Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

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Date of inspection visit: 14 July 2015
Date of publication: 15/09/2015

Ratings

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

Overall summary

We inspected the service on 14 July 2015. The inspection was unannounced. Eden Lodge Residential Care Home is a care home (without nursing) which provides long term and respite care services. The home is registered for accommodation up to a maximum of 60 people. On the day of our inspection 24 people were using the service. This was because the provider is only currently using one section of the service.

We carried out an unannounced comprehensive inspection of this service on 22 July 2014. A breach of legal requirement was found in relation to the Mental Capacity Act 2005 (MCA) and we asked the provider to make improvements. After our unannounced comprehensive inspection we also received some concerns in relation to the service.

We undertook this focused inspection to confirm that the provider now met legal requirements and to look at the concerns we had received. This report only covers our findings in relation to those requirements and what we found in relation to the concerns raised. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eden Lodge Residential Care Home on our website at www.cqc.org.uk

Summary of findings

We found the manager had made the required improvements in relation to completing appropriate assessments where people lacked the capacity to make certain decisions.

However we found that incidents in the service were not always being responded to appropriately and there were not always enough staff to support people with their care and support and staff were not always being recruited safely.

The systems in place to monitor the quality and safety of the service were not effective and this had resulted in fire safety systems lapsing.

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 always safe.

People felt safe in the service and knew who to speak with if they had any concerns. However incidents were not shared with the local authority to ensure they were investigated and dealt with appropriately.

There were not always enough staff to provide care and support to people when they needed it and staff were not always being recruited safely.

Requires improvement

Is the service effective?
The service was effective.

We found that action had been taken to improve how people gave consent to care and support. People were supported to make decisions in relation to their care and support and where they lacked the capacity they were protected under the MCA.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Requires improvement

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

The systems in place to monitor the quality and safety of the service were not effective and this had resulted in fire safety systems lapsing.

Requires improvement

Eden Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Eden Lodge Residential Care Home on 14 July 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 22 July 2014 inspection had been made. The team inspected the service against two of the five questions we ask about services: Is the service safe and is the service effective. This is because the service was not meeting some legal requirements and we had received some concerns about the service. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with three people who used the service, two relatives, three members of care staff, the cook, the deputy manager and the manager. We observed care and support in communal areas. We looked at the care records of three people who used the service, as well as a range of records relating to the running of the service including audits carried out by the manager. We looked at the physical environment of the service, and reviewed maintenance records and risk assessments.

Requires improvement

Is the service safe?

Our findings

All of the people who used the service that we spoke with told us they felt safe. They told us that if they were concerned they would talk to a member of staff or the manager. One person said, "I am safe and the deputy manager is lovely and I can talk to her if there are any issues."

Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise and respond to allegations or incidents of abuse. However people could not always be assured that incidents would be responded to appropriately. We found that there had been some incidents in the service which should have been shared with the local authority for consideration under their safeguarding protocols. For example there had been an incident where a person had an accident whilst staff were assisting them using a hoist. Another person, who lived with a dementia related illness, had left the service without staff being aware.. We found this information had not been shared with the local authority and that we had not been informed about the incidents either.

We saw from the care plan of one person that they displayed behaviour which may challenge staff or present a risk to other people who used the service. We saw the care plan in place meant to guide staff in how to respond to this lacked information to guide them. There was no information on how to avoid the circumstances which might trigger this behaviour nor what action staff should take if the behaviour was displayed. This posed a risk that staff may not know how to respond and protect this person and other people from harm.

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

People we spoke with told us they were happy with the care they received from the staff. However two people who used the service and the relative we spoke with felt there needed to be more staff on duty at certain times of the day. The relative told us that care staff were responsible for doing people's laundry as well as delivering care. The people we spoke with told us that sometimes they had to wait for assistance from staff. One person said, "There are more residents now but they have not increased the staff."

We observed this to be the case at times during our inspection. On several occasions when people asked for assistance from staff we heard staff respond by saying, "I will be with you in a minute" or "I will come back when I have finished." During lunchtime there were times when there was only one member of staff in the dining area and we observed there were three people who needed support to eat their meal. One person struggled to eat their meal with a knife and due to only one member of staff being in the dining room this was not noticed for 10 minutes. This person had lost some weight and it was recorded in their care plan that staff should prompt them to eat. This did not happen during our observation.

Another person, who had lost weight and needed encouragement to increase their nutritional intake, was known to leave the dining table frequently during meals. There was guidance in the person's care plan informing staff they were to prompt the person back to the table to finish their meal as they had lost some weight. We saw the person leave the table when there were no staff available to prompt the person back into the dining room to eat their meal. A third person did not receive the support they required and as a result upset another person. If there had been more staff available to assist people then these examples could have been avoided.

We also noted there were not sufficient hours allocated to cleaning to enable housekeeping staff to keep the building to the expected level of cleanliness.Cleaning staff worked hard to clean the building but did not have the time to go back and clean communal toilets a second time and we found these to be dirty later in the day.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of harm in relation to new staff recruited to the service. We looked at three staff files and found that when staff were being recruited to work in the service, safe recruitment practices were not always being followed. For example, we found one member of staff had started working in the service prior to their Disclosure and Barring Service (DBS) check being received. A DBS check helps employers to make safe decisions regarding recruitment. The provider informed us this person would only work supervised by experienced staff and would not be counted in the numbers of active staff until the DBS was received. However during our inspection we noted the staff member worked unsupervised whilst

Requires improvement

Is the service safe?

assisting people who used the service. Additionally the rota for the day of our inspection identified the staff member as an active member of staff on duty and not as a supernumerary staff member under supervision of another. These shortfalls in recruitment placed people at risk of harm.

A second staff file did not contain photographic evidence of the staff member's identification and a third staff member had offered DBS checks from previous employment. Whilst it is at the provider's discretion to choose to accept DBS checks from previous employment, risk assessments should be in place to confirm this decision has been taken and the provider was assured of the good character and conduct of the employee in previous employment. A risk assessment had not been carried out for the member of staff who offered their DBS check from a previous employer.

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

Prior to our inspection we received information about the maintenance of the environment. At the time of our inspection the service did not have a maintenance team in place due to staff turnover. However, the provider had made interim arrangements to ensure the maintenance of the building was carried out.

We saw records which showed that requests for repairs and other maintenance were recorded in a designated book which was reviewed by the maintenance staff. The record showed that all requests were addressed in a timely manner and where professional assistance was required this was obtained. For example Portable Appliance Testing (PAT) of small electrical items. Staff we spoke with told us maintenance requests were dealt with promptly and the building appeared in a good state of repair. Records showed that equipment used to meet people's needs, such as hoists, were well maintained and regularly serviced.

Appropriate measures were taken to reduce the risk and spread of legionella, a bacteriological disease found in stagnant water which can cause a potentially fatal form of pneumonia. We saw records which showed the required actions were taken to prevent the formation of this bacteria. We noted however that the legionella risk assessment and policy were not specific to the service and required updating to identify risks and areas of concern for any staff not familiar with the building.

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Requires improvement

Is the service effective?

Our findings

The last time we inspected the service we found there were improvements needed in relation to how people who lacked the capacity to make certain decisions were protected under the Mental Capacity Act 2005 (MCA). The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability. The provider sent us a written plan telling us what improvements they would make and when they would make them by.

We found at this inspection that improvements had been made in relation to people consenting to their care. People were now more involved in making decisions about their care and where people lacked the capacity to do so; the manager had completed the appropriate assessments.

Three people we spoke with told us they were supported to spend their day as they wished. One person said, "The home is nice and we can get up when we want and go to bed when we want."

People were protected under the MCA when they lacked the capacity to make key decisions about their life. We saw from the records of two people that they lacked the capacity to make certain decisions. We saw the manager had assessed each person's capacity for individual decisions and had carried out a best interests meeting with people involved in their care. The discussion had been documented on a best interest's record and was placed in each person's care plan.

The manager displayed a good understanding of the Deprivation of Liberty Safeguarding (DoLS) and we saw she had made the appropriate referrals when it was felt a person's freedom may be restricted. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

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Requires improvement

Is the service well-led?

Our findings

The systems in place to identify and bring about improvements were not effective. Prior to our inspection we were informed of some concerns relating to the maintenance of fire systems in the service. The concerns were that the provider had not replaced emergency lighting when parts of this system failed. The provider had been told about these failings by maintenance staff but the provider had not taken action to make the improvements.

These concerns had then been shared with the fire safety officer from Nottinghamshire Fire and Rescue Service and they had visited the service on 19 June 2015 to assess fire safety. The fire safety officer had instructed the provider to carry out remedial work to address concerns regarding fire safety at the building within six weeks, including the replacement of some emergency lights. At the time of our inspection we saw that emergency lights had been replaced. However it is of concern that the emergency lighting issue had not been addressed earlier by the provider despite the maintenance staff highlighting these faults for several weeks.

At the time of our inspection the provider did not have an appropriate fire risk assessment in place for the building. The fire safety officer had instructed the provider to appoint a company to carry out this assessment and the provider was obtaining quotes for this. Again it is of concern that the provider's systems for monitoring the quality of the service had not identified this shortfall.

After our visit we received further information of concern about the safety of people should a fire break out in the service. The Nottingham City Council safeguarding officer had visited and instructed the provider to take remedial action to make sure people were not placed at risk should a fire break out. This meant that despite the fire safety officers visit and our visit, highlighting concerns about the risk of the spread of fire, the provider's systems for assessing the safety of the service had not been effective in recognising the risk.

This was a breach of Regulation 17 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 regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected against the risk of abuse or harm. Regulation 13 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate systems to assess the quality of the service. Regulation 17 (1) (2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff deployed in the service to meet the needs of people. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated with unsafe systems for staff recruitment. Regulation 19 (2)(a)(b).