Indigo Care Services Limited

Chatsworth Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Chatsworth Lodge is registered to provide personal care for up to 39 adults, which may include some people living with dementia. This inspection was unannounced and took place on 15 March 2017. At the time of our inspection there were 36 people living there.

There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. This is the first inspection under this provider. The registered manager and staff transferred to the new provider ensuring continuity of care. All care planning and paperwork was carried over. This was not always suited to purpose.

During our inspection visit we observed that staff were friendly and approachable. When possible they spent time sitting with people to offer them comfort or stimulation. We observed staff delivering care which met people's individual needs and which supported them in a respectful and appropriate way.

Accidents and incidents were investigated and plans put in place to reduce risk. However some staff members who delivered care had very long finger nails and this had not been addressed. This could cause damage to fragile skin.

There were training and processes in place to keep people safe and staff followed these. People's physical and mental health was generally promoted. However staff were not trained to meet the special needs of people such as people living with the effects of strokes or living with dementia. Medicines were administered and recorded as prescribed. However storage of medicines was a little chaotic and unorganised.

We saw staff ensured people were comfortable. We saw people were supported in a relaxed and unhurried manner. However there were not enough staff to meet people's personalised needs and wishes. Some people had to wait longer than they wanted to for care or to use the toilet. There were very few social activities for people to partake in. We saw they were left un-stimulated and showed signs of boredom. There was a well-equipped craft room in the service, however people did not have access to this.

Staff were caring and communicated well with people. People were offered choices at meal times and were seen to enjoy their food.

Staff focused on people they were caring for rather that the task they were carrying out. Staff spoke in a positive manner about the people they cared for and had taken the time to get to know people's preferences and wishes. Staff had a good understanding of people's needs and this was demonstrated in their responses to people and recognition of when people required additional support.

People's privacy was respected. People had their independence promoted. Where possible they were

offered choice on how they wanted their care delivered and were given choices throughout the day. However, dignity was not always promoted while they were been assisted to move using a hoist.

People were supported to maintain relationships with family and friends. Visitors were welcomed at any time. Records we looked at were not always personalised and had not always included decisions people had made about their care including their likes, dislikes and personal preferences.

People, relatives and staff spoke well of the registered manager and felt the home was starting to be well-led.

The registered manager was relatively new in post and was managing in an inclusive manner. This was starting to be reflected in the service in so far as people and staff had their wishes and their knowledge of people respected. Most staff were aware of their roles and responsibilities for people's care. The provider and registered manager had systems in place to review the service and to ensure the service responded to the on-going needs of people, however this was not always effective.

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.

Staff knew how to keep people safe and how to report any concerns. However risks were not readily identified and therefore staff were not always fully aware of risk management in all areas of people's lives which meant there was potential risk to people that was not always managed.

There were systems in place for the storage and administration of medicines. Staff understood these and administered medicines as prescribed. However storage of medicines appeared chaotic and unorganised.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive the training the provider recognised as necessary to deliver care. This included specialised care. Most staff knew people and their individual care needs. However, not all staff were aware of the extent of how DoLS impacted on people.

People's nutritional needs were understood and met, although not always recorded appropriately. People were supported to ensure their physical and mental health was promoted.

Is the service caring?

Good

The service was caring.

Staff knew what was important to people. The registered manager and staff ensured important aspects of people's lives were recognised and responded to. Staff were caring and compassionate but did not have a lot of time to spend with people. However there were times when people's dignity was not always promoted.

Staff ensured they always obtained people's consent, either verbally or by understanding their body language prior to assisting them. They generally ensured the privacy and dignity of

people using the service was always promoted

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always easy to follow and did not contain personalised information and direction to staff on how to care for people with complex needs. People were not offered the opportunity to participate in their interests. They were not offered mental and physical stimulation and showed signs of boredom.

Is the service well-led?

Requires Improvement

The service was not always well.

Care plans were not always easy to follow and did not contain personalised information and direction to staff on how to care for people with complex needs. People were not offered the opportunity to participate in their interests. They were not offered mental and physical stimulation and showed signs of boredom.

Chatsworth 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.

The inspection took place on 15 & 16 March 2017 and was unannounced. It was carried out by one inspector, one inspection manager and one specialist advisor whose speciality was the care of older people on the first day and one inspector on the second day.

Before the inspection we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Usually before an inspection visit we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However this is a new service and we did not ask the provider for it.

As some people were living with dementia at Chatsworth Lodge we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with six people and three relatives. We spoke with four staff members, the registered manager and a regional manager. We observed how care was delivered and reviewed the care records and risk assessments. We checked medicines administration records and reviewed how complaints were managed. We looked at four staff recruitment records and staff training records. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "It's safe here." Another said, "The girls keep me safe. What more could I want."

However risk was not always identified and action plans were not always in place to mitigate the risk. For example we were given conflicting information on who had a pressure area and whose responsibility it was to care for them.

All people had risk assessments as part of their care planning. However most were hand written and were difficult to read. Therefore the risks and the directions to mitigate risk were not clear. We saw one risk assessment carried out by the registered manager with regard to an outbreak of a virus in the service. This had been written out in a clear and concise manner with very clear directions to staff on how to keep people safe and ensure infection control. However this was the only clear risk assessment. Others were tick boxes without clear personalised information and directions to staff. The registered manager told us they planned to review all risk assessments to ensure risks to people's safety were clearly identified and with clear directions to staff on how to keep people safe.

We saw some areas of risk were well managed. When people needed the assistance of a hoist to move this was done in a safe manner. Staff assured and re-assured people they were assisting. When a person was anxious staff chatted to them to distract them and make the experience as safe as possible. However we noted some staff members who delivered hands on care had extremely long finger nails. This was a risk to people and could have caused injury to fragile skin such as those people who were receiving end of life or palliative care.

Records were kept when people fell or when there was an incident that may cause them harm. The records were reviewed and actions taken to reduce the risk of falling. This included allocating a member of staff to care for one person on a one to one basis to keep them safe.

The service had a safeguarding adult policy in place. Staff we spoke with were aware of this and knew how to report any concerns or allegations of abuse. They told us they were confident in raising any concerns they had. One staff member said, "Yes I know I have to act and would do so." All staff knew the process of escalating their concerns should they need to. To date the have been no referrals.

Personal emergency evacuation plans (PEEP's) were in place for each person in the case of an emergency, such as a fire. This showed the service was aware of risk, risk assessment and emergency procedures.

The registered manager told us they used a recognised tool to determine the staffing levels in the service. There were enough staff to keep people safe but these were not sufficient to provide personalised care. A review of rotas dated back to registration in February this year showed the required six members of care staff needed for the day and four members of care staff needed for the night were not always met. For example for the week ending 26 February there were several days where the rotas show there were staff

shortages. Almost half of the people needed the assistance of two staff to keep them safe while assisting them to get ready for the day. This meant when there were staff shortages people were at increased risk of poor or inadequate care.

Staff told us they work well together. However it was difficult to understand how staff were deployed or how their work was managed. For example we were unable to get a concise answer on how many people day staff had to assist to get ready for the day. Staff were deployed on floors rather than on need and wishes of people. On the day of our inspection visit up to half the people were assisted to prepare for the day by night staff. There was no clear evidence people wanted to get up early and we saw some people were dressed and then left on their beds rather than be taken to the dining room. Staff told us they could do with at least one more staff member to assist them in the mornings.

The provider followed a safe recruitment process to ensure the staff had the right skills and attitude to meet the needs of the people living at the service. The provider undertook criminal records checks called Disclosure and Barring Service (DBS), prior to prospective staff commencing employment at the service. This was carried out to ensure prospective staff were suitable to work with vulnerable people. The provider also ensured suitable references were sought. We saw from records staff did not commence employment until all the necessary checks and documentation were in place.

People's medicines were safely managed. All of the people we spoke with said they were taking regular medicines. Although few people were able to tell us precisely what medicines they were taking, they felt content they were getting the correct dosage and at the correct times. Staff explained to people what their medicines were and what they were for. They encouraged people to take their medicines. However, one person resisted all attempts to get them to take their medication. Staff left them for some time and offered them again when they were taken. This showed staff were aware of people needs and habits.

Staff responsible for medicines administration had completed training in safe handling and administration. Staff also told us they had been observed giving people their medicines by a member of the management team to ensure they followed best practice guidance. We observed staff giving people their medicines safely and in a way that met with recognised practice. However aspects of medicine administration were a little chaotic and disorganised, this included storage and the administration of PIR medicines. For example there was no PRN protocol for prescribed PRN Paracetamol. PIR medicines are offered to people on a need basis, such as pain relief.

Records showed medicines subject to special controls were managed in accordance with good practice recommendations. This included two staff signatures whenever it was necessary. Checks on a sample of medicines held in stock were found to correspond with the records held for them. Other records showed the temperature for the safe storage of refrigerated medicines was met. This showed medicines management was taken seriously and staff ensured people received their medicines safely and as prescribed.

Requires Improvement

Is the service effective?

Our findings

Most staff had basic training in how to care for people. This included how to assist people to move safely, infection control and how to keep people safe. There was a plan in place to ensure all staff received basic training as a priority. However this plan did not include training the provider considered necessary to 'deliver the highest standards of care.' This is set out in their Statement of Purpose. A Statement of purpose is a document that sets out the care to be provided by the service. For example a high number of people were living with the consequences of a stroke. Only one staff member (a nurse) had received training in this.

There was no system in place for this training to be passed on to staff, though they said they would answer staffs' questions if asked. Other people lived with dementia, again staff had not had specialised training to assist people to live as well as possible. Without this specialised training staff were not able to 'deliver the highest standards of care.' We saw staff struggle to communicate effectively with people who were non-verbal in their communications.

New staff completed a period of induction and shadowed more experienced colleagues.

Staff explained to people and sought their agreement before they provided any care and support. Staff recognised the need to obtain people's consent before they provided care. The registered manager and staff understood the requirements of the Mental Capacity Act 2005 (MCA). The 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.

The registered manager understood their responsibilities to ensure applications were made for those people whose freedom and liberty had been restricted. People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When required, the registered manager had made applications for assessment to the local DoLS team. The provider had policies and procedures in place for staff to follow in relation to the MCA. The registered manager understood the importance of acting in people's best interests and the key principles of the MCA. However some staff struggled to understand the act. No staff member other than the registered manager was aware of who had been subjected to a DoLS for their own protection.

People who were identified as needing their nutrition monitored could not be sure this was done consistently and effectively. People who were identified as requiring their food monitored were not fully protected from the risk of poor nutrition because their food and fluid intake was not always monitored in a clear and concise manner. For example staff were not told the optimum amount of food and drink for the person to take in and their intake was not assessed for the day, or 24 hour period. Also the output was not

measured. This mean no one took an overview of their fluid and food intake and judged the consequences of this on people's health.

One person said meals were, "Very good and well-cooked." Another person said, "The food is very good." We saw people were offered their breakfast at a time they chose. People who get up early in the morning, we saw that was almost half of the people living there, did not get offered a drink until the kitchen opened at eight o'clock. This had been recognised by the managers and the night staff were directed to make sure people were offered a hot drink when they got up.

We saw staff knew people well and were aware of individual dietary and related support needs. People, who needed it, were provided with the support to eat and drink.

Record showed people's health care needs were not always been met. For example people who were assessed as needing to be turned on a two hourly to prevent pressure areas did not always have this. The record of one person showed on the 20 February a person was turned at 4.08, 6.39, 10.40 and on the 22 February 4.25 and 7.20. This could have put them at risk of a pressure area.

People told us they had a variety of health needs and were registered with the local medical centre. People consistently told us, if they wanted to see the doctor they would let one of the members of staff know and arrangements were made. One person said, "They [staff] will always get a doctor if you need one." We saw documentation which supported people had access to healthcare professionals.

Good

Is the service caring?

Our findings

We saw staff were kind, caring and compassionate in their interactions with people. They ensured people were comfortable and took the time to communicate what was happening in a friendly and reassuring manner. One person said, "The girls are excellent, they are so helpful and kind no matter what you ask." Another said, "Yes they are all kind, but some are very kind."

During the day, one person who was living with dementia had times when they were anxious and confused. Staff were understanding, compassionate and caring of the person's needs. We saw staff took it in turns to spend time with the person providing reassurance.

People's privacy and dignity was not always promoted and respected. When staff were assisting people to move using a hoist their clothing 'rode' up and their underwear was clearly visible. The registered manager undertook to deal with this as a matter of urgency. Other staff were seen to ensure the person set the walking pace and walked alongside them offering physical and emotional support.

Some areas of the home's environment did not always assist staff to maintain people's dignity. Curtains were in place in one area of the service that should have had doors. The registered manager was aware of this and had a plan in place to address this.

We spoke with staff and they were able to give us examples of how they respected people's dignity and privacy and acted in accordance with people's wishes. For example, staff told us about how they maintained people's privacy while assisting them during personal care.

The service had photographs of people who used the service, family and friends, joining in with members of staff at various events. We saw from these photographs that people were laughing and showing signs of enjoying themselves.

The service had a 'resident of the day' scheme in place. This meant that for one day usually monthly the service looked at all aspects of their care to ensure they were been cared for in a kind and dignified manner.

People were supported by staff to make day-to-day choices and decisions. For example, staff asked people where they would like to sit and would they like to join for lunch. Where staff assisted people with meeting their care needs, they ensured people understood what their choices were.

Staff ensured lunch was a pleasant and friendly occasion. They engaged people in conversation and we heard people laugh and joke. People were supported to keep their clothing clean and fresh during lunch. They were given the choice of full clothing protector or a napkin. People confirmed this was usual practice. One person said, "Yes we get choice." Another said, "The food is very good." We saw all people were offered an opportunity to freshen their hands before lunch. Lunch was served in an organised manner ensuring each table was serviced together. Staff assisted people to eat in a dignified unhurried manner.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care. All the people we spoke with said there was not enough staff or they have to wait too long for their needs to be met. This included been taken to the toilet.. One person said, "At this moment I want to go to the toilet by there is no one about." Another said "The girls work really hard but there is not enough of them." A third person said, "I guess they don't have the money for staff." This meant the service was not responding to people's needs as people did not get the care they needed when they needed it.

This is a new service having been registered in February 2017. They carried the care planning over from the last provider and were using this to care for people. All people had a care plan however, they were handwritten and major parts were very difficult and in some instances impossible to read. The registered manager told us they were under review. We asked the registered manager to give us two care plans they had reviewed and were happy with. Again it was the same very difficult handwriting that was very difficult to read. This meant that the information in care plans was not readily available to staff and staff we spoke with agreed the information was difficult to extract. Most of the care staff we spoke with had not read the care plans. They relied on handover notes and direction from senior staff. Without clearly legible and detailed care plans there is a risk poor information gets handed on or good information is lost and this could impact on people's care.

Areas of care planning that were legible showed care plans were not always person centred. For example we saw, [person] 'is PEG fed so does not join in for meals'. There was no information on how this affected the person or what staff should do to distract or comfort them if this was needed. Another relative told us that, their relative was hard of hearing but their care plan showed their hearing was good.

Despite this most staff we spoke with were able to tell us about most people's care needs and wishes. They were able to talk us through people care needs and how they were met. However, we found the health care needs of people were not always clear and we received conflicting information on one person's health and welfare in particular.

People were not offered stimulation. One person said, "No there are no activities, it's very quiet during the day. The social aspect of care planning was not fully explored. Hobbies cultural and religious sections were not always completed. Some life histories had been completed by families. This information would help staff care for people who were no longer able to communicate their needs and wishes clearly or at all.

We heard staff ask if people wanted the television switched off and they said they did. Following that there was not any other stimulation. People were not offered newspapers, magazines or any objects that would offer them comfort such as a familiar soft object, photograph of people close to them. We saw on the second day of the inspection visit the service had a 'crafts' room. This was full of interesting objects bought to promote people's interests and to offer stimulation. However this was not used on the days we visited. People who were living with dementia need stimulation to assist them to maintain as much brain function as possible. We saw people were bored and dozed to pass the time. However we noted that when staff

arrived people opened their eyes and dropped off again when there was nothing interesting offered to occupy them.

The service had a garden that stretched down to the local river. People did not have access to this as the area was uneven underfoot and could pose a risk of tripping. The registered manager had plans to make this area safe thus giving people more access to the garden and fresh air.

People and relatives told us they knew how to raise a concern and who to make a complaint to, should it be necessary. One person said, "If I wanted to complain I would go to the office first, I think they would sort it out." We saw there were noticeboards with lots of relevant information on display, to guide and support anyone staying or visiting the service. Included were details of how to make a referral to the local authority's safeguarding team should anyone believe it necessary. One relative said, "It is all up on the wall just as you come in the door with a number to ring." The provider had a procedure for handling and dealing with complaints. This is a new service and to date there have been no complaints.

Visitors were welcomed to the service at all times. During our inspection visits we saw a steady stream of people visiting the service.

Requires Improvement

Is the service well-led?

Our findings

Chatsworth Care Home is required to have a registered manager and one was in post. A senior manager and registered manager were present throughout the inspection and both knew the people and the day-to-day running of the service.

They were aware of the provider's responsibilities to send statutory notifications to the Care Quality Commission when required. Statutory notifications are changes, events or incidents providers must tell us about.

This is a new service, however the registered manager and staff transferred to the new service and there was very little disruption. The registered manager said they were using the paperwork of the previous service and there were areas of this that needed to be addressed. However we looked at examples of care planning the registered manager said they had reviewed and was happy with. We found these care plans difficult to follow and read and were therefore not fit for purpose.

The provider did not ensure there were enough staff to keep people stimulated and engaged throughout the day. The registered manager had increased staffing levels and while we found there was enough staff to keep people safe there was not enough staff to deliver personalised care in a timely manner to people.

The provider had a quality assurance process in place and a recent audit highlighted areas of concern. These included monitoring staffing attendance and staff training. However this training did not cover areas of specialism so the provider could deliver the quality of care set out in their Statement of Purpose. Staff told us they valued their induction, training and the support they received from their colleagues and the wider management team. However there were no systems in place to validate training from more qualified and experienced staff such as nursing staff to care staff. .

Staff told us since the change in management they felt supported. They said the registered manager was very supportive and had an open door policy. One staff member said, "The manager is in and out of the office all the time. [manager] is lovely and you feel comfortable with [manager]." Visitors confirmed they knew or they were starting to get to know the registered manager and felt they could talk to them should they need to.

One member of staff told us they participated in supervision with their line manager and said, "They (supervisions) are a good thing; it is a way of voicing any concerns as well as recognising success." There was a plan for all staff to receive supervision regularly. Supervision is a process where staff meet with their manager to discuss their work performance and any training and development needs.

Staff told us they felt supported by the registered manager and the management team. One staff member told us, "[Registered manager] is good; I can talk to her about anything." Another member of staff said, "[registered manager] is approachable and visible." Staff saw the supervision process as positive and a time to share concerns and success.

The service was starting to be managed in an open and inclusive manner. However people told us they were not included in the planning of the service therefore it had not be tailored to meet their needs and wishes.

There were plans in place to ensure people were offered stimulation in the future, however we are unable to comment on the effectiveness of these plans until we see them in practice.