Susash UK Ltd

Barons Lodge

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced focused inspection of this service on 21 July 2015. When we last visited the home on the 10 October 2014 we found the service was breaching regulations in relation to care and welfare, safety and suitability of the premises, safeguarding people from abuse and notifying CQC of incidents. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their action plan and to confirm that they now met legal requirements and had addressed all areas where improvement was needed. We found the provider had taken all the necessary action to improve the service in respect of the breaches and issues we found.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Barons Lodge on our website at www.cqc.org.uk.

Barons Lodge is registered to provide accommodation and personal care for 22 people with mental health needs. On the day of our visit there were 21 people using the service.

The home had a registered manager. 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.

Summary of findings

During the inspection we found the provider had taken the necessary action to improve in relation to the breaches we identified at our last inspection. However, we identified systems to reduce the risks of people being scalded from hot water were insufficient. You can see what action we told the provider to take at the back of the full version of the report.

People were protected from abuse because the manager and staff had received training in safeguarding and understood how to keep people safe. The manager encouraged staff to report any concerns they had about the service. The manager reinforced safeguarding responsibilities at handovers, staff meetings and supervisions. They shared information about any safeguarding referrals which had been made and updated the team on progress with these to increase their awareness of safeguarding. The service assessed whether people were at particular risk of abuse and put care plans in place for staff to follow to support them in relation to this, as part of keeping them safe. Procedures were in place to keep people, who made repeated allegations of abuse, safe.

At the last inspection we found people were at risk of infections. This was because people they were not always appropriately supported by staff to clean their bedrooms. During this inspection we found the service had improved. Domestic cleaners cleaned all areas of the house each day, including people's bedrooms. People were encouraged to participate in cleaning, where appropriate, as part of maintaining their independent living skills.

Previously we found the premises were not always appropriately maintained. However, at this inspection we found the necessary repairs had been carried out. The home was in a good state overall and a system was in place for the provider to identify and action repairs in the home ongoing. However, systems to reduce the risks of people being scalded by hot water were insufficient and the provider told us they would take immediate action to rectify this.

The provider had revised the system in place to plan people's care. We found the provider regularly reviewed people's needs and put care plans in place for staff to follow in relation to their identified needs. Staff reviewed these care plans each month and the information in them was reliable for staff to follow as it was accurate and up to date.

Since the last inspection the manager notified CQC of a number of incidents, as required by law, including allegations of abuse, serious incidents and deaths of people using the service. Because of this CQC are able to monitor the service as part of our regulatory function.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe as systems to reduce the risks of people being scalded by hot water were insufficient.

A programme of renovation and refurbishment was underway and the home was in a good state of repair.

The service had taken the necessary action to improve the way they responded to allegations of abuse to keep people safe.

Arrangements to keep people's bedrooms clean and reduce the risks of infection had also improved while still involving people in the cleaning to build and maintain their independent living skills.

Requires improvement

Is the service responsive?

The service was responsive because the provider had taken the necessary action to ensure people's care was planned in response to their needs. Care plans contained accurate information about people and were updated each month as a minimum so staff could reliably follow them in supporting people.

Good

Is the service well-led?

The service was not always well-led. While some checks of water temperature were in place, these had not identified the risks to people that we found.

The manager ensured they notified CQC of incidents such as allegations of abuse as required by law. In addition, the provider improved their auditing procedures to monitor safeguarding, care planning and notifications.

Requires improvement

Barons 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 checked 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 21 July 2015 and was unannounced. It was undertaken by a registration inspector and an inspector. The registration inspector was inspecting the premises in relation to an application to increase the number of beds in the home while the inspector was checking that improvements to meet legal requirements planned by the provider after our 10 October 2014 inspection had been made. The team inspected the service against three of the five questions we ask about services: Is the service safe? Is the service responsive? Is the service well-led? This is because the service was not meeting some legal requirements at our 10 October 2014 inspection.

Before our inspection we reviewed all information we held about the service and the provider including looking at the previous inspection report and reviewing this in line with the action plan the provider submitted to CQC after the last inspection.

During the inspection we spoke with seven people who used the service. We also spoke with a district nurse, a director, the registered manager and two members of staff. We also observed how staff interacted with people using the service. We looked at five people's care records to see how their care was planned and records relating to the management of the service including health and safety and quality audits.

Requires improvement

Is the service safe?

Our findings

At the last inspection on 10 October 2014 we found the service was breaching the regulation relating to safety and suitability of the premises as some parts of the home were not adequately maintained. For example, a radiator cover which had been damaged and removed during an incident had not been replaced for several months. Some bathrooms had missing tiles, floor skirting, grout and paint was peeling and chipped in some areas. Some items of furniture in people's rooms were also not in good condition.

After the inspection the provider wrote to us to set out the action they would take to become compliant. They told us a rolling programme of refurbishment, repair and renewal would be in place across the home. The way repairs and renewals were arranged would include strict times for completion and these would be audited each month during the providers' auditing visits. The provider told us they would become compliant with the relevant regulation by 31 May 2015.

During this inspection we found the provider had taken the action they set out in their action plan and were no longer breaching this regulation. The rolling programme of refurbishment, repair and renewal was in place and we saw rooms were well maintained. One person told us about the renovations, "They've done a good job." Several rooms, including bedrooms, had been repainted and upgraded and people told us they had been consulted in the process. We saw people's bedrooms, as well as communal areas, were in a good state of repair. A person said, "If things are broken they are fixed quickly. I'm happy with my room." The provider told us of other works scheduled as part of renovating the home over the next few months, including replacing armchairs, painting communal areas and replacing flooring. The service had installed a lift to help people with limited mobility to move between the two floors of the home.

However, during this inspection we found ineffective systems for ensuring the temperature of hot water was controlled to reduce the risks of people being scalded. We tested the hot water temperatures in several people's en-suite sinks and showers, as well as in some communal bathrooms and found some were above 50°C. This meant people were at risk from scalding.

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

The provider told us they would ensure working thermostats were in place on all hot water outlets people had access to. They also told us they would put in place weekly tests of all hot water outlets to identify any faults so they could be rectified, reducing the risks of people scalding.

At the previous inspection we also found the provider was breaching the regulation in relation to safeguarding. This was because it was not always clear how the service determined allegations of abuse people made were unfounded where people had histories of making these. Concerns had not been discussed with the local authority safeguarding team. In addition, people did not have risk assessments in place to protect people, staff and others in relation to those who had a history of making unfounded allegations.

After the inspection the provider wrote to us with their action plan which set out how they would become compliant. They told us they would provide the staff and manager with further training in safeguarding and to encourage whistleblowing and reporting abuse through staff supervision. The service also set out how they would follow multiagency safeguarding procedures to report to and liaise with the local authority safeguarding team when allegations of abuse were made. They told us they would be compliant by 31 March 2015.

During this inspection we found the provider had taken the action they set out in their action plan and were no longer breaching the relevant safeguarding regulation. People told us they felt safe. One person said, "I feel safe here, that's why I stay here, I feel safe because of the environment and staff". Another person told us, "I feel safe. [The staff] always check the doors in the evening. If [there are incidents the staff] see to the matter and take action. If I felt scared I'd talk to the manager."

Records showed allegations of abuse had been reported appropriately to the local authority safeguarding team and the service had liaised with them while concerns were investigated. Staff showed us the contact details of people staff could raise safeguarding concerns with, including the safeguarding team, were on display in the home. Staff told us and records showed the manager encouraged staff to raise concerns at any time, including during supervision,

Requires improvement

Is the service safe?

handovers and team meetings and they also shared information about allegations of abuse which had been made. Our discussions with staff showed they had a good understanding of allegations which had been made and how to keep people safe in relation to them. Staff also received training in safeguarding as part of their induction and annually and understood the signs that may indicate people may be being abused. People had risk assessments and care plans in place detailing the particular risks of abuse people faced and how staff should support them to reduce the risks.

At the last inspection we found people were not always appropriately supported by staff to ensure their bedrooms were clean. Some people's rooms were dirty which meant they were living in unpleasant living conditions which could put them at risk of the spread of infection. The manager wrote to us to tell us the action they would take in relation to this. They told us domestic staff would clean people's rooms on a daily basis where people consented to this. People would continue to be encouraged to participate in cleaning and tidying their rooms as part of their care package to build and retain their independent living skills.

During this inspection we inspected all rooms in the home with people's consent. People told us their rooms were cleaned by domestic cleaners each day and they had agreed to this. Some people also told us how they would also contribute to keeping their rooms clean and tidy. One person told us, "A cleaner cleans my room so it's always clean and tidy". Another person told us, "I keep [my room] clean and tidy and a cleaner hoovers."

Good

Is the service responsive?

Our findings

At our last inspection on 10 October 2014 we found the provider was breaching the regulation in relation to care and welfare. This was because people's care was not always planned in response to their needs. For example, changes in people's risk of falling, pressure ulcers and continence were not always accurately assessed with suitable care plans put in place for staff to follow to support them. One person's care plan did not contain realistic goals in supporting people as it said staff should use a particular talking therapy which they were not qualified or competent in to deliver.

After the inspection the provider wrote to us setting out the action they would take to become compliant. They told us they would review the care planning system so that people's needs in all areas, including risk of pressure ulcers and falls, were adequately and regularly assessed. They said they would ensure care plans were in place in relation to all people's identified needs, and that these would be reviewed each month as a minimum. In this way staff could rely on them providing accurate information about people and so could follow them with confidence in supporting people.

At this inspection we found the provider had taken all the actions set out in their action plan. They had improved the way they assessed people's needs and planned their care and they were no longer breaching the relevant regulation. This meant that there was a greater likelihood that the support people received would fully meet their needs.

Requires improvement

Is the service well-led?

Our findings

At the last inspection on 10 October 2014 we found the provider was breaching the regulation relating to reporting incidents to CQC. This meant CQC were unable to monitor how incidents were being dealt with in keeping people safe. In addition, we found that, while the provider had audits in place to assess the quality of the service, they had not identified the issues we found in relation to safeguarding, care planning and notifications.

After the inspection the provider wrote to us to tell us they would ensure they reported all notifiable incidents, such as allegations of abuse, to CQC without delay, and this would be kept under review by the provider.

Before the inspection we reviewed the notifications we had received since the last inspection and noted the manager had notified us of a range of incidents including allegations of abuse and applications to deprive people of their liberty. The manager had also notified us promptly when people using the service had died, as required by law. During the inspection we confirmed the manager had notified CQC of all notifiable incidents and were complaint with the relevant regulation.

At this inspection we found the auditing systems had been reviewed and monthly checks now incorporated suitable checks of safeguarding, care planning and notifications. However, while some checks of water temperature were in place, we found these had not identified and mitigated the risks to people that we identified. For example, staff told us when they supported people to bathe they ensured the water temperature was below 44°C with thermometers, which we saw available in each bathroom. Records showed these temperatures were recorded for individuals each day. However, some people bathed without staff support and so were at risk of scalding. The provider had also contracted an external company to carry out checks of the water system so they were keeping people safe in relation to Legionella. Legionella is a bacterium which can multiply in hot water systems if adequate controls are not in place and can cause illness. Each month the contractor tested hot water temperatures of various outlets across the home. However, these checks had not identified outlets we found which put people at risk of scalding. In addition, the provider carried out daily checks of hot water at a small number of outlets each day, but these checks had also not identified the issues we found.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not assess the risks to the health and safety of people using the service and do what is reasonably practicable to mitigate any such risks. They also did not ensure the premises were safe for their intended purpose. Regulation 12(1)(2)(a)(b)(d)