Ramesh Chandra Chopra and Partners

Lodge Care Home

Inspection report

82 Kirby Road
Walton On The Naze
Essex
CO14 8RJ

Tel: 01255850809

Date of inspection visit:
06 January 2016
14 January 2016

Date of publication:
04 October 2016

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 6 January 2016 and 14 January 2016 and was unannounced.

Lodge Care Home provides accommodation and personal care for up to 36 older people and people who may be living with dementia. The service does not provide nursing care. At the time of our inspection there were 33 people using the service.

There was a registered manager in post at the 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.

There were sufficient staff who had been recruited safely and who had the skills and knowledge to provide care and support in ways that people preferred but improvements about the way staff were deployed needed to be sustained over time.

Input from relevant health professionals such as the Speech and Language Therapy team (SALT) was needed so that people's nutritional needs could be managed effectively.

The adaptations and design of the premises met people's needs and promoted their independence. Improvements needed to continue to enable people to make full use of the facilities available, such as the completion of the kitchen area near the upstairs lounge.

The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service.

People were safe because the management team and staff understood their responsibilities in identifying abuse or poor practice.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was following the MCA code of practice.

People were treated with kindness and respect by staff who knew them well.

Staff respected people's choices and took their preferences into account when providing support. People were encouraged to enjoy pastimes they enjoyed and were supported to maintain relationships so that they

were not socially isolated.

Staff were supported by the management team.

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 consistently safe

There were sufficient staff who had been recruited appropriately and who had the skills to care for people safely. Improvements to how staff were deployed needed to be sustained

Improvements were needed to the information in risk assessments and care records so that people could be confident staff knew how to keep them safe.

Staff understood how to protect people from abuse or poor practice.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The adaptations and design of the premises met people's needs, but improvements needed to continue so that the premises were used effectively.

People's health needs were met by staff who understood their individual needs and preferences but some improvements were needed to assessing people's nutritional needs so that they received support based on current best practice.

Staff received the support and training they needed to provide them with the information to support people effectively but improvements were needed to training around dementia.

Where a person lacked the capacity to make decisions, there were correct processes in place to make a decision in a person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring when they provided care and support.

Staff treated people with respect, understood their needs and maintained people's dignity.

People were encouraged to express their views and these were respected by staff.

Is the service responsive?

Good

The service was responsive.

People's choices were respected and staff understood their preferences around care and support.

Staff understood people's interests and encouraged them to take part in pastimes and activities that they enjoyed. People were supported to maintain family and social relationships with people who were important to them.

There were processes in place to deal with people's concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was run by a competent manager with input from the provider, who demonstrated a commitment to make improvements where necessary. Areas for improvement should continue to be identified to drive up quality in the service.

Staff received the support they needed to provide people with good care and support.

There were systems in place to obtain people's views and to use their feedback to make improvements to the service.

Lodge 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.

This inspection took place on 6 January 2016 and 14 January 2016 and was unannounced. The inspection team consisted of three inspectors.

We reviewed all the information we had available about the service including notifications sent to us by the registered manager. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including social care professionals. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection we spoke with eight people who used the service and two relatives about their views of the care provided. 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. We also used informal observations to evaluate people's experiences and help us assess how their needs were being met and we observed how staff interacted with people. We spoke with the provider, the registered manager, four members of care staff and one of the catering staff. We also spoke with two visiting relatives.

We looked at five people's care records and examined information relating to the management of the service such as health and safety records, recruitment and personnel records and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

On our first day of our inspection we saw that the majority of people spent the day in the downstairs lounge. However there were three people who remained upstairs in their rooms and we noted that for a period of over an hour there were no members of staff upstairs. One person who was in their room did not have a drink. We chatted with the person but it was evident that they were quite confused. There was a call bell in the room but they did not appear to understand what it was for. Later, when we were upstairs we noted the person was distressed and evidently required some assistance. Even with support the person was unable to ring their buzzer for help. When we did this on the person's behalf a member of the care team from downstairs responded promptly. In another room was a person who was also confused and unable to use their call bell. This person had a drink in the room but when we examined the person's care plan we noted that they had been identified as being at risk of choking. The care plan specified that the person was at risk of choking from food and not from liquids. However, the risks had not been assessed by a professional from the speech and language therapy (SALT) team to identify the risks for the person.

We discussed our observations with the provider and the manager about how risks were being managed for those people who stayed in their rooms upstairs. Although staff went upstairs to check on people, when they were busy downstairs the checks were not frequent. The provider and manager confirmed that they would make the necessary improvements to keep people safe. On our second visit the following week we noted that significant improvements had already been made. Both the upstairs and downstairs lounges were being used and there were staff based on both floors. People received support more promptly and those who preferred to stay in their rooms were monitored regularly. This new arrangement significantly improved safety for people who were in the upstairs rooms but who were unable to call for assistance. The improvements to how and where staff were deployed needs to be sustained so that they can continue to respond promptly to people's needs so that they can be confident they will receive safe care and support.

Staff told us that sometimes they could do with more staff. One care staff told us, "It can be a strain, particularly in the mornings between 8:00am and 10:00am. Evenings are more relaxed, still busy but less so." We noted on our first inspection visit that staff were busy and care was task led rather than person centred, but we saw that the changes made to how staff were deployed resulted in a more effective way of working. A member of staff said that the new arrangements were working well.

People's care records contained risk assessments that related to their needs. We saw a range of risk assessments including people who were at risk of developing pressure ulcers and people with risks related to mobility and falls. The care plans did not always contain detailed information to guide staff on the best way to support the person to reduce the risks identified in the risk assessments. Staff were able to demonstrate an understanding of how people needed to be supported but additional details in the care plans would give staff the necessary information so that people could be confident of receiving care consistently from all members of staff.

People told us they felt safe. One person said, "I feel safe and I am happy here." Staff understood their responsibilities to keep people safe and protect them from harm. They knew how to recognise abuse. Staff

were able to tell us about the signs of abuse and the reporting process for concerns. They said if they had any problems or worries they would go to a senior first and then the line manager.

The provider had systems in place to recruit staff that helped to keep people safe because relevant checks were carried out before newly recruited staff were employed. This included Disclosure and Barring Service (DBS) checks to confirm that an applicant was not prohibited from working with people who needed care and support. Staff were also required to sign a declaration that there were no changes and there were no convictions to declare. This declaration was completed every three to six months. The staff records confirmed that appropriate references were taken up before the new member of staff commenced.

We saw that systems for the safe receipt, storage and administration of medicines were in place. Staff administering people's medicines followed safe procedures. There were appropriate storage facilities to store medicines securely and records were completed correctly.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the food, however, some improvements were needed for people who had specific nutritional needs. For example, staff told us that there were three people who required a 'soft diet'. Care staff had noted that certain people were struggling with chewing and swallowing and kitchen staff prepared soft or pureed food for these people. However, there had been no referrals to relevant health professionals such as the speech and language therapy (SALT) team. People who develop difficulties in swallowing should be assessed by a health professional with the required skills and knowledge to evaluate the person's needs so that appropriate foods of the correct consistency were identified.

The registered person had failed to ensure that risks related to people's nutritional and hydration needs were appropriately assessed. This is a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

The adaptation and design of the premises was appropriate and there was sufficient communal space for people to meet with visitors, socialise or spend time alone. However, the communal rooms were not all being used effectively as most people were supported to sit in the downstairs lounge. On the first of our two inspection visits we noted that the downstairs lounge was very busy and staff were working hard to meet people's complex needs, which resulted in mostly task orientated care and support. For example, before lunch there were many people who were supported to use the bathroom and this resulted in people sitting waiting in wheelchairs in the corridor waiting their turn to use the room. One person told us, "What they need to do is get organised." We also observed that, whilst the care and support was concentrated in the downstairs lounge, there was an upstairs lounge that was pleasantly furnished but was not being used. There were also a few people who chose to stay in their rooms upstairs and they were not receiving regular support. We discussed the situation with the provider and manager who agreed they would consider how they could make improvements.

On our second visit to the service we observed that the situation was much improved. The provider had deployed teams to work upstairs as well as downstairs and people were using both lounges. This resulted in a much calmer and less busy atmosphere as there were fewer people using the downstairs lounge. The area was no longer congested with people waiting to use the bathroom. Staff were working more effectively in the quieter atmosphere than we had observed during our previous visit. These improvements to the way the environment was managed enabled staff to use their time more effectively. However, because of the time they had been in place the long term effectiveness of the processes could not be measured at this time.

A member of staff told us they had a three day induction during which they shadowed an experienced member of staff. Following induction the member of staff told us they received a range of training including manual handling and infection control. They said, "I find some of the training very helpful but some not so much [for example] the watching of videos." The provider explained that all of their training was delivered in face-to-face sessions but they also had videos that staff could use to refresh their knowledge.

Training records confirmed that the majority of staff had received dementia training. However, we saw

evidence that not all staff had a good understanding of dementia. For example, we observed a member of staff who was sitting with someone who was distressed. The member of staff spoke kindly and gently to the person but as the person's anxiety increased they clutched at the member of staff's hand and the staff responded, "No, no, don't pinch." This was repeated two or three times and did not help reduce the person's anxiety.

We saw that some staff did not interact with people in a way that showed us they understood good practice in supporting people with dementia, however we also saw some good practice. We spoke with a member of staff who demonstrated a deep knowledge and understanding of the specific individual needs of people living with dementia. They were able to give us examples of what helped to soothe individuals when they were distressed. The member of staff was also able to explain what were the best activities or methods to use to stimulate and engage people with dementia. These observations showed us that further training was needed for some staff so that they could improve their understanding of good practice when supporting people who were living with dementia. A member of staff told us they would like more practical training around working with people with dementia.

We discussed assessments and input from healthcare specialists with the provider during our first inspection visit and received assurances that referrals would be made to relevant health teams.

People made positive comments about the food. One person said, "The food is all right, we do get a choice. There is no menu but the food is brought up to you and if you don't like it you can ask for something else." Another person said, It is lovely here, they look after me. The food is lovely and lots of it." People could choose where to have their meals, whether in the dining room or at individual tables in the lounge. One person said, "We choose what tables we want to sit at in the dining room." If people had specific dietary needs or preferences catering staff told us they would support their wishes. One person said, "I'm a vegetarian so they will make meals that I can eat." A family member told us, "They are good at keeping fluid levels up." and said their relative always had enough to drink.

Kitchen staff told us that meals were organised on a four week rolling menu plan. There was a choice of cereal or toast for breakfast. They said that were not set choices for the lunchtime meal, however the cook went round to see people after breakfast and told them what was planned for lunch. If people did not like what was planned, then they could have something else, for example a jacket potato, an omelette or a salad. However, some people, who were living with dementia, did not always remember what they had been offered. Kitchen staff told us that they had pictorial cards that could be used to support people to make choices but we did not see evidence of these being used. However, we saw that there was a record of people's likes and dislikes and staff referred to this when planning meals for people.

We saw that some people had been provided with plate guards and one person had specialist cutlery with soft wide handles that were easy to grip so that the person could maintain their independence with eating and drinking.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We noted from the care records we examined that there were completed forms to assess people's capacity to make day-to-day decisions. These forms are referred to MCA 1 records. We saw completed MCA 1 forms relating to personal care, dressing, continence and medication. These identified the decision that was made in the best interests of the individual.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the service was working within the principles of the MCA and, where appropriate, DoLS applications had been made to the local authority.

Staff told us they had received MCA and DoLS training and were able to discuss importance of gaining consent and supporting people with decision making and offering choices. One member of staff told us that it was important not to assume what people wanted just because it was in their care plan. They said, "Still always ask them what they would like and to support them by showing them choices."

Good

Is the service caring?

Our findings

People told us that they were happy living at the service. One person said, "I have lived here a long time. I like it, it's quite nice." People also told us that the staff were lovely. One person said, "I like it here, it's very nice. The staff are very good." Another person said, "What's good about the home, there is humour." Family members who had completed surveys as part of the provider's quality assurance processes also made positive comments about staff. One relative commented, "Staff have always been good here." and "Staff are very helpful and understanding."

Throughout both of our inspection visits we saw kind and positive interactions between staff and people living at the service. For example two members of staff were supporting a person to get up from their chair. The person said, "I like you" to which the member of staff responded, "I like you too" which made the person smile.

People told us that staff were polite and treated them with respect. One person said, "The staff are very nice. I get up when I want to. The staff are polite. They always knock before entering the room and ask me if I am ready to get up." Although staff were polite and treated people with respect more thought could be given to small details that could be improved relating to dignity and respect. For example, one person had a plan in place around continence issues and how they were supported at night. This 'night toileting plan' was attached to the person's wardrobe door which was in view of anyone walking past the person's room when their door was open.

We observed a member of staff chatting to people and demonstrating good communication skills. The member of staff got down on the same level as the person, made eye contact and touched their arm to hold their attention. Staff spoke with people in a friendly manner, using their preferred names and people responded with smiles.

A family member told us, "If anyone gets upset the girls [staff] are quick to comfort them." We saw instances of staff carrying out their role thoughtfully and with a cheerful approach. For example, we observed two members of staff transfer a person from armchair to wheelchair using a stand aid hoist. They explained to the person what they were going to do and when, they also used humour to reassure the person.

Good

Is the service responsive?

Our findings

People told us they were happy with the care and support and their individual preferences were respected. One told us, "I get up when I want and get the right care when I need it."

We saw from care records that people had their needs assessed. Some of the care records contained evidence that the person or their representative had consented to their plan of care. In two cases it was not clear how involved the people and any family were in their care planning. A member of staff told us that they were responsible for reviewing and updating three peoples care plans and this was done every month. The member of staff confirmed that families were, "very much involved" and gave examples of their input.

Staff were able to tell us about people's background and knew their personal history; they demonstrated a good understanding of people's likes, dislikes and preferences. Staff said that, when they noticed changes, this was discussed with the manager and care plans were updated. Although we observed that staff knew people well and understood their preferences we noted that some care was task orientated staff were busy and appeared to rush to complete tasks rather than take their time with individuals. However, on our second inspection visit staff were less rushed and care was not so task focussed.

People were able to take part in organised activities and events or could spend their time doing things that they wanted. One person told us, "We have bingo this afternoon. I love bingo." A family member told us, "My [relative] has always been a bit of a loner and doesn't really like to mix. Sometimes staff have the time to sit with people." They said they were happy that their relative was well cared for. One person told us about the work they used to do. They said, "I like to be busy. I told them I would love to do things, lay the tables." We saw this person tidying up tables and folding napkins after lunch, which demonstrated that staff supported the person to engage in activities that were meaningful to the individual.

We saw enthusiastic and positive interactions from a member of staff who was facilitating music and singing activities in the downstairs lounge. The member of staff spent a few minutes of individual time with each person, going round the room and encouraging people to join in. However, there were 21 people in this lounge and there were three televisions around the room so it was very busy and quite noisy. Despite the efforts of the activities person, some people were not engaging with the music. The member of staff acknowledged that the layout of the lounge area could make it difficult to engage with people as it was so noisy. One person told us the food was all right and the staff were quite nice but what they did not like was the boredom. They said, "They all just sit here in a row, it's very boring."

On our second visit we saw that people were more relaxed in the lounge. The second lounge upstairs was being used, some of the chairs from downstairs had been removed and there was more space for people to sit without all the chairs being placed close together. As a result, visiting family members were able to pull up a chair and sit in the lounge with their relative. They told us that this was much better, they could just sit with their relative in comfort and did not need to disturb them to go to their room as they may have previously done.

People knew how to make complaints and most were satisfied with the outcome and how the complaints were managed. One person told us, "I have never had to complain. If I needed to I would." Family members who had completed surveys as part of the provider's quality assurance processes were confident they could raise concerns. One relative stated, "I have no complaints." and another wrote, "Minor matters raised with [the manager] and these were dealt with immediately." "However, one person that we spoke with on the first day of our inspection told us they had raised an issue. They said, "I have made complaints but I don't feel listened to."

Requires Improvement

Is the service well-led?

Our findings

The provider made resources available to improve the service. For example, on our first inspection visit we identified issues about overcrowding in the downstairs communal areas when there was an upstairs lounge that was not being used. On our second visit the provider had addressed the issue and, as well as using the upstairs lounge, a small area was in the process of being refurbished to provide a kitchen so that staff could prepare fresh drinks and snacks for people using the upstairs lounge. A relative who had completed a survey as part of the provider's quality assurance processes wrote, "The entire home has been refurbished to a high standard."

There were processes for auditing and checking health and safety issues such as fire systems and identifying improvements to the environment. The provider had a maintenance person come in regularly to check systems and make repairs were necessary.

There were systems in place for managing records. People's care records, including care plans and risk assessments recorded dates when the records had been reviewed but changes were not always recorded. The information to inform staff of people's needs relating to risk was quite basic in some of the records we examined. Staff, however, did have a good understanding of people's individual risks and how to manage them. Monitoring the quality of people's care documents by regular audits to identify areas for improvement would drive up quality.

Other information about the management of the service was found to be completed to a satisfactory standard including staff records. Documents relating to people's care and staff records were kept securely when not in use. People could be confident that information about them which was held by the service was confidential.

Staff told us they were happy working at the service and they felt well supported. One member of staff said, "I have been here for just over a year. I love it here. It is hard work but the people are nice". A member of staff told us that they felt well supported by colleagues and the management team. They said, "Support is 100%. We have staff meetings a couple of times a year and in general the teamwork is good." Another member of staff said that they felt able to express their views

The provider had processes in place for monitoring the quality of the service that included formal meetings with relatives which were held between two and four times a year. These meetings gave the provider and registered manager the opportunity to update relatives on issues such as improvements that had been carried out or were planned for the environment, sharing information about inspections and informing them of any staff changes. There were opportunities for a 'question and answer' session as well so that relatives could raise issues or discuss any of the information given at the meeting.

The provider sought feedback from people and their relatives to improve the quality of the service. The registered manager told us that they sent out surveys to families. We saw from the last surveys that had been completed that there was positive feedback about the standard of care and how the service was managed.

Family members who had completed surveys as part of the provider's quality assurance processes wrote, "The manager is always available to speak to. Very helpful."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person had failed to ensure that risks related to people's nutritional and hydration needs were appropriately assessed by a professional with the required skills and knowledge.