told us actions would be taken to resolve these complaints. One relative told us that the registered manager and provider responded to concerns. We saw another complaint had been resolved

and actions taken. A healthcare professional told us the home implemented changes as a result of concerns raised.

People's preferences and choices for their end of life care were not discussed with them and recorded in their care plans. Where people lacked capacity to communicate all of their end of life wishes, families and people with power of attorney had not been involved in developing this plan. The gaps in people's end of life care plans included people's spiritual and cultural needs and where the person wanted to be cared for at the end of their life. We raised this with the registered manager who told us they would take action to address this. One healthcare professional told us the home had looked after someone very well at the end of their life.



Our findings

People told us the home was managed well. One person told us, "It is run well". One person's relative told us "I give it [the home] five stars". One healthcare professional told us, "[the registered manager] is responsive and cares". Another healthcare professional told us, "I would be happy for my mum to live there". However two staff and two healthcare professionals told us improvements were required to how the service was managed. Two staff told us they did not feel supported by the registered manager and provider and that actions were not always taken in response to concerns raised by staff.

There was not an effective governance system in place to ensure that the home met the requirements of the regulations. The provider had instructed a consultant to support their governance arrangements. The consultant had visited on the 23 October 2017 and identified a number of areas that required action, including training for the registered manager and staff on the Mental Capacity Act 2005, mental capacity assessments and the completion of care plans. The registered manager told us they felt they now had a governance system to start using following this visit but all of the actions had not yet been implemented and the required changes made. For example, the registered manager told us they now had paperwork for a care plan audit but this had not yet been completed. The registered manager told us they had arranged training on the Mental Capacity Act 2005 for the following week of our inspection.

There were systems in place to record incidents and accidents in the service but this was not effective to identify action required and any safeguarding concerns. We looked at some incidents and accidents in September and October, November and December 2017. Not all incidents had full records of action required to ensure people received safe care. The registered manager told us they were not aware of all of the recorded incidents. We identified some safeguarding concerns from reviewing these records and asked the registered manager to share this information with the safeguarding authority. The registered manager did this the same day.

Records relating to the management of the home and care planning and provided were not all fully completed. This included care plans, mental capacity assessments, best interest decisions, records of action taken in response to concerns, evaluation of accidents and incidents and audits of care provided. Care plans generally lacked detail of people's current needs and how risks were being managed. Personal confidential information was stored in the office but personal information was discussed in communal areas by the registered manager and staff. We raised this with the registered manager and provider at the end of our inspection.

Documents were not completed to record whether people had advocates and representatives who could be consulted, such as relatives or those with power of attorney. Care plans did not clearly evidence that these people had been involved in the decision making.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were not involved in developing or identifying improvements to the service. They also told us they felt communication was poor in the home and two staff told us other care staff were not always respectful to colleagues. They told us these issues were not dealt with effectively. They told us a meeting had taken place to discuss the issues but they could not find the record of this meeting. Three staff told us suggestions around improvements to the service, such as staffing were not always responded to by the provider. We identified concerns about staffing levels as part of our inspection. We asked the registered manager and provider about one complaint between staff.

Staff understood how to whistle-blow and told us they would raise concerns about people's practice with the registered manager or provider. All staff told us they did not have any concerns about people's current practice towards residents and were clear about their responsibilities. One member of staff told us their duties were explained during induction and told us, "I know what is expected of me".

The registered manager submitted statutory notifications as required to notify us about certain changes, events and incidents that affect their service or the people who use it.

The provider and registered manager involved people, their families and healthcare professionals to identify improvements to the service. The provider sought feedback from people and their families on how the service was provided. There were arrangements in place to get feedback from people via residents' and visitors' questionnaires. One relative told us, "They [the provider] want to talk to you and ask is there anything we can do better?" A person told us, they could talk to the registered manager. Health and social care professionals fed back that they felt information they fed back was listened to and shared with staff. However four healthcare professionals identified that further improvements were required. One healthcare professional told us the service could be "more organised and professional" in terms of training for staff, completion of care records, and maintaining confidential information. Another healthcare professional told us the care records were not detailed enough.

The provider responded promptly to the concerns and shortfalls identified during the inspection to ensure the safety of people living at Cheybassa Lodge Rest Home. The provider was co-operative, open and transparent and provided an action plan following feedback at the end of the inspection to address some of the improvements required.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risks relating to the health and safety of service users of receiving care and treatment were not fully assessed and mitigated. Medicines were not always managed safely. Regulation 12(1)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The systems and processes in place to assess, monitor and improve the service were not effective. The systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were not effective. Accurate, complete and contemporaneous records were not being kept in respect of each service user. Regulation 17(1)</p>