Care Quality Commission

Baytree Community Care (London) Limited

Baytree Lodge

Inspection report

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Ratings

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

Overall summary

We inspected this service on 7 September 2015. The inspection was unannounced. Baytree Lodge is a care home registered for a maximum of twelve adults who have mental health needs. At the time of our inspection there were eleven people living at the service. The provider is also registered to provide personal care at a supported living unit next door.

The service is located in two large adjoining houses, on two floors with access to a back garden and spaces for parking in the area to the front of the houses.

We previously inspected the service on 29 May 2013 and found that the regulation about safe management of medicines was not being met. We carried out a follow up inspection in October 2013 to look at medicines management and found the provider had made the improvements required and was meeting the regulation.

At the time of our inspection the registered manager was on leave and an acting manager covering in his absence. 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.

Summary of findings

Since the inspection on 7 September 2015 there have been some changes in the management of the service.

Referrals to the service are made by local authorities. At the time of our inspection there were residents from Barnet and Enfield living at the service.

People using the service informed us they were mostly satisfied with the care and services provided, however some people said they did not always get the type of food they preferred. In particular, Halal food was not routinely provided for a Muslim person who used the service.

At this inspection we saw that the building was in need of redecoration and some repairs were required. We found that people were not protected from the risks of infection, as there were ineffective cleaning and food hygiene processes in place. The residents' fridge was not clean. In the fridge in the main kitchen there were two open cartons of food with no date of opening on them so people were at risk of eating food that was no longer fresh.

Some of the equipment for cleaning the home was not in good condition and there was evidence of poor cleanliness in some communal areas. There were mouse droppings in an airing cupboard on the first floor.

There were ineffective quality monitoring systems and records. Management of medicines was not safe. People using the service felt safe most of the time, but one person using the service said they were affected by the behaviour of other people using the service, as they were loud and didn't behave in a 'nice' way. Management of people's money was not robust enough to prevent abuse.

We reviewed risk assessments and care plans for people using the service. We found all risk assessments and care plans had been updated, however there was not enough detail in some of the documents to ensure the needs of people using the service were met.

Staff recruitment procedures were not always thorough and some of the required information was not obtained in line with the provider's recruitment policy to make sure staff employed were suitable to work in a care home.

We observed some good interactions between staff and people using the service.

Staff had been provided with training but lacked training in the Mental Capacity Act 2005 and not all staff had received training to work with people who have behaviours that can be challenging. Staff need a broad range of training to enable them to care effectively for people.

The home had an activities programme but people did not have enough social and leisure opportunities and their spiritual needs were not always met.

We found the provider was in breach of standards relating to the safe care and treatment of people using the service, safeguarding people from abuse, nutrition, staff recruitment, premises and equipment and monitoring the quality and safety of the service.

We are taking enforcement action against the provider for one of the breaches. Details of these breaches are 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?

Inadequate

The service was not safe. The system for managing the money for people who use the service was not adequately implemented to prevent abuse.

Management of medicines was not robust putting people who use the service at risk of not receiving their medicines safely.

Cleanliness and hygiene standards were not effectively maintained.

The building is in need of decoration and minor repairs need attending to.

There was no evidence that the fire safety equipment had been serviced in the last twelve months and maintained to a safe standard.

Staff recruitment processes were not always rigorous enough to ensure staff employed were suitable for the job.

Staffing numbers were sufficient to meet people's individual needs.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not understand the Mental Capacity Act 2005 and some had not received training in working with people with challenging behaviour.

Staff told us they felt supported by their manager. Although staff told us they had received supervision, records were not available to evidence this taking place on a regular basis.

People using the service did not have sufficient choice of food and some people felt access to food was limited.

People using the service were supported to attend health appointments.

Is the service caring?

Requires Improvement

The service was not always caring. Cultural and religious requirements were not always respected.

We observed some good interactions between staff and people using the service, and people who use the service spoke positively about staff.

The provider had recently informally adopted local stray cats and the people using the service were enjoying having pets at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans and risk assessments were not sufficiently detailed to enable staff to support people with all their needs. These also did not assess the risk of people's behaviour on other people using the service.

Summary of findings

Activities identified in care planning were not always followed through for people using the service and staff did not support people with the activities plan displayed in the home on a regular basis.

There was not a personalised response to managing the preparation of food. All of the people using the service were judged unable to prepare their own lunch or dinner, but there were not risk assessments to evidence this.

Is the service well-led?

The service was not well led. There was a lack of audits taking place in the scheme resulting in a poor quality of service in relation to the safety of the environment, and infection control.

Audits undertaken relating to managing people's money and medication were not thorough enough to notice errors.

Requires Improvement

Baytree 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 7 September 2015 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who attended the inspection has experience of working with people with mental health needs.

Before the inspection we reviewed the information we held about the service including notifications received from the provider.

During the visit we spoke with five people using the service and one relative. We inspected all communal rooms and looked in two bedrooms.

We spoke with two support workers, the Quality and Systems Director and the temporary acting manager as the registered manager was on leave at the time of our visit. Following the inspection we spoke with two health professionals who support people who live at the service.

We looked at the care records and risk assessments for five people living at the service and one person who had recently left. We looked at four staff recruitment files and after the inspection asked for information on three more staff. We looked at supervision and training records for four people.

We looked at the system for managing medicines and at shopping receipts for nine weeks for the main supermarket shop.

We checked fire safety including equipment, testing of the alarm, lighting and the regularity of fire evacuation tests, and information relating to incidents and complaints. We looked at audits for maintenance, infection control, and fire, gas and electrical safety checks, minutes of residents meetings and staff team meetings.

Inadequate

Is the service safe?

Our findings

All of the people using the service said they felt safe as they had a roof over their head. One person said "I feel safe because the staff are nice and they look out for me all the time." But one person said "I used to feel safe in the home but not anymore." They felt intimidated by the behaviour of another resident. This was not reflected in their risk assessment.

We found all risk assessments and care plans had been updated recently, however there was not enough detail in some of the documents to ensure the needs of people using the service were met. For example, one person had difficulty chewing certain foods due to dental problems, but the care plan did not highlight food in particular as an issue, it noted they had to have assistance to maintain good dental hygiene.

Staff were able to identify abuse and had safeguarding training. This told them what to do in the event of an allegation of abuse.

Parts of the building were in a poor state of repair. In one of the laundry rooms there was a cupboard door hanging off its hinges and the shelf was sufficiently damaged to be unsafe to hold anything of weight. There was a risk of the door or shelf falling on people who use the service.

The above concerns were a breach of regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence that the fire safety equipment had been serviced in the last twelve months and was of a safe standard.

This was a breach of regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not protected from the risks of infection, as there were ineffective cleaning and food hygiene processes in place. The cleaner worked weekdays only and as we arrived on a Monday morning before the cleaner, communal bathrooms were unclean. There were also no facilities for drying your hands in the communal bathroom.

Staff did not ensure the fridge in the residents' kitchen was cleaned regularly and some food had not been labelled or covered when opened. Lack of cleanliness in the kitchen area could expose the people who lived in the service to the risk of food poisoning.

The mops for cleaning the home were old and looked unclean. The system for using different mops and buckets was not effective. There were mouse droppings in an airing cupboard. The manager was not aware they were there. Pest control had last visited the service at the end of July 2015.

The above concerns were a breach of regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines was not safe. Although the manager had been carrying out audits on a weekly basis for four out of the last five weeks, the recent audit had not highlighted that twenty eight tablets were missing of a medicine for one person living at the service. This could lead to people using the service not having their medicines when required.

The provider had not returned medicines to the pharmacy when no longer required. The packages were stored in a plastic bag on the floor. In one package there were sixteen tablets left. Although the room was kept locked there was the potential for misuse of medication which should have been disposed of.

This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected from the risk of financial abuse. The provider had introduced a more rigorous procedure for managing people's money more effectively in June 2015, following a safeguarding concern. However, this was not being followed robustly. This resulted in a mismatch between the amount recorded and the money held for two people of the seven finance records we looked at, and the money belonging to two people using the service was stored together contrary to their new policy.

This was a breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes for staff were not always robust. For two staff only personal character references were on file,

Inadequate

Is the service safe?

not work related. The provider had not followed its own recruitment policy as for two other members of staff there was only one reference on file and no evidence they had been verified.

This was a breach of regulation 19 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People who used the service felt staff were knowledgeable and well trained for the role.

Staff had been provided with an induction and training and told us they felt supported by the acting manager. Although staff told us they had received supervision, records were not always available to show this occurred regularly. The manager was unable to provide an explanation. There were no appraisals on the staff records we looked at as staff had not been employed for a year.

Some staff lacked training to enable them to care effectively for people. For example, not everyone had received training in challenging behaviour nor had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This placed people using the service at risk of unlawful restriction or limitation.

For example, staff lacked awareness of the implication for freedom of movement for people who could not leave the building on their own, whether due to anxiety or because they needed support to keep them safe. This was relevant as following an incident outside of the service in which the police had become involved, it was recommended by the police one person should be supported if they are going to a specific area.

Health professionals we spoke with had differing views as to the skills of the staff in working with the people living at the service. One noted a significant improvement in one person's health and well-being since moving to the service, whilst another was of the view that some staff members lacked experience in working with people with complex needs and this was reflected in the way their care was delivered.

People who use the service were supported to access health appointments and there were close links with the local mental health services.

The building is not suitable for anybody with significant mobility problems be they residents, staff or visitors. This was not an issue for the people who used the service at this point in time as nobody had any mobility problems.

We recommend that the training given to all staff is reviewed and staff receive training in the Mental Capacity Act 2005 and in working with people who have behaviours that can challenge.

Requires Improvement

Is the service caring?

Our findings

Two people using the service spoke well of the staff. One person said, "The staff are very good to me. They look after me they give me a hand in the bath."

We also saw positive interactions between staff and people using the service.

Regular residents' meetings took place on a monthly basis and there were minutes for four out of the last five months to evidence this. The menu for the following week was discussed at each residents' meeting. This provided a time for people who use the service to discuss with staff issues that were important to them.

Lunch and dinner was prepared by staff in the main kitchen which was kept locked when not in use by staff. Breakfast was prepared by staff for those unable to do so independently. People using the service who were able to prepared their own breakfast in the second, residents' kitchen which was always unlocked.

On the day of our inspection the fridge in the residents' kitchen had only milk and margarine in it. There was also bread, tea, coffee and cornflakes available for people using the service to prepare for breakfast.

One person using the service said some residents "dominate the food." They said "They get food first and I get less." Two people said they really liked Sunday roast, but one person told us they hadn't had it for about three weeks.

A health professional who is a regular visitor to the service reported that they regularly had to ask staff to put more food into the residents' kitchen (from the staff kitchen) due to people reporting to them that they were either hungry or didn't like the choice of food available for lunch or dinner.

Cultural and religious requirements were not always respected. For example, one person using the service told us "I am Muslim and would prefer to have Halal meat and Indian food". In the care plan for this person under a section relating to ethnic, cultural and spiritual needs, 'not applicable' was typed.

A relative explained "I told them he is a Muslim and needs Halal meat but no one seems to care".

We looked at the detail of the weekly shopping delivery for nine weeks and whilst a substantial amount of meat was purchased, Halal meat was only purchased on two occasions.

We observed a non Halal chicken takeaway being purchased on the day of our visit for lunch for all residents.

Another person who used the service told us they would prefer to have more Indian food than they currently had.

The above concerns were a breach of regulation 14 (1) (4) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who use the service wished to attend a mosque or church. Daily notes showed that one person had only attended church twice since 19 July 2015. Whilst another person had attended mosque regularly his relative had to take him the majority of the time. They said they would like staff to take him more regularly, but staff said his relative was choosing to take him.

The provider had recently informally adopted local stray cats and the people were enjoying having pets at the service.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive the personalised support they needed. Activities identified in care planning were not always followed through for people using the service. For example it had been recommended by a health professional that one person using the service should take a walk three times weekly for fifteen minutes. There was no record of this taking place since July. Another care plan indicated a person using the service should be encouraged to swim once weekly. Records showed that they had not been swimming in the last month.

Staff said sometimes people using the service had refused these activities but it was not recorded in their records.

Everyone was deemed to have the capacity to go out alone but some people lacked confidence to do so.

Some people were supported to carry out some activities. There were examples of people attending Mind, the cinema, shopping or the park. One person was going to the hairdressers on the day of our inspection.

Some people using the service felt confident to go out unaccompanied so they were able to pursue their own interests. At the time of the inspection two people were out of the service, one visiting family and one in the local area.

There was not a personalised response to managing the preparation of food. All of the people using the service were judged unable to prepare their own lunch or dinner due to issues of safety, but there were no risk assessments to evidence this. This common approach limited an individual's opportunities to exercise choice and control over their lives, and was not encouraging people to develop better independence skills. One relative confirmed in their view independence was not encouraged as much as it could be.

Whilst the activities programme identified the need to offer opportunities to cook for individuals, there was no evidence this or the other activities on the list regularly took place. Three people told us they spent a lot of time watching TV or sitting in the garden.

People using the service said they felt able to make a complaint to the manager if they were unhappy with any aspect of the service. One person told us "If you speak to the manager he sorts it out quick, there and then."

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not in day to day charge of the service so a temporary acting manager was overseeing the running of the service at the time of the inspection.

People using the service spoke well of the acting manager and felt he was approachable and available.

There was a lack of effective leadership in the running of the service at the time of the inspection and there were ineffective quality monitoring systems and records. In addition, in some areas there was a lack of guidance for staff as to the expectations the manager had of them in carrying out their duties.

Regular audits were not taking place in relation to cleaning and maintenance. This resulted in damage to the structure of the building not being identified and remedied, and people using the service being put at risk of infection or injury. Examples included a cupboard door hung off its hinges, a shelf was badly damaged, and a section of flooring in the lounge for people who use the service was in need of repair.

The service was not consistently clean at the time of our visit.

Despite there being mouse droppings in an airing cupboard, the provider had not requested pest control to carry out another visit since July 2015.

The provider was not carrying out regular audits of the premises with a timely action plan to remedy any issues and minimise the risks to people living at the service

In relation to management of medicines, although the manager was auditing the medicine weekly, we found there were tablets missing for one person using the service. This proved the audit was not effective as it had not found this problem.

The new system for managing the money of people using the service was not being adhered to robustly. Auditing the money as part of the inspection process highlighted problems in reconciling records with actual money in two out of seven people's funds. Also, money belonging to two people was merged contrary to the new policy. The acting manager's audits were not effective as they had not picked up these concerns.

We asked to look at complaints and safeguarding concerns for the last twelve months. Apart from a recent complaint and safeguarding concern there were no historical records available to us. The acting manager was not able to find them.

Whilst there were incident forms completed in the months from March to 16 August 2015, a serious incident had occurred in the local community in the two days prior to our visit. Despite the police being involved an incident form for within the service, had not been completed by staff or manager. Also there had been no action taken over medicine which had been mislaid during the incident over the weekend. This was the second occurrence of this type of incident involving the police in a month.

Overall there was a lack of coherent systems in the service to ensure that high quality and safe care was provided to people using the service. Where quality assurance processes were available they were not effectively implemented.

This was a breach of regulation 17(1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who use the service were not protected from the risk of theft, misuse or misappropriation of money. Regulation 13(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The provider did not meet the requirements of service users for food and hydration arising from the service users' preferences or their religious or cultural background. Regulation 14(1)(4)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The provider could not evidence that fire safety equipment had been serviced in the last twelve months and was of a safe standard. Regulation 15(1)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider did not ensure there were systems or processes in place to assess, monitor and mitigate the risks to the health, safety and welfare of the people living at the service. Regulation 17(1)(2)(a)(b).
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not follow effective recruitment procedures in order to ensure that no person is employed unless that person is of good character and has the qualifications, competence, skills and experience necessary for the work. Regulation 19(1)(a)(b).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person failed to provide safe care and treatment to people who used their service. Regulation 12 (1)(2) (d) (g) (h)

The enforcement action we took:
We served a Warning Notice on the Registered Provider, to become compliant with the regulation by 17 October 2015.