Chelcare Limited

Doddington Lodge

Inspection report

Doddington
Hopton wafers
Cleobury Mortimer
Worcestershire
DY14 0HG
Tel: 01584 890864
Website: www.doddingtonlodge.co.uk

Date of inspection visit: 15 and 21 September 2015
Date of publication: 21/12/2015

Ratings

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

Overall summary

This inspection was carried out on 15 and 21 September 2015 and was unannounced.

Doddington Lodge provides accommodation and personal care for up to 41 people, some of whom are living with dementia. At the time of our inspection there were 36 people living at the home. Doddington Lodge had two separate living areas. The Mortimer residences for people who have complex health needs and the Malvern Suites for people living with dementia.

There was a Registered Manager in post. 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.

The service lacked effective leadership. People not involved in the running of the service. The provider had no systems in place to make sure that quality checks

Summary of findings

were completed, that risks to people's care was managed and that they had consented to their own treatment. People did not have their medicines as prescribed by their doctor.

People were not always treated with dignity and respect. Staff were unable to care for people in a way that consistently met their needs. People were left anxious and distressed. The provider had not considered people's right to privacy when they used their own bedrooms.

People felt the staff were caring and they responded quickly when they asked for support. There were enough staff to meet people's care and support needs and keep people safe, but people were not given the time for meaningful opportunities to take part in hobbies and interests that were personal to them.

There was a system in place to make to respond and deal with complaints. However concerns raised by staff about people's care were not acted upon appropriately.

Staff had access to training that was appropriate to their roles. However staff did not have adequate support and supervision to implement what they had learnt effectively. There were no regular staff meetings and no systems in place to keep staff informed of what was going on and best practice in the home.

The provider had not followed the principles of the Mental Capacity Act 2005. We saw some people who did not have the capacity to make certain decisions for themselves. There were no mental capacity assessments for these people. This meant that people who did not have capacity were receiving treatment even though there were no processes to make sure that this was in the person's best interests.

We found the provider in breach of Regulations. 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?
The service was not safe.

People were not always safeguarding from harm because even though staff knew what to do if they suspected abuse risks were not identified and managed appropriately.

People did not always receive their medicines safely as there were no systems to ensure that medicines had been given as prescribed.

There were enough staff to keep people safe and meet their health needs, but there was no system in place to determine how staff numbers were identified.

Requires improvement

Is the service effective?
The service was not effective.

People who lacked capacity to make decisions about their care and treatment did not have their human rights protected because staff had not followed the principles of the Mental capacity Act 2005.

Staff received ongoing training in areas relevant to their work, but did not have the support and supervision to implement it effectively.

People were supported to access other health professionals to maintain their health and wellbeing.

People had access to food and drink throughout the day. People told us that the food was good.

Requires improvement

Is the service caring?
The service was not caring.

Some staff were kind and caring, but people did not consistently receive the care they needed.

People's privacy and dignity was not always respected and they were not involved in their care as much as they wanted to be.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not receive care that reflected their individual needs. They did not have the opportunity to have their own individual needs and preferences reflected in the care they received.

People and their relatives knew how to complain, and there was a system in place to respond to complaints.

Requires improvement

Summary of findings

Is the service well-led?

The service was not well led.

The provider and registered manager did not include the people that lived there in its day to day running and development.

There was no system in place for the provider to be assured that the care being provided was safe and effective. The provider and registered manager had failed to identify and address concerns to the quality of care being provided.

Requires improvement

Doddington 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 15 and 21 September 2015 it was unannounced and carried out by two inspectors.

As part of our inspection we checked information held about the service and the provider. We looked at information received from the local authority commissioner and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law.

We spent time looking at the care people received in the communal areas of the home where people were happy to share their experiences of life at the home. We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We also spoke with six people who lived there, four relatives, a health professional, the registered manager and 11 care staff.

We looked at the records of five people, which included medicines, mental capacity, care plans and assessments of people's needs. We also looked at the systems for monitoring the safety and quality of the service.

Requires improvement

Is the service safe?

Our findings

We looked at how people's medicines were managed. We found that one person's medicine was being crushed and put into food to disguise it without all of the necessary procedures in place to make sure this was done safely. The prescription for this medicine stated it could not be crushed, however when we spoke with staff they told us the medicine was crushed and put into the person's food without their knowledge. We asked the registered manager about this they could not tell us why the prescription instructions had not been followed to ensure that these medicines were administered safely.

One person was prescribed a strong medicine that required stricter control measures being in place for its storage, administration and disposal. The registered manager had actively encouraged staff to work against safe medicines practice. Staff had been instructed to dispense and sign the medicine record to indicate that a medicine had been taken by the person it was prescribed for, even though it was left out for the night staff to give later in the evening. Day staff did not know at the time of dispensing whether the medicine was going to be taken, but were recording in the medicine record that it had been. The night staff administered medicines without dispensing them themselves which meant that they had not checked the medicines they were giving and this increased the risk of medicine errors happening for the person. The registered manager told us they had changed the way this medicine was dispensed and administered without consulting with the person or a doctor. These medicine practices did not show the provider had ensured people received their medicines as prescribed and in the right way so that risks to their safety and wellbeing were reduced.

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

We found that people's individual risks were not effectively managed in order to keep them safe. For example, a person needed support with their behaviour which challenged staff. At times this had an impact on other people who lived at the home as people had been hurt. Staff told us that this happened on a regular basis and another person who lived in the home had been hurt. We looked at this person's care records and saw there were no care plans or strategies in place for staff to refer to. There were no clear guidelines to show staff how to manage the person's behaviour and how to keep the other people safe. Staff told us that they had discussed their concerns about the safety of the person with the registered manager. The registered manager was aware of this and of the staff concerns but had not taken action to protect people and support staff. The registered manager had failed to refer this situation to the local authority because they were concerned a safeguarding referral may have affected the relationship between the two people. Neither person had the capacity to make decisions around their safety and needed staff to support them so that risks to their wellbeing and safety were reduced.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe. One person said, "They [staff] are very good at looking after me." A relative said "I have not seen anything to suggest people are not safe." Staff were able to tell us about the signs of abuse and what they would do if they suspected abuse was happening. There was information in place of who to contact and what action needed to be taken if abuse was suspected.

People told us that staff gave support when it was needed, but that staff did not have the time to spend with them to talk or do anything around their hobbies. One person said, "They [staff] are very busy all of the time". On the days we visited we were told by the registered manager that they had a full complement of staff. The registered manager told us that they did not have a system in place to determine the amount of staff needed. They told us, "The staffing levels are really just as they have always been". Staff told us that there were enough staff to meet people's basic needs but felt that there were not enough staff to allow for meaningful time to be spent with people. One staff member told us, "You just feel like you are here to meet people's basic needs".

Staff told us that checks were made to make sure they were suitable to work with people before they started to work at the home. These included references, and a satisfactory Disclosure and Barring Service (DBS) check. DBS helps employers make safer recruitment decisions by preventing unsuitable people from working in care.

Requires improvement

Is the service effective?

Our findings

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 in their best interests and as least restrictive as possible.

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.

We checked whether the service was working within the principles of the MCA.

On Malvern suite we saw 15 people seated in the lounge area. We saw that people did not have the capacity to make certain decisions and choices about the care they received. Staff we spoke with had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS) and were able to tell us about the main principles about acting in people's best interests when people did not have capacity. They said that they tried to make sure people were given the opportunities to make choices around day to day support such as what people wanted to eat or drink, and our observations confirmed this happened. However some of the care and treatment did not show how the principles of the MCA and people's best interests had been considered before being carried out. One person who did not have capacity had their medicines hidden in their food without their knowledge. A mental capacity assessment had not been carried out and we could see no evidence that a best interest meeting had taken place. This person's capacity to understand and make this decision had not been assessed. For the people on the Malvern suite there were also regular visits from other health professionals and on occasions treatments had been given. We spoke with the registered manager and looked in people's care records, but could not be assured that treatment for people without the capacity to make decisions for themselves was always made in line with the MCA and in people's best interests.

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

All of the people that we spoke with said that staff had the skills and knowledge to meet people's needs. One person who lived at the home told us, "They [staff] know how to look after me". A relative said, "They [staff] seem to know what they are doing. They are fine." All of the staff that we spoke with said they had induction training when they commenced working at the home and felt they had access to on-going training. Staff told us they felt they had adequate training to meet people's needs. One staff member told us, "I have had the chance to complete training in end of life care and dementia. It's been really useful." Another staff member said, "We all get good training and frequent refreshers around important areas such as safeguarding." However staff also felt that they did not get adequate support and supervision. One staff member said, "The supervisions are not much use, nothing ever gets done". Another staff member said, "You can say anything in supervisions and you never get feedback. I did raise about the fact I feel we need more staff to do things. Nothing changed and I did not even know if it was taken any further". Another staff member said "Our voice [staff] and the people's voice are not heard by the managers here." This showed staff did not have effective support in terms of putting learning into practice.

People told us they enjoyed the food and that they were given choice over what they wanted to eat. Menus were prepared in advance and provided a choice for people. We saw that where people did not want what was offered on the menu an alternative of their choice was prepared. During the mealtime we saw that people received the right amount of support and appeared to enjoy their food. One person who lived there said, "The food couldn't be better. We get a good choice." A relative said, "The food is good. They always make sure people are happy with what they are eating." Staff offered people a choice of drinks at all times through the day and provided support where required.

We spoke with four people about how they were supported to maintain good health. People told us they had access to health care services when they needed it. They told us that when they were unwell or required a doctor's appointment these were arranged straight away and staff supported them at their appointments. One person said, "They [staff] ask how you are and if you are not well they get the doctor straight away." Staff told us that on occasions they had

Requires improvement

Is the service effective?

identified people were unwell and that once they told the senior staff member appointments with the doctor were quickly arranged. A relative said, “We have never had any problem with how they manage [person’s name] health.”

Requires improvement

Is the service caring?

Our findings

The six people we spoke with told us that staff were caring. We saw staff talking with people with kindness and empathy. Relatives told us that they found staff to be kind and caring. One relative said, “The staff are marvellous.” However we also saw that for some people they were not actively involved in making decisions about their care and support. We saw one person asked to go their own room. Staff told them they had to wait two hours because the cleaners were in there. We spoke with the staff who told us that it did not matter because they kept the person out of their own room to keep them safe. We saw staff repeatedly asked people to sit down when they also wanted to move around the lounge or other parts of the home. The registered manager told us that people should have the freedom to move around the home as they pleased but they knew that this did not always happen. The registered manager could not tell us why they had let this restrictive practice continue. We spoke with the registered manager about this and they told us people should have the freedom to go to their room, but was aware this did not always happen. We saw examples of where people that wanted to move from the lounge area were redirected to sit down. This happened throughout the time we spent in the Malvern Suite.

People we spoke with told us they saw the registered manager and that they were approachable. The registered manager told us that they had frequent contact with the people that lived there, but also acknowledged that there was nothing in place to promote people’s views about the care they received. We asked staff about how they involved people in their care. They told us that they always made sure people had choice, but all the staff we spoke with said they did not have much time to spend with people due to the other tasks they had to do.

Staff told us that they had all recently attended training on equality, diversity and human rights. They were able to tell us about how they made sure people’s dignity was respected. We saw through our observations that when responding to people’s personal care staff maintained people’s privacy and dignity, however some aspects of people’s care did not always promote dignity and respect. We saw a hole in one person’s bedroom door where a lock had previously been fitted. The hole gave people the ability to see into the person’s bedroom and this could have compromised their privacy. The person had dementia so we were unable to ask them about how they felt about this. We spoke with the registered manager and they could not tell us how long the door had been like this and that there were no immediate plans in place to address the issue. This did not reflect an approach that promoted dignity and respect.

We recommend that the service seeks advice and uses guidance for current best practice in dementia care.

Requires improvement

Is the service responsive?

Our findings

People told us that they felt the support they received was not always tailored around them as individuals. Some people were able to tell us what hobbies and interests they had. We asked them if they had the opportunity to do any of their interests. They said that they did not. One person who lived there said, "They [staff] have never asked. I will probably just sit here for the rest of the day." We spoke with staff about this person and asked if they knew their interests. Despite the person having lived at the service for a number of years the staff did not know about their hobbies or interests. One staff member said, "They [people that lived there] are not interested in anything anymore." Our observations were that people were not being engaged in any meaningful activities. For example during the time we spent in the Malvern Suite we found people to be either asleep or being redirected to sit down when they tried to leave the lounge area.

None of the care records we looked at contained people's life histories or interests and care plans focused on tasks rather than the person's individual likes, dislikes or needs. We spoke with the registered manager about this and they could not tell us why this information was not in people's individual care records. They told us, "The activities person will be able to do this." Currently there was an activity person working one day a week and they had been trying to recruit another activities coordinator. From our observations and what people told us we found that hobbies and interests were not routinely planned to enrich people's quality of life. This approach did not promote people's individual preferences, personalities or respect their personal histories.

This was a breach of Regulation 9 of the Health and social Care Act 2008(Regulated Activities) Regulations 2014.

We observed that staff used different methods in response to a person's anxiety. Whilst we saw that some staff responded to the person in a way that reduced the person's anxiety, we saw that the way other staff responded lead to an increase in the person's anxiety. We spoke to the staff about how they supported this person. Staff did not demonstrate to us that they used a consistent response. We looked at this person's care plans and risk assessments and found that it did not contain the necessary information to inform staff of the way to manage this person's anxiety.

People we spoke with told us that they saw the registered manager and found them approachable. They told us that they knew that if they had a concern or complaint they could raise it with the registered manager or staff. Relatives we spoke with told us that they had been given information about how to complain. We could see no complaints had been received and the provider had procedures in place to act upon and respond to complaints.

Visitors to the home that included relatives and professionals were made to feel welcome at the home. Relatives were able to provide support if they wished and we saw that some relatives chose to visit around lunchtime so that they could help their family member with their lunch. Relatives told us that they were always made to feel welcome by the registered manager and staff. One relative said, "There is an emphasis here on maintaining good family contact."

Requires improvement

Is the service well-led?

Our findings

We found that the management, leadership and governance of the home was not effective. This had an impact on the care people received as areas requiring improvement were not identified and actioned. We spoke with the registered manager about the quality assurance systems they used in the home and how they and the provider were assured about the quality of the service provision. They could not tell us how they assured themselves that care and treatment provided to the people living in the home was safe and effective. There were no regular audits or checks and no records of any feedback being collected from the people that lived there or their relatives relating to care and support. This showed that there was no consistent system for the provider to identify, address and monitor any concerns or risks relating to care. We discussed with the registered manager about the care practices that we had observed as needing improvement. We spoke in particular about the Malvern suite and the inconsistent responses by staff to people's anxieties. They told us that they were not surprised by the care practices we had seen and stated they would have to change things. They explained they had a way of working that had not got through to everyone yet. The registered manager did not challenge staff practice and was not supporting staff as needed.

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

Staff we spoke with all said that they saw the registered manager regularly and felt that they were approachable.

We asked the registered manager about how people's views and experiences were included in the day to day running of the service. They told us that they worked alongside staff in supporting people in the home and that this gave opportunities to talk with people who lived there. However staff told us that they were not confident that their views or concerns would be listened to by the provider or registered manager. Staff told us that there were no regular staff meetings and that they did not feel involved in how the service was run or developed. There was no system to ensure that all staff had the information they needed to provide consistent good care and support.

All staff were aware of the whistle blowing policy and said that they would feel comfortable to whistle blow if they felt that this was needed to ensure people's safety. One staff member said, "I wouldn't tolerate any kind of abuse happening and if needed I would blow the whistle."

The provider had when appropriate submitted notifications to the Care Quality Commission. The Provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This means that we are able to monitor any trends or concerns.

The registered manager felt supported by the provider to be able to make decisions relating to the service. They told us that an example of this was the additional resource of an activity coordinator that was currently being advertised. However when we asked the registered manager about their vision of the service and what developments they had identified to improve the quality of the care, they could not tell us that any actions had been identified.

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 9 HSCA (RA) Regulations 2014 Person-centred care **People did not receive person centred care and support.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Treatment for people without the capacity to make decisions for themselves was carried out without applying the principles of the Mental capacity Act (MCA).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not receive their medicines safely.**

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 **People were not safeguarded from abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Effective systems were not in place to ensure that the service was meeting the needs of the people, keeping them safe and managing risks.**

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.