Paradise Lodge Care Home Limited

Chignal House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The provider ensured that the environment was kept clean and maintained to a safe standard, and that people living at the service had been enabled to furnish their bedrooms with their own furniture and tastes. However, some general maintenance was needed in a few places, and the registered manager took this forward during the inspection.

People at the service told us they felt safe and supported by staff working there, and we saw risk assessments and care plans that promoted their independence whilst managing well any potential risks.

Medication was provided by staff that were trained, and supported people's safe involvement. However, it was not safely stored. The registered manager took immediate action to remedy these concerns.

Whilst we saw that staff received good supervision, oversight, and support by the registered manager, recruitment processes were not robust and we fed back to the registered manager that the provider should review these processes urgently.

Once employed, staff received training and support to carry out their care duties to a good standard. We saw that staff received regular training updates and attended regular staff meetings to keep up to date with changes in the service and to review the care they provided to people.

People at the service told us that staff treated them with dignity and respect. We saw that staff were caring and supported people with a compassionate and caring approach. However, some wording in care plans was condescending and did not represent the care that people told us staff provided and that we observed. We requested that the registered manager review these urgently.

Care provided was inclusive and supported people to remain independent, learn new skills, and lead fulfilling lives. We saw that the provider and registered manager, supported staff to meet people's individual communication, physical and mental health needs in a manner that supported people's preferences and involved other relevant agencies and resources to ensure that these could be met.

Governance systems in place were not robust and did not reflect the good standard of care that people received. However, the registered manager had already identified that systems needed a thorough review to be more effective and at the time of inspection was already in discussions with external organisation to review these processes. It was evident however, that staff felt they were supported by a management team who were visible, and approachable to both staff, and people living at the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not undergo robust recruitment process and these needed urgent review.

Medications were not stored safely, although staff safely supported people with administration of medicines.

Risk assessments identified the needs of people and appropriate management plans were in place to minimise risks.

Is the service effective?

Good

The service was effective

Staff had a good understanding of capacity and people were supported to remain independent.

Training and support from managers allowed staff to carry out their care duties effectively.

Healthily eating was promoted, and people had good choices of food. Individual's preferences were supported.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring.

Individual's received care and treatment that supported their sexuality in a respectful and dignified way.

Confidentially was respected for all people at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did were not always person centred and did not demonstrate that they had been regularly reviewed with people.

People's physical, mental health and communication needs were managed in a responsive way.

Is the service well-led?

Requires Improvement

The service was not always well led.

Governance systems were not robust in monitoring the service provided. However, the service were reviewing these.

The manager had not taken immediate action to address issues that had been identified through the services governance systems.

Staff felt supported by the manager and the provider, and the manager and the provider were visible and approachable to people, relatives and staff at the service.

Chignal House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over one day on 26 January 2017 and the inspection was unannounced. The inspection team consisted of one inspector due to the small size of the service.

Before inspecting the service, we looked at all the information that we held about the service on our systems including notifications that the service had sent us. This is information about important events, which the provider is required to send us by law. The service had also submitted a PIR (Provider Information Return) that contained important information about how the service was run.

During the inspection, we spoke with all three people who lived at the service and health and social care professionals. We spoke to the registered manager and the member of care staff on duty. We reviewed three staff files and all three people's care plans, risk assessments and nursing notes. This included information from other health professionals about the needs of people at the service. We also carried out care observations of staff and people at the service.

We checked the physical environment and examined processes including how people's medicines were managed. We reviewed the service's policies and procedures relating to the management of the service and care of people. We also checked if recruitment practices were robust to ensure that staff were recruited safely.

Requires Improvement

Is the service safe?

Our findings

Recruitment policy was clear that staff employed should have an enhanced criminal records check (DBS) to ensure that they had no previous criminal convictions that might place people at risk, and that two references should be sought for each new member of staff, including a reference from the last employer. The policy also included reference to ensuring that all gaps in employment were explained.

Whilst it was clear in staff records reviewed that staff had undergone an enhanced DBS prior to working with people at the service, pre-employment checks were not conducted in line with the requirements of the regulations. Gaps in employment were not explained in the three staff files we looked at. For example, one member of staff Gaps in employment were not explained and no employment history documented, although had left school for many years. We discussed this with the registered manager and requested they review the remaining staff files and act appropriately to gather information missing

The fridge storing food had a temperature recorded as being higher than the provider's acceptable level to keep food stored safely over a period of 20 days. On one occasion, it exceeded the food hygiene acceptable safe level. Staff had completed daily temperature monitoring charts, but had not reported it as per the providers own policy and instruction's on the monitoring form. We brought this to the manager's attention immediately because inappropriately stored food could cause people to become unwell. The manager gave assurances that this would be checked immediately following the inspection and the provider was able to inform us that the issue was investigated and rectified.

Medicines were not always stored safely. The pharmacy the service used had carried out a medicines audit and found that the medicine fridge where insulin was kept was broken and did not lock. The registered manager told us they had identified this issue a week prior to the audit and that the pharmacy was sourcing a new fridge. However, the fridge remained unlocked and accessible to both staff and people in the kitchen for over 20 days. There had been no attempt to take action to mitigate this whilst waiting for the new fridge. For example, keeping it in the locked manager's office and chasing up for the new fridge. We advised the registered manager to take immediate action to secure the medicines. And they immediate relocated the fridge to a locked room that could only be accessed by staff.

However, we did find that medicines were safely dispensed. Some people at the service were able to self-administer medicines with oversight from staff. For example one person to self-administering insulin to manage their diabetes. Some people also on occasion, required PRN (as required) medicines when in distress. There was a clear medicine policy and PRN procedures in place. We saw that staff had appropriate training and medicines handling updates and the manager completed observations of staff administering medications.

When people required PRN medicines, the manager would be contacted, and advice sought. We saw documentation when staff were supported to try other distraction techniques and support to reduce distress rather than use medicine. This was good practice and meant that the least restrictive options were considered and PRN was only used as a last resort. Regular medicine audits of peoples medicines

administration records (MARS) were carried out to ensure that medicines were being administered safely.

The service had a clear expectation of staff to speak up if they had concerns about whether people at the service were at risk of bullying and harassment. Risk assessments identified if people were a risk to each other and care plan interventions ensured that people were supported to remain safe, whilst encouraging mutual respect of others living in the home. When people had become unhappy with each other, staff had the information and the skills to de-escalate potential conflict in a way that supported and respected people. Clear whistle blowing policy and procedures were in place for staff to use to express concerns about care and treatment of people at the service.

We spoke to staff who had a good understanding of safeguarding concerns and procedures in place to alert the relevant people if they were concerned about vulnerable people. All staff received safeguarding training as part of their mandatory training. Health and social care professionals who worked with people living within the service told us that people were safe. One person said, "I have not had any concerns, or safeguarding issues regarding this service. The service always informs and reports to the relevant authorities, of any safeguarding concerns they have raised relating to individual service users. The home manager will always share this information with me, as appropriate."

Staff completed appropriate incident forms when incidents occurred, such as if someone injured themselves, or if there was an issue with the environment. The registered manager reviewed these and updated risk management plans accordingly. Where people had the ability to remain independent in the community without staff oversight, risk management plans identified potential risks and how to support people in the least restrictive way. We saw that the manager and staff at the service knew people's daily routines and had good relationships with the local community businesses and local community police. Shopkeepers in the local community knew people at the service and had the care home's telephone contact should they be concerned about a person.

When people left the house staff documented what they were wearing, mood they were in and what their plans were. This protected people in the least restrictive way. Whilst infrequent problems occurred, we saw evidence in care notes and incident forms when these measures had been used to ensure the safety of people should they experience any difficulties in the community.

Although the service only cared for three people, we saw that sufficient staff were employed to meet all their individual needs. This included one member of staff to support people throughout the day and night, and additional staff attending during the week to help people access clubs and activities that they enjoyed. Should a person require visits for health check-ups, additional staff would support people to access these so that they were not missed

Whilst a separate service, another small home owned by the provider and jointly managed by the registered manager, was a few doors away, and we saw that staff collaborated at times with other staff to cover shifts, annual leave and appointments. This meant that there was a regular pool of staff who people at the service knew very well and this ensured good continuity of care for people.

Good

Is the service effective?

Our findings

The registered manager told us that they ensured that staff received regular training updates to meet the needs of the people at the service. This included regular mandatory training such as moving and handling and fire safely and first aid training, but also additional training that would support staff to care for people effectively. For example, Makaton which uses signs and symbols to help people to communicate and other forms of communication training to help staff support peoples individual needs and understand their preferences.

If people living at the service had additional physical health needs, such as diabetes, the registered manager also sourced training in these areas as well as an addition to the regular mandatory training. This type of training was organised across both the homes managed by the registered manager, with two to three months' notice, and in conjunction with the people living at the service weekly activity plans. This ensured that staff were able to attend various training dates, without interfering with people's routines and activities. We did see training certificates in staff files demonstrated such additional training had taken place.

Formal supervision took place at three monthly intervals and we also saw that staff received regular informal observation and supervision from the registered manager.

Yearly staff appraisals documented their progress and progression, strengths and areas of practice to build on. We saw that the provider was planning to start a new service, and considering how to progress existing staff to support this service, what new skills and learning they would need, and how to ensure that these new plans did not disrupt the care provision of people living at the existing service. This also meant progressing care staff into more senior roles within the existing service, considering the additional management training they would need to be effective in their role, such as advanced diploma's.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

In spite of staff receiving mandatory training in Mental Capacity Act and DOLs, we found that assessments of people's capacity were out of date and poorly recorded. Information found in some of these assessments did not clearly identify what measures would be taken to support the person in their best interests. We discussed this with the registered manager who was able to demonstrate that they had identified that Mental Capacity Assessments were poor and that they had already arranged to attend a Care Quality Commission Mental Capacity Act workshop open to providers, which they were going to use to inform staff at the service.

Although the capacity assessments themselves were poor, risk assessments, care notes, care plan interventions, and multi-disciplinary team meetings demonstrated that people were being asked their views and that staff supported people to make appropriate choices. Evidence in care plans documented whether people were able to make decisions and whether they had a power of attorney identified for health and finance. A power of attorney can be assigned to act in the persons best interests by a court of law, should they not have mental capacity to make decisions.

Care plan interventions and care notes demonstrated that people's choices and preferences were always considered with the least restrictive support. This included using advance decisions if made, and interventions that were designed in conjunction with people's preferences and collaboration with assigned power of attorney, social workers and other health professionals.

For those people who enjoyed food and cooking, this was greatly encouraged by staff through supporting people to shop for ingredient's and follow recipes. People were supported to access cookery classes, and in some cases organising transport and in discussions with local restaurateurs to support people to independently eat out at their favourite restaurant. When people had specific preferences for food that were not always healthy, staff used positive interactions and education to engage people to try new things and make healthier choices. This included care plan interventions that maximised a person's choice but also encouraged some self-management which staff would work out with the person.

We saw evidence where people had a risk of choking that the SALT (Speech and Language Therapist assessment), and dietician assessment had been organised in conjunction with local health professionals and the GP surgery. Consequently, people were supported to eat and drink and maintain a balanced diet.

Care notes and care plans documented when people had been seen by other health professionals and demonstrated action plans and interventions for staff to follow in managing individual's varying health needs. We saw that this access was good. For example, people received regular dental support, eye tests, hearing tests when the need was identified, and regular health check-ups with the local GP.

Good

Is the service caring?

Our findings

Staff treated people in a kind and compassionate manner, with dignity or respect.

People told us that staff were caring and respected their personal preferences and choices. People at the service valued their independence and we saw that staff respected this.

People were not afraid to speak up and say if they were unhappy or if they needed something. This was evidenced in interactions with staff. One person said, "I tell them what I need, and they help me," another said, "Staff are nice here I like them." We saw lots of observed staff supporting people in a supportive and encouraging well. Interactions demonstrated that people felt comfortable with staff and we observed lots of friendly banter between staff and people at the service that demonstrated mutual understanding and respect.
Care plans were accessible to people at all times, and clear notes were on care plans that stated that staff had to request permission from the person to look at the care plan. This was respected by all staff. Staff told us, "We are guests in their home. This is information about them; we have to respect them like we would want to be respected."

People were supported to live well and we saw that in some cases people had experienced difficulty in settling into previous homes. This service had managed to find the right balance to support people needs and minimise risks that were previously difficult to manage. Staff told us this was because they saw past any disability to the person.

Care reviews and staff discussions demonstrated that staff knew people really well. When people had specific communication needs, such as language barriers, the registered manager had been creative and provided care plans and activity plans in different languages as well as easy read formats. An understanding of staff skills also ensured that the right member of staff was employed to support people, for example in attending health appointments with a member of staff who spoke a specific language and could translate information for a person.

Activity plans were tailored to the preferences and abilities of individual's living at the service. Care interventions carried out by staff sought to maximise the independence of the person wherever possible. For example if the person needed a specific intervention for health needs, staff would consider their capacity and try various techniques throughout the day to support the best outcome for the person. This included the knowledge of whether a person preferred a particular member of staff to support in an activity, such as having a male or female carer to carry out care.

Regular meetings took place with people at the service, facilitated by staff and the registered manager. We saw meeting minutes of these and that activity, the home, food, and holidays were all discussed in conjunction with people, both collectively and individually.

The service did not include people in staff interviews however, although one person at the service would be

introduced to the potential new member of staff following interview and would be able to show them around and ask them questions. They would inform staff whether they liked the person or not and the registered manager would consider this, before offering a post.

People's bedroom areas were personalised, including their own furniture and décor. These were clearly personal spaces and people could have protected time in their rooms. People's sexuality was respected and they were treated with dignity at all times. Care plan interventions that evidenced this were written in a dignified and caring manner, whilst still offering staff enough information to support the person. People we spoke to were open about their personal needs and staff were professional, respectful, and considerate in their responses, whilst also considering people's safely and the safety of others.

A person's religious beliefs were also taken into consideration and people were supported to attend church groups and church activities if they chose too. People told us they enjoyed the local activities at the church.

Requires Improvement

Is the service responsive?

Our findings

It was evident that people received personalised care that was responsive to their needs. However, documentation in care plans was not always clear and at times was contradictory to the standard of care recorded, documented, and verbalised by staff and people at the service. Unhelpful and labels were added to care plans, such as "I'm suffering from Downs Syndrome." We discussed this type of language with the manager who agreed that this language could be seen as patronising people in their care and that they would review the care plans to consider this."

There had been a recent move to introduce care plans that people could be easily read, as the traditional care plans had been long and complicated. These were personalised and person centred for unique needs, however where two people had similar needs, such as needing support with personal care, we saw that both care plans contained identical text and on one occasion the guidance had clearly been copied and pasted from one care plan to another, with the other person's name crossed out but still visible". The provider should note that this would not be considered as good practice and that careful consideration should be given to personalise these areas of basic care need.

Care plan folders also held too many versions of care plans, which made reading them complex even for a person without communication difficulties. They did not all have dates of when they were completed, or when they should be reviewed, and signatures of staff who had completed them or from people at the service were not recorded. However, we did note from care notes, daily records and from talking to people at the service, that care interventions remained relevant. Following the inspection the provider sent us evidence to demonstrate that one person's care plan had been reviewed over two consecutive months."

People living at the service had been asked to sign a behaviour agreement. This was wordy, long, and complicated. We discussed this with the registered manager, as people at the service would have had difficulty comprehending the information signed. There had been no advocacy support or consideration to making this an easy to read document. The registered manager told us that they would review this form.

The service did carry out yearly satisfaction surveys and held regular meetings with people at the service to find out if people were happy with the service they received. One person told us if they were unhappy about something, they would tell staff and gave an example. Others were not as able to complain, however, staff understood patterns of individual behaviour and were able to identify when people were unhappy with something and work with them to discover what had caused their distress and remedy this.

The registered manager also regularly spoke to relatives and other health professionals to ensure that people's experiences were positive and address any concerns that people may have. There were no active complaints open against the service.

Requires Improvement

Is the service well-led?

Our findings

The service was not always managed well and governance systems and overall monitoring of the service needed to be improved. For example, regular staff meetings and group meetings with the people at the service were undertaken and people were encouraged and supported to express their views. However, when meeting minutes did identify need it was not clear who would follow it up. In addition, at the next meeting feedback about previous actions was not documented. This meant that there was a risk of actions not been followed through and lessons not being learnt.

Care plan and risk assessments were not always dated and signed, and it was difficult to decipher which plan of care was current and how a person had been involved. Whilst we identified some good person centred care, it was not clear when this was regularly reviewed and whether people had agreed to the interventions. There were no systems in place to ensure that care plans were regularly reviewed to keep interventions relevant to people.

A folder documenting clinical audits, cleaning schedules, fridge temperature's and other maintenance issues was kept alongside record of people's individual daily needs, such as cream charts to document application of creams. These forms were disorganised and did not identify areas needing review and improvement.

For example, the fridge temperature where food was kept was documented as being above the top temperature of five, as eight and nine. No one had used this information to alert the registered manager and the registered manager had not checked the information in the folder.

The lack of good governance is a breach in Regulation 17 of the Health and Social Care Act 2008.

However, the registered manager promoted a positive culture at the service and people and staff at the service told us that they felt they could raise concerns and suggest changes and that these would be listened too. They had identified that their internal governance systems needed improving and were planning to obtain independent guidance on what areas they could improve on.

Following the inspection the provider provided us with a monthly care managers responsibilities audit form that would function as a checklist for managers and also as a prompt sheet if they need to raise any matters with a Director at one of the regular senior team meetings. Implemented in January, this form would also be used to discuss improvements needed to the service.

Director and manager meeting minutes, provided post inspection demonstrated that issues found at the service were discussed and how improvements would be made. We saw that in minutes for these meetings the provider took seriously any issues highlighted by the registered manager. For example, if additional and on-going maintenance was needed.

The service had a clear philosophy that people should feel that they were living in their own home. We saw

that managers and staff respected these values and empowered people to be as independent as possible by empowering them to achieve their goals.

Behaviour contracts signed by people living at the home were not written in a way that would support their understanding of what they were signing. These contracts identified the behaviour expected of people at the home to ensure that all living there had their rights respected. There had been no consideration about whether people understood what they were signing.

In spite of this, we saw that people at the service were supported to be considerate and inclusive with each other and there were few disputes between people. This was partially due to the managers and staff understanding of the individual needs of the people at the service.

There was visible positive role modelling from the registered manager who had excellent relationships with people at the service. We observed a number of very positive interactions between people, staff and the manager at the service.

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 17 HSCA RA Regulations 2014 Good governance There was a lack of good governance systems in place to monitor the quality of the care provided by the service.