St. Denis Lodge Residential Home Limited

St Denis Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced focused responsive inspection of this service on 4 and 5 October 2018.

The home is registered to provide accommodation and personal care for up to 21 people. At the time of our visit there were 16 people living in the home.

St Denis Lodge Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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.

We inspected the home against three of the five questions we ask about services: is the service safe, is the service effective, and is the service well led?

Systems and processes were not always effective. Audits and quality assurance processes were taking place but had not identified that people's consent forms for areas such as care provision and bed rails had been signed by representatives without the necessary legal authority to do so. They also had not identified that risk assessments were not always personalised and one of the conditions of a person's Deprivation of Liberty Safeguards (DoLS) was not being met. This meant that the service was not always working within the principles of the Mental Capacity Act 2005 (MCA 2005). The MCA 2005 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.

Staff felt supported by management and enjoyed working at the home. One staff member said, "It is a joy to work here. We get along like a family." Staff had regular, in-depth supervision where they received both praise and had opportunity to develop their practice. People, relatives and staff felt included and listened to. They had confidence that if they raised concerns with management action would be taken to resolve things. The home had established and maintained pro-active working relationships with health professionals which were helping people to stay well for longer and prevent unnecessary hospital admissions.

People were supported by staff who did not always have up to date training. People were supported to have a balanced and varied diet. People were supported by staff who understood the importance of working effectively with health and social care professionals to meet people's needs. When people's health

deteriorated or fluctuated staff sought advice and guidance in a timely way. Support also extended to accompanying people to routine appointments, courses of treatment, or when receiving visits from health professionals.

People told us that they felt safe living at the home. Staff had a good understanding of how to safeguard people from harm and abuse. They understood what signs to look for and how to raise a concern. The home had robust recruitment processes to ensure that people were supported by staff who were suitable to work with them. People had risk assessments that staff used to help reduce the risk of avoidable harm. We recommended that they make these personalised as they were generic. Medicines were managed safely. Staff demonstrated confidence when supporting people with their medicines and had regular, formal observations to check their competency. The home conducted audits to ensure incidents or near misses were opportunities to learn from and reduce the chances of them happening again.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remained safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The best interest decision process was not being followed as some people's consent records for such things as provision of care and bed rails were signed by representatives without the correct legal authority to do so.

People were supported by staff who did not always have up to date training.

People were supported by staff who understood the importance of working effectively with health and social care professionals to meet people's needs. When people's health deteriorated or fluctuated staff sought advice and guidance in a timely way.

People were supported to eat a balanced and healthy diet.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had not identified the issues with regards people's consent forms being signed by next of kin or representatives without the necessary legal authority to do so.

Audits had not identified that a condition attached to the granting of a person's Deprivation of Liberty Safeguard (DoLS) was not being met.

The auditing had also not identified that people's risk assessments were not always personalised.

Auditing had not identified that some staff member's due dates for training in areas such as MCA and first aid had expired.

People were supported by staff who liked working at the home

and worked well together.

The management at the home were visible and approachable.

Staff felt respected and valued.

The home had established and maintained good working relationships with health and social care professionals.

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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 focused responsive inspection was prompted in part by notification of an incident that indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the incident, which we will consider separately, we did look at associated risks. The incident indicated potential concerns about the timeliness of staff seeking medical treatment for people with deteriorating health. This inspection examined those risks.

This inspection site visit took place on 4 October 2018 and continued on 5 October 2018. The first day was unannounced and the second day announced. The inspection was carried out by two inspectors.

The team inspected the service against three of the five questions we ask about services: is the service safe? Is the service effective? Is the service well led. No risks, concerns or significant improvements were identified in the remaining Key Questions through our ongoing monitoring, or during our inspection. We therefore did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

We reviewed information about the service including safeguarding records, complaints, and statutory notifications since the previous inspection. Notifications are information about specific important events the service is legally required to send to us.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with four people using the service, and one relative. We also spoke with the registered manager, care manager, supervisor, three care staff, a chef, and a domestic assistant. We also spoke with a GP by telephone, a Community Psychiatric Nurse (CPN), a community support worker, and three district nurses.

We looked at six people's care plans. We also looked at records relating to the management of the home including staff rotas, mental capacity assessments, consent forms and medicine administration records. We looked at three staff files, the recruitment process, training, meeting minutes, and supervision records.

Good

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection of this service on 2 and 3 May 2018. After that inspection we received concerns in relation to an incident that indicated potential concerns about the management of risk in the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Denis Lodge Residential Home on our website at www.cqc.org.uk.

People told us that they felt safe living at the home. Two people told us, "Very much so" when we asked them this question. Another person said that they felt reassured at night from having staff nearby and that they responded quickly when they pressed their alarm.

Staff had received training in how to safeguard adults and demonstrated a good understanding of what signs and symptoms could indicate that people were experiencing harm or abuse. They knew what to do to raise concerns both internally and externally. One staff member said, "If the management were not listening I would speak to safeguarding or CQC."

Risk assessments were not always personalised. Although staff had assessed people's risks the records within people's care plans were generic and did not include their name. For example, one person's risk assessment for bathing identified risks and control measures generally associated with bathing. This was raised with the management who immediately started creating more personalised risk assessments for people using information in their care plans. In practice staff took a personalised approach to the risks that people faced. Where another person's fluid intake had reduced daily records showed early identification by staff and referral to a relevant health professional for advice.

People who were at risk of damage to their fragile skin had personalised repositioning care plans in place. This was to reduce pressure on high risk areas. Care plans detailed the support people required to change position. Records showed that staff had supported people as prescribed by the tissue viability team including welfare checks at the correct time intervals and frequency. Staff demonstrated an awareness of people at the home who were at increased risk and the additional monitoring that was in place for example with their food and fluid intake and re-positioning.

Systems were in place which helped ensure equipment was regularly serviced and repaired as required. This included the fire system and equipment. Each person, including people on respite, had up to date Personal Emergency Evacuation Plans (PEEP) in place which guided staff on the most appropriate way to support them to get out of the home safely in the event of an emergency such as a fire or flooding. Staff had recently received refresher fire training and knew what to do in the event of a fire. Regular fire drills had been held which included detail of who had taken part.

There were enough staff on duty to meet people's needs. Management told us they reviewed staffing levels and deployed them based on areas such as people's needs, staff workload and competencies. Staff were

not rushed and told us the rota supported them to spend meaningful time with people. The registered manager said they had never used agency workers as the current team had always been flexible in responding to increasing needs, staff annual leave or periods of sickness.

The service had safe procedures for the ordering, storage and disposal of medicines. Medicines that required stricter controls by law were stored correctly in a separate, lockable cupboard and records kept in line with relevant legislation. People were supported to have their prescribed medicines on time and at the correct dose. Staff doing this task had been trained to support people safely and competently. People were given choice as to whether they took their medicines and how. One person being supported with an inhaler was asked, "How would you like to use it today?" Staff were observed giving clear and simple explanations about what the medicines were and what they were for. For example, one staff member was heard saying, "[Name] I have some paracetamol for you to stop your back pain coming along."

The home was visibly clean throughout and had no malodours. Staff had training in infection prevention and control and made use of personal protective equipment appropriately. The home had an up to date cleaning schedule. Procedures by laundry staff helped ensure that soiled clothing did not come into contact with clean items. Staff understood their responsibilities with regard preventing and controlling risks of infection.

People were supported by staff who understood their responsibility to record accidents and near misses, and report these in a timely way to an appropriate member of staff. Incidents and near misses were investigated. Records showed that this included a description of what had happened, the result of the investigation, and follow up action taken. This auditing meant that the home could identify potential patterns to prevent more serious incidents occurring. For example, when a person had experienced a choking episode the home worked with a speech and language therapist to create a diet that was acceptable to the person and gradually reduced the risk of it happening again. Outcomes were shared with staff including during team meetings, supervision, and handovers.

Requires Improvement

Is the service effective?

Our findings

We carried out an unannounced comprehensive inspection of this service on 2 and 3 May 2018. After that inspection we received concerns in relation to an incident that indicated potential concerns about the management of risk in the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Denis Lodge Residential Home on our website at www.cqc.org.uk.

People were supported by staff who did not always work within the principles 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.

Where people had been assessed as lacking capacity to make more complex or one-off decisions, their plans identified when they had a person with the legal authority to make decisions on their behalf such as a deputy or lasting power of attorney and the scope of this authority, for example whether it covered finance and property and / or health and welfare. Despite this, the best interest decision process was not being followed as three out of six people's consent records for such things as provision of care and bed rails showed that representatives had signed to give consent on behalf of people when they did not have the correct legal authority to do so.

People told us that staff did consistently seek their consent before looking to support them. One relative said, "What I like is that whatever the person's capacity they involve them to that extent. I see that in staff engagement with other people. I regularly see that." A staff member said, "If a person had a representative with last power of attorney for finance they wouldn't be able to sign for anything concerning the person's health and welfare. Next of kin can't sign for anything if they don't have lasting power of attorney. Unless you have that bit of paper, you can't make decisions on a person's behalf." Although we found that consent forms were not always signed by people with the correct legal authority the care staff we spoke with at the inspection were able to demonstrate that MCA training was informing their practice.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. Applications had been made for people who required Deprivation of Liberty Safeguards (DoLS). One person had an authorised DoLS in place with three conditions attached to it. One of these conditions was not being met. The condition stated the home needed to consider mental capacity assessments and best interests decisions as part of the person's care planning. There were no records on the person's file to confirm this had happened and the registered manager was not aware that this was one of the conditions of this person's DoLS. This was a practice and records issue as a deterioration in the person's health, which was confirmed by the registered manager, had not resulted in a review of this person's capacity and any subsequent best interest decision meetings. When we raised this with the

registered manager they told us this would be resolved as part of an action plan to improve compliance with the MCA 2005. We were shown an action plan by the end of day two of our inspection which included this.

People's needs and choices were assessed and care, treatment and support was provided which achieved effective outcomes. People had thorough pre-assessments which supported their move to the home and informed their ongoing care and support. When people's health and care needs changed reviews were held with the person's involvement.

People were supported by staff who did not always have up to date training. The care manager told us that each month, as part of quality assurance, they would review the training records to see who had completed or was due to undertake training. This had not always identified when training due dates had expired for example with regards MCA and first aid training. When this was raised with the care manager they told us they would consider the merits of the current system to see if it needed making computerised to support better tracking. Although five staff out of 39 staff were overdue for training on MCA only two of those were care staff. The other three were administrative staff and kitchen staff who had less direct interaction with people. The five staff with overdue training for MCA had completed courses that covered MCA concepts. First aid training for five members of staff had expired in July 2018 and when this was raised at inspection the service acknowledged and sought to update this promptly. Staff told us that they felt well trained and that it gave them the skills to respond to people's specific needs. One staff member said, "You continuously learn here and never know it all." One staff member told us that they had been put on a dementia awareness course after they had expressed an interest to the management team that they wanted to increase their knowledge in this area. Another staff member said, "I've just done an end of life course. They support learning and development here."

People were supported by staff who had received an induction. This included a probationary period involving shadow shifts with more experienced staff and regular competency checks covering areas such as medicines administration and moving and assisting.

Staff received regular supervision and told us that they were given the opportunity to discuss and reflect on anything including questions about practice and personal development. Records confirmed this.

People were supported to eat a balanced and healthy diet, food and fluid charts were maintained where required. The food was well presented and people could have as much or as little as they wanted. For example, one person was supported to have six small meals a day as observations had shown that they got tired eating three larger meals. Another person was heard replying, "Yes but not too much" when they were asked if they wanted a pudding. Each day the chef spoke with people to see what they would like to eat. A rolling eight-week menu was in place to give variety and to ensure everybody's preferences were catered for. People requiring support were helped in a way which respected their dignity including being provided with adapted cutlery. This enabled them to be as independent as possible. Support was at the person's pace with natural, warm conversation making this a pleasurable experience. We heard one person who required extra support being gently encouraged by the staff member who told them, "You're doing really well."

Finger foods and snacks were provided outside of typical meal times. People could have alcohol rather than soft drinks if they wished with some people choosing to have their favourite bottle of drink stored for them in the home's pantry. Meal times were relaxed with people observed chatting freely with each other. Relatives were welcome to stay if they wanted to. We heard one staff member saying to a person's relative, "Do you want to sit with your [relative] at the table?" One person, when asked if they had enjoyed their meal, replied, "Very much so." We observed a staff member helping a person with limited sight by describing what food was on their plate.

People were supported by staff who understood the importance of working effectively with health and social care professionals to meet people's needs. When people's health deteriorated or fluctuated staff sought advice and guidance in a timely way. For example, one person was supported with regular visits from a diabetic nurse. Another person had been accompanied by staff for emergency dental treatment. One relative told us, "Whenever there is the slightest concern the staff have contacted me and reassured [relative]." One person's file showed regular input from a CPN, GP and diabetic nurse.

Health professionals told us that information sharing and communication with the home's staff was good and that their recommendations were followed. A GP said, "The staff are very good. They always ask for visits. I think they are very responsive to people's needs. I have no qualms in terms of their timeliness. I am absolutely confident that they would contact us in good time." Another health professional echoed this when telling us, "They are extremely timely in getting us involved and keep us informed. A lot of the staff are really knowledgeable about the [people] here. They make accurate records and have questioned decisions by the GP and gone back to the CPN. They listen to instructions and take on our advice." Staff were clear about what they would do and who they would involve if a person required emergency medical treatment. One person said, "They are very good at calling in help if needed."

The home was set out across two floors and had been adapted with slopes, handrails and two working lifts to ensure people could access different areas of the home safely and as independently as possible. The spacious, enclosed garden was planted with shrubs to act as a point of interest and had tables with parasols so people could sit outside and relax. We observed one person enjoying exercises around the garden with their walking frame. This person said they tried to do three circuits of the garden each day and left us cheerfully commenting, "If you don't use it you lose it." The sitting room, dining room and conservatory all provided direct views onto the garden.

Requires Improvement

Is the service well-led?

Our findings

System and processes to monitor the quality of the service required improvements. Although audits were carried out to help maintain the quality of the service, and included spot checks of care practice, support with people's privacy and dignity, and care plans, they had not identified the issues we found with regards people's consent forms being signed by next of kin or representatives without the necessary legal authority to do so.

The auditing had not identified that the person with a DoLS condition requiring the home to consider mental capacity assessments and best interests decisions as part of their care planning did not have records relating to meeting the conditions attached to DoLS on their file. When we asked the registered manager what DoLS conditions this person had they were not aware of this condition.

The audits had not identified that people's risk assessments were not always personalised. These contained generalised language and did not include the person's name.

Audits had not identified that five staff member's due dates for training in MCA and five staff member's training for first aid had recently expired. We raised this with the care manager who said they would resolve this and look to implement a system that was easier to track when training was due.

When these issues were raised with the registered manager and care manager they started developing an action plan to resolve the concerns we had. They also started drafting more person-centred versions of people's risk assessments.

People were supported by staff who liked working at the home and worked well together. One staff member said, "It is a joy to work here. We get along like a family." Other staff member comments included: "I love it here. It is friendly and I get on well with the other staff" and, "This is a happy place to work. We genuinely care about each other's work and know about [each person]. It's a relaxed home." Our observations confirmed that the home was run in a calm and professional manner.

The management at the home were visible and approachable. One staff member told us, [The registered manager] is always hands on." One relative said, "The management are very, very easy to talk to. They are regularly in contact. They are all equally good. They bend over backwards always."

Staff felt respected and valued. One staff member confirmed, "I get praise and a thank you." Another staff member told us, "I feel very much supported by management." On the noticeboard in the staff room we saw a message from the management which stated, 'We got platinum [GSF status for provision of end of life care] the highest you can get. Well done everyone. You are all amazing!' A poster in reception detailed the staff 'fluid champion of the month.' This was an example of good practice being recognised and celebrated in a creative way. A staff member said, "The management tell us we're doing a good job. Where it's warranted we get praise in supervision." Another staff member told us, "I have regular supervision but I don't have to wait until then if I have concerns as [the registered manager]'s door is always open."

Team meetings were held twice a year and the minutes showed they were well attended. These were scheduled in a way that supported attendance from both day and night staff. This helped to make a cohesive team with good levels of communication amongst staff. The most recent team meeting had included feedback about a fundraising event with an organisation supporting people with cancer, notice to staff that management would be focusing on the quality of daily notes and staff feedback after attending courses on dementia and behaviours that challenge.

The registered manager and owner spoke with people, relatives and staff regularly to get their views on the care and support provided and aspects of the home such as the décor and links with the community. People, staff and relatives said that they felt respected, listened to and involved. We observed a staff handover where key information was shared and each staff member had input. One staff member said, "the handovers give us all the information we need when we are on shift."

The service worked in partnership with other agencies, such as GPs, community mental health teams and district nurses to help maintain people's health and well-being. Health professionals told us that that the management and staff team were "really knowledgeable about the people at the home" and "kept good communication."