Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

Park Road
Bestwood Village
Nottingham
NG6 8TQ
Tel: 0115 977 0700
Website: www.example.com

Date of inspection visit: 22 July 2014
Date of publication: 28/10/2014

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 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 2012 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

At our last inspection in June 2013 we found that the care provider was meeting the essential standards of quality and safety in all five outcomes we inspected against.

Eden Lodge Residential Care Home provides accommodation and personal care for up to 60 people. On the day of our inspection 22 people were using the service. The registered provider told us this was because they had closed a section of the home.

Summary of findings

The home did not have a registered manager and has not had one since July 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs). We saw information that best interest assessments had been completed for some people who lacked capacity. However the provider was not always making sure people were free from restrictions. We found the location was not meeting the requirements of the Deprivation of Liberty Safeguards.

The acting manager made safeguarding vulnerable adult's referrals when needed and staff knew how to respond to incidents if the acting manager was not in the home. People were not always protected under the Mental Capacity Act 2005. This meant people were safeguarded from the risk of abuse but where people lacked capacity, they were not always supported with decisions appropriately.

Staff had the knowledge and skills to care for people safely. Referrals were made to health care professionals for additional support or any required intervention when needed. This meant people would receive support from the appropriate people when their needs changed.

We observed people were treated with dignity and respect. People who used the service told us they felt staff were always kind and respectful to them.

There were systems in place to monitor the quality of the service and to involve people in giving their views of how the service was ran. Audits had been completed that resulted in the acting manager implementing action plans to improve the service. This meant there were effective systems in place to monitor and improve the service.

We found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010 at Eden Lodge Residential Care Home. People's capacity to make decisions was not always assessed and the provider was not always making sure people were free from restrictions.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Good

The service was not consistently safe.

People who lacked capacity were not always protected under the Mental Capacity Act 2005 and the service was not meeting the requirements of the Deprivation of Liberty Safeguards.

However, people were protected against the risk of abuse. Incidents were managed appropriately and people told us they felt safe in the home.

The rating for this question was changed as a result of the ratings validation exercise described in the 'Background to this inspection' section of this report.

Is the service effective?

Requires Improvement

The service was effective.

Staff had received the appropriate training and support to carry out their roles.

People were supported to eat or drink enough to maintain their health and referrals were made, where appropriate, to health care professionals for additional support or any required intervention. This meant people were protected against the risks in relation to their healthcare.

The rating for this question was changed as a result of the ratings validation exercise described in the 'Background to this inspection' section of this report.

Is the service caring?

Good

The service was caring.

People were supported to develop a life history for their care plan, detailing their likes, dislikes and preferences for care. People and their relatives told us they were happy with the care they received. This meant people were being given the opportunity to be involved in the planning of their care.

Our observations throughout the day demonstrated that staff showed dignity and respect towards people and that people were listened to. This meant people were treated kindly and with respect.

Is the service responsive?

Good

The service was responsive.

Staff we spoke with knew the needs of people they were supporting. We saw there were activities and events which people took part in.

People told us that they knew how to raise concerns and records showed that complaints were dealt with appropriately. This meant people were supported to raise concerns and knew they would be acted on.

Summary of findings

Is the service well-led?

The service was well led.

However there was not a registered manager in place. People we spoke with, their relatives and staff we were very complimentary about the acting manager.

There were effective procedures in place to monitor the quality of the service and where issues were identified there were action plans in place to address these.

Requires Improvement

Eden Lodge Residential Care Home

Detailed findings

Background to this inspection

This was an unannounced inspection. Some people were unable to speak with us due to their communication needs, we observed their care. We visited the home on 22 July 2014 and spoke with nine people living at the service, four staff, two relatives, the acting manager and the registered provider. We observed care and support in communal areas and some people showed us their bedroom. We looked at the care records of five people using the service and three staff files as well as a range of records relating to the running of the service.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had expertise in older people's services.

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

We contacted Commissioners (who fund people's care) of the service and asked them for their views. The provider submitted a 'Provider Information Return' when we asked them to. This was information for them to tell us how they provide a safe, effective, caring, responsive and well led service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

The rating for this question was changed as a result of the ratings validation exercise described in the 'Background to this inspection' section of this report.

We saw that the provider did not always follow the principles of the Mental Capacity Act 2005 (MCA). This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability. The two staff we spoke with had a good understanding of the MCA and described how they supported people to make decisions. We looked at the care records for six people and saw there were MCA assessments and best interest decision assessments in place for some of them. However in one there were MCA assessments which determined the person did not have capacity to make certain decisions but the best interests part of the form was missing. In another there was conflicting information as one assessment stated the person had the capacity for self-caring in relation to a health need but there was further information which stated the person did not have capacity to make such decisions. This meant people's capacity to make decisions was not always assessed appropriately and this person may not be supported with their health need.

The acting manager knew about the recent Supreme court ruling, which could mean people who were not previously subject to a DoLS may now be required to have one. However she had not read the details of this and so did not understand that she should have considered whether some people using the service may now need to have a DoLS in place. One person told us they wanted to move out of the home and live elsewhere and they wanted to go out alone but were being prevented from doing so by the staff. This person lacked the capacity to make some decisions but had not been considered for a DoLS under the recent change in legislation. We also saw from records that one person was resistive to personal care but staff were continuing to give the care, in order to protect the person from neglect. Staff told us they sometimes needed to hold the person's hands whilst delivering this care. However there had been no consideration given to applying for a DoLS. This meant steps had not been taken to ensure the care was being given in the least restrictive way.

We saw this person had challenging behaviour and regularly resisted care from staff. There was not a care plan in place to inform staff what they should do when this person resisted the care. Staff had sought advice from a dementia specialist and they had recorded that senior staff should put in place a care plan which detailed how they should deliver care and what methods of passive restraint could be used. These recommendations had not been carried out. This meant staff did not know how they should care for this person safely.

This meant there had been a breach of Regulation11 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

The acting manager told us that one person had been subject to a Deprivation of Liberty Safeguard (DoLS) assessment. The DoLS procedure aims to 'safeguard' the liberty of the individual by ensuring that a rigorous and transparent procedure is followed prior to any deprivation of liberty. They told us this person had then settled into the home and the DoLS had been removed.

Five people told us they felt safe and happy at the care home. One person said, "It's comfortable and they look after you well." Another person said, "I felt safe here, I like it." However, one person said they felt restricted. They told us, "The problem is you can't do anything. [I feel] I have to ask permission." One person raised a concern with us in relation to the care they received and we passed this on to the acting manager to investigate. The acting manager dealt with this issue following the appropriate procedures. Relatives we spoke with told us that they felt their relative was safe at Eden Lodge. One relative told us: "The staff are good, I have no concerns."

All staff had received training in the safeguarding of vulnerable adults. Staff we spoke with had a good understanding of what constituted abuse. Staff told us that if they suspected abuse they would report it to the acting manager. The acting manager demonstrated that they had made safeguarding referrals to the local authority following incidents of suspected abuse. This meant the provider could be sure that safeguarding concerns would be reported appropriately.

People's risks were appropriately assessed, managed and reviewed. We looked at three people's care records and saw that they had individual risk assessments for identified risks such as moving and handling and nutritional risks. For example one person needed assistance from staff to

Good

Is the service safe?

transfer using equipment. There was clear information in the plan detailing what support the person needed and what equipment should be used to provide the support. This meant risks around people's needs were recognised and assessed.

We sampled three staff files to ensure the required checks had been made to ensure staff were safe to work with vulnerable adults. Application forms with a history of the person's employment were in place and there were two references in place from previous employers. Appropriate checks had been made to ensure staff were safe to work with vulnerable adults prior to them starting work in the home. This meant there were effective recruitment and selection processes in place.

The acting manager told us that they would increase the staffing if people's needs changed or more people were admitted to the home. Staff told us they felt there was usually enough staff working in the home. Throughout the day we observed there were enough staff with the right skills to support people. When people asked for assistance staff gave them support quickly without them having to wait. When we spoke with people they told us they were given support when they asked for it. This meant that the service safeguarded people from inappropriate care by ensuring that enough staff were available to meet people's assessed needs.

Requires Improvement

Is the service effective?

Our findings

The rating for this question was changed as a result of the ratings validation exercise described in the 'Background to this inspection' section of this report.

People we spoke with told us they felt they were cared for well by staff who knew what they were doing. They told us that they had seen the doctor and that both opticians and chiropodists came into the care home. One person said, "It is a revelation. I have never had my feet attended to before and I think it is wonderful. Other comments we received about the staff were, "I can't fault them, really", "They treat you as a person", "They know all my little ins and outs" and "I wouldn't want to go anywhere else."

Records showed that all staff had received training in different areas of work, for example the safe administration of medicines, safeguarding vulnerable adults, infection control and moving and handling. New staff undertook an induction and completed a work book which covered essential areas of good practice. We spoke with staff about the needs of three people they were caring for and they were knowledgeable about the needs of these three people. They were able to tell us what support each person needed and if there were any risks in relation to their health.

Staff we spoke with told us that they had regular support and supervision with a senior team member, where they were able to discuss the need for any extra training and their personal development. Records we saw supported what they had told us. This meant people were cared for by staff who were given training and guidance to support people safely.

We saw evidence that staff sought advice and intervention from a wide range of external professionals such as the falls prevention team, the dementia outreach team and dieticians. We saw one person had developed behaviour which staff may find difficult to manage. The dementia outreach team had been contacted and had given staff advice on how to care for this person and how to respond to the behaviour. Staff told us this had helped them and they felt they now had the understanding and knowledge they needed to support this person. Records also showed that when people became unwell staff were quick to seek advice from the person's GP.

We saw that people had a choice of food and drinks offered to them and we observed people asking for specific drinks and staff fetched these. For example one person had their lunch in their room but then sat in the dining room and asked for an alcoholic drink. The member of staff fetched this and the person was happy their request had been responded to. People we spoke with told us that food was plentiful and there was always a choice. We observed one person who was unhappy with their lunch that day and the carer found them something they preferred and the person ate this.

We saw that when people were regularly assessed in relation to their nutrition and where weight loss was noted, the appropriate changes were made to support the person with their nutrition. For example we saw that one person had started to lose weight. This had been noted by staff when they weighed the person and had resulted in a referral being made to the dietician. We saw the dietician had advised the person's weight be monitored more frequently and for staff to provide them with a diet which was higher in calories and monitor how much they ate. We saw staff were following this advice and the person's weight was now more stable, with no further weight loss. During the inspection we saw that people were supported to eat and drink.

Good

Is the service caring?

Our findings

We spoke with people who used the service and asked them if they were happy in the home. Seven people were able to confirm that they were well treated and the staff were caring and compassionate. One person told us they could, “have a laugh” with them [staff]. A further person told us they needed help with intimate care and that staff didn’t make them feel embarrassed, “I feel very comfortable.”

People we spoke with consistently said staff were caring and kind, with one person saying, “Staff are marvellous in here.” We observed that staff interacted with people with warmth and in a kind and caring manner. We saw staff respond to choices people made and explained what they were going to do prior to giving people care or support. For example a member of staff approached one person to ask them if they would like to go to the toilet. This was done in a sensitive discreet manner which respected the person’s dignity and choice.

Relatives we spoke with confirmed the view that the staff treated people with dignity and respect and that they were happy for their relative to be cared for at Eden Lodge. During our inspection we saw that staff knocked on people’s doors before entering and interacted with people at a level and pace they understood.

However, we saw in charts used to record when people living with a dementia related illness displayed challenging behaviour that staff were using words such as, ‘In a mood’ or ‘nasty’ when describing behaviour. This is not a positive way to describe behaviour or learn from what had caused the person to display behaviour.

People we spoke with told us they were treated as individuals. When we spoke with the acting manager and three members of staff it was clear they knew people’s needs and how they should be supported. We spoke with two visiting hairdressers and they told us the home had improved in the last year and that it was a, “Pleasure to visit.” They told us the acting manager and the staff knew people’s individual needs and the atmosphere was more relaxed and welcoming. People using the service had chosen whether to visit the hairdressers and we observed them making choices about what they would like the hairdresser to do.

Care records we looked at held information about people’s lives and achievements. It was clear people and/or their relatives had been involved in developing their own life history profile. It was not clear if people had been involved in the reviews of their care plans, however people told us they felt they were involved in making decisions about their care.

The acting manager told us that there was not anyone currently using an advocate but that recently this had been discussed with a person who used the service and their family. We saw there was information displayed informing people of how they could speak with an advocate.

Good

Is the service responsive?

Our findings

Notices were displayed informing people of entertainers who were going to visiting the home. People we spoke with told us they enjoyed the entertainment they were provided with. We saw there were religious services held in the home for people who wished to attend.

Eden Lodge has extensive gardens and we saw there were different areas for people to sit in and areas which had been made more accessible with hand rails and raised flower beds. People were seen sitting enjoying the garden with staff and relatives during our visit. There were activities for people to get involved in and we saw photographs and advertisements which showed that there had been a variety of parties, events and visiting entertainers in the home. There had been a new member of staff employed to support people to pursue their hobbies and interests. We observed an activity taking place and saw people were supported to get involved. There were two visiting hairdressers and we saw this was a positive experience for people and there was much laughter and talking between the group.

Most people's bedroom doors had a photo of the person living there and an interesting fact about them below the photo. The main corridor had a number of paintings, pictures and murals on it to add interest. There were items to encourage the use of touch, such as items made of different textures in the corridor and signs to aid orientation. This would support people living with a dementia related illness.

Individual care records we looked at were not always clear with the current needs of people. The acting manager had recognised this and was in the process of developing new care plans which would detail people's health care needs. We looked at one of the new care plans the acting manager had developed and this contained a comprehensive care plan to inform staff how to manage the person's specific health needs. We spoke with staff in relation to the people whose records we looked at and they knew the needs of people and how to support them.

We asked the people who used the service whether they felt they could raise concerns and what had or would happen. Three people said they would talk things through with their relatives who would deal with things if there were any problems. Three other people told us they felt they could ask staff anything. One person said, "I can approach the staff for help." One person told us they had had a problem and they had felt happy to raise concerns with the acting manager. The person told us they, "I felt listened to and things were sorted out." Another person said, "They consult you on pretty much everything."

The acting manager told us that the people who used the service had not attended planned meetings in the past. To address this they were planning to re-introduce a 'monthly chat' with groups and individuals and these would be recorded and action taken where people felt improvements could be made. She told us that people and their visitors knew they could approach her at any time if they wanted to discuss anything. One person confirmed this and said if they had any issues they would speak with the acting manager.

We looked at the complaints records. There was a clear procedure for staff to follow should a concern be raised. Staff told us they were confident on the procedure they should follow if a person made a complaint when the acting manager was not in the home.

We saw one complaint had been raised and this had been documented, investigated and resolved with the person raising the complaint. Staff we spoke with knew how to respond to complaints if they arose and people we spoke with were aware of who to speak with if they wanted to raise any concerns. This meant that people knew how to make complaints and could be assured they would be acted on.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager and has not had one since July 2011. The provider assured us that the acting manager was going to apply to register with us imminently. We are monitoring this to ensure the acting manager applies to register with us.

People we spoke with told us the acting manager was approachable. One person said, "They treat you as a person, especially her in charge, she's fantastic." Another person told us they had great faith in the acting manager and said, "[Acting manager] will sort it out for me, she's alright."

The staff we spoke with told us that they felt supported by the acting manager and that they were approachable. Staff told us they felt a key strength was that they all worked together as a team and that the acting manager worked shifts with them every other weekend so she could assess how well people were being cared for.

The acting manager told us they had been meeting with other care home managers to share knowledge and improve Eden Lodge. The acting manager felt they had made improvements in the home already but were working towards making further improvements. They had agreed to take part in a pilot for end of life care training and planning. This was because they recognised this area of care delivery needed improvement.

Regular staff support and supervisions took place every eight weeks. Staff had opportunities to contribute to the running of the service through regular staff meetings. We saw the minutes of these meetings and saw staff were involved in discussions about how the service could improve.

The acting manager recognised where the service could still improve. They told us a key challenge in the home was recruiting and retaining staff. To try and retain staff and determine their reasons for leaving, the acting manager had implemented a form for staff to complete prior to leaving employment. This meant the acting manager took steps to respond to the challenges in the service.

The acting manager had conducted an annual survey in March 2014 and sought the opinion on the quality of the service from people who lived there, their relatives and health professionals. We saw the results of the survey had been analysed and were mainly positive. The results had been shared with people using the service and their relatives, with an overview displayed in the home. There was also an action plan to address where people thought improvements could be made. We sampled two of the actions and saw they had been addressed and the changes made. This meant people were given the opportunity to give their opinion on the quality of the service and the acting manager and the registered provider listened and acted on what they said.

Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service. We saw that audits had been completed in areas such as: medication, fire, health and safety. We saw that when actions had been identified this was followed up to ensure that action had been taken.

When we fed back our findings to the acting manager and the registered provider they were open to our feedback and were able to provide evidence they had already identified that care planning needed to be improved. They told us they were working through the care plans to make sure they contained the required information of people's healthcare needs and how staff should support them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 **Safeguarding people who use services from abuse** The registered person did not have suitable arrangements in place for acting in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.