Care Quality Commission

Chandrakantha Prathapan

Gable Lodge

Inspection report

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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

Overall summary

This inspection took place on 14 November 2014 and was unannounced. When we last visited the home on the 4 October 2013 we found the service was meeting all the regulations we looked at.

Gable Lodge is a care home for up to nine older people. At the time of our visit there were seven people living at the home, many of whom were living with the experience of dementia.

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.

People were not always protected from the risks of choking as the manager had not ensured that people who were at risk of choking had been adequately assessed, and that guidelines in place were adequate. Not all staff had the necessary knowledge to provide people with suitable first aid in the event of people choking. You can see what action we told the provider to take at the end of this report.

Summary of findings

The premises were not always safe. Risks in a number of areas were not identified so plans could be developed to minimise risks to people.

The provider was not meeting the requirements in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provide legal safeguards for people who may have restrictions placed on them as part of their care plan. The manager had identified that two people required authorisation to deprive them of their liberty but had not made the applications within a reasonable time period. However, staff had understood the importance of obtaining consent from people before they provided care and support. You can see what action we told the provider to take at the end of this report.

People enjoyed the food and were provided with a variety of food to choose from. Staff monitored people's weight and referred them on for specialist support, when they were concerned about their risk of malnutrition.

Staff understood people's health needs and people had access to health professionals according to their needs. Care plans and risk assessments were in place regarding a range of different needs. Medicines management was safe.

People using the service and their relatives described the manager and staff as being warm and caring, and were happy with the care and support they received. We saw that care was delivered with kindness, dignity and respect. People had good relationships with staff and received care and support to meet their individual needs. Staff had a good knowledge of people's backgrounds and preferences which meant they knew how people would like their care delivered. People were supported to spend their time as they pleased.

The manager involved people and their relatives in their care and sought people's views and suggestions via meetings, surveys and regular informal contact. The service had an accessible complaints procedure which people and their relatives were aware of. Relatives told us they had never had cause to complain.

Staff had clear lines of responsibility and the manager, who was also the owner, directly oversaw all aspects of the service. A range of audits were in place to monitor the right standards in different aspects of the service.

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. The way in which care was given to people at risk of choking did not always ensure their safety.

The premises were not always safe. Risks in a number of areas were not identified so plans could be developed to minimise risks to people and others.

Staff knew how to identify abuse or neglect and how to respond to keep people safe. Recruitment procedures were robust and there were enough staff employed by the service. Medicines management was safe.

Requires Improvement

Is the service effective?

The service was not always effective. The provider was not meeting the requirements in relation to DoLS as they had not made the necessary applications in a timely manner where people might have been deprived of their liberties.

Staff received effective induction, training, supervision and appraisal to help them to carry out their roles. People enjoyed the food and were given choice. Food was served in adequate quantities. Staff monitored people's health needs and referred them on to healthcare professionals where necessary.

Requires Improvement

Is the service caring?

The service was caring. People using the service and relatives commented on how warm and caring the manager and staff were. Care was delivered with kindness, compassion, dignity and respect.

Good

Is the service responsive?

The service was responsive. People received care and support to meet their individual needs and were offered activities that were important and relevant to them. The manager was responsive to the views of others, and there was a robust complaints system in place.

Good

Is the service well-led?

The service was not always well-led as the quality assurance systems had not identified the issues we found in our inspection.

People using the service, relatives and staff were confident in the manager. The manager was supportive to staff and sought feedback from people using the service, staff, relatives and healthcare professionals.

Requires Improvement

Gable 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 14 November 2014 and was unannounced. It was undertaken by a single inspector.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make. We reviewed this, as well as other information we held about the service and the provider. We also contacted the local authority commissioning and safeguarding teams to consult with them about their views of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We spoke with four people who used the service and three relatives. We observed care and support using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager and six members of staff. We looked at four people's care records to see how their care was planned, three staff recruitment files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The way in which care was planned and delivered in relation to people who had difficulty swallowing was not always safe, and did not follow best practice. We observed staff supporting two people at a mealtime and saw the people had difficulties swallowing and coughed during their meals. Their care plans indicated they were at risk of choking. However, it was not clear whether their ability to swallow had been appropriately assessed by a professional. The British Geriatrics Society guide care providers on the risks of choking for people who have difficulties swallowing in 'Nutrition advice in common clinical situations (2009) Good Practice Guides'. They advise that people at risk should be carefully observed and have their ability to swallow screened by someone who is specially trained, with a prompt referral to a Speech and Language Therapist (SLT) for early risk assessment. However, neither person had been referred for assessment by a SLT. When we discussed this with the manager they advised us they had not thought this input necessary, but immediately made arrangements to obtain the necessary specialist advice.

Care plans and risk assessments that were in place for people who had difficulty swallowing were not comprehensive enough and had not been informed by specialists. We observed that two people whose assessments indicated they were at risk were not supported to eat while sitting upright, which reduces the risks of choking, and care plans did not mention the desired position. Care planning documents for two people guided staff to puree food and to thicken drinks for one person to reduce the risks, and we observed food was prepared in this way. However, there was no specialist input to confirm this was the required texture or consistency for each person. Care plans did not mention the quantity of food staff should provide during each mouthful. This meant that staff were not supporting people to eat and drink in a way which minimised risks to them.

Staff did not have the required knowledge to support people in a medical emergency that could result if people have not swallowed food or drink appropriately. We asked three staff how they would respond if a person began to choke on their food with a severe obstruction and two said they would rub or pat the person's back lightly so as not to hurt them. However, this response goes against current clinical guidance, meaning people would be at risk. The manager had a good knowledge of how to respond to a person choking and informed us she would reinforce this with staff immediately and arrange further first aid training.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The premises were not always safe because there was unmonitored access to a fire escape leading to the road. As many people using the service were living with dementia there was a risk that people could leave the home via this door and come to harm, due to being disorientated to time and place, while staff were unaware. After the inspection the manager confirmed they had installed an alarm on this door to reduce this risk.

In addition, there was no evidence that the risks of Legionella developing in the water system had been assessed and recorded to ensure the right controls were in place. Although the water had recently been tested and shown not to have Legionella, this bacterium can accumulate rapidly in hot water systems if the controls are not suitable. This meant that people were not protected against the risks of acquiring Legionella infections. After the inspection the manager told us they had commissioned a specialist to carry out a Legionella risk assessment and implement the advised control mechanisms.

We found that equipment and systems in relation to the premises were maintained and checked. The central heating and electric wiring system had been tested to ensure they were safe. The temperature of hot water outlets was tested regularly to reduce the risk of people being scalded. There were smoke detectors and fire extinguishers on each floor. Fire alarms and evacuation procedures were checked to ensure they were suitable and people were aware of what to do in the event of a fire.

Items of equipment required for the care of people or for their individual use were also checked and maintained to ensure these were safe to use. Records showed that the hoists and slings, portable electrical appliances (PAT) and fire-fighting equipment were properly maintained, having been checked within the past year by external companies. Pressure relieving mattresses and cushions had been provided for people who required them. This helped reduce the risk of people developing pressure ulcers.

Requires Improvement

Is the service safe?

Accidents and incidents were recorded and the records and situations were reviewed by the manager. Staff told us and records confirmed that where a person had a high number of falls they were referred to healthcare professionals to find the cause and provide support.

The service had responded appropriately to allegations of abuse by liaising with the local authority safeguarding team during their investigation. Staff received training in safeguarding adults as part of the induction, annually and as part of their diploma in health and social care. Staff had a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place.

People using the service, staff and relatives told us the staffing levels met the needs of the people using the service. Our observations were in line with these views as we saw that staff responded to people in a timely manner throughout the inspection, were not rushed and had time to sit and talk with people. The manager increased staffing levels according to people's needs, and had recently increased staffing levels at night.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the service. This included considering applicants' health, obtaining suitable references and completing a criminal record check to help ensure staff were safe to work with adults. This helped to ensure that people were protected from staff that were known to be unsuitable.

People's risk assessments had been completed for needs such as personal care, moving and handling, preventing falls and nutrition. The information in these documents was up to date and regularly reviewed. This meant that staff had access to current information about the people they supported and how to keep them safe.

Audits of medicines in stock were carried out every time a medicine in its original packaging was administered. When we checked stocks we confirmed medicines had been given as indicated on the Medicines Administration Records (MAR). Written guidance was available for all medicines to be administered when required (PRN) and for homely remedies, which had been agreed by the GP. This enabled staff to administer these medicines correctly. Staff received regular training in medicines administration and the manager was carrying out a programme of assessing the competency of all staff in this area. The pharmacist had recently carried out an audit of procedures in relation to the management of medicines and had found these to be satisfactory.

Requires Improvement

Is the service effective?

Our findings

The provider was not meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and legislation to help protect people's human rights in relation to capacity and consent. Although the manager had identified that two people required authorisation to deprive them of their liberty they had not made the necessary applications within a reasonable time period. This meant the manager had not followed procedures to act in people's best interests where they did not have capacity to consent in relation to DoLS. People's human rights may not have been protected as they may have been deprived of their liberties unlawfully. Although staff had a basic understanding of the Mental Capacity Act 2005, having received training in this, they did not understand DoLS. These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported by staff who had a range of training and support to do their jobs. A training programme was in place and each staff member completed a variety of training. Topics that were considered mandatory by the provider included safeguarding adults from abuse, medicines awareness, infection control, manual handling, fire awareness, food safety, equality and diversity and dementia awareness. Staff were also supported to do more in-depth training, such as distance learning courses in medicines management, advanced safeguarding, diplomas and foundation degrees in health and social care and leadership and management. Staff told us that the training provided was good and equipped them well to do their jobs.

Staff told us they received frequent supervision in which they discussed a range of issues such as training and support requirements and how best to support people. Records confirmed this. One staff member told us, "I have supervision every six weeks and we talk about different things, like safeguarding and health and safety. I feel supported." Staff also received annual appraisals of their competence to carry out their work role and told us supervision and appraisals were a valuable part of the support they received, helping them to deliver care to people in the best possible way.

People told us they enjoyed the food. One person using the service said, "The food is very good. I get to eat my favourite food." One relative said, "The food is fantastic. I've often felt like eating it myself, it's that good!" Another said, "The food looks good. I see people been given cooked breakfasts sometimes." Staff had a good knowledge of people's dietary preferences and requirements and these were recorded in their care plans. We saw that people were asked what they would like to eat before each meal, and were also provided an alternative meal if they changed their mind when it came to the mealtime. Records showed people had meetings in which they were involved in menu planning and were encouraged to feedback on meals' quality.

People were encouraged to eat a healthy and balanced diet and staff had received training in nutrition and healthy eating. Staff monitored people's weight and records showed they obtained advice where there were concerns about people's nutrition. For example, when a person had lost weight they had been referred to a dietitian whose guidance to provide high calorie food and dietary supplements was being followed.

Our discussion with staff showed they had a good knowledge of people's health needs and records showed people were supported to access and receive care from healthcare professionals. One person told us, "If I'm poorly I tell staff and they sort it out." Records showed people received regular health checks and treatments from the GP, dentist, opticians and chiropodists. When people's needs changed, referrals were made quickly to relevant health services, besides the two people for whom prompt referrals to SLT were not made. For example, a person who was presenting with mental health needs was referred to a psychiatrist. For another person staff knew the signs they could be unwell and promptly sought the GP's support. A person who started to fall frequently was referred to the falls clinic. Some people had been referred to the end of life team and were regularly seen by a tissue viability nurse to help prevent pressure ulcers.

Good

Is the service caring?

Our findings

People told us they were happy living at Gable Lodge and received a good standard of care. One person told us, "All the staff are nice, especially the manager." One relative told us, "They go over and above what they need to do. They put their heart and soul in to it. When [my relative] goes to hospital, staff are always there with them, even at night." Another told us, "They go out of their way to care for [my relative]. They do their best to retain people's dignity, comfort and that gives us a lot of reassurance." Another relative said, "It's absolutely brilliant, they are very, very caring." In the care home's recent annual survey a healthcare professional had also made positive comments about the staff being polite and people using the service being happy and content.

Care plans were based on people's individual needs and included information about people's likes and dislikes, their background and family. Staff demonstrated an in-depth knowledge and understanding of people's care, support needs and routines. Care was delivered to people in line with their individual care plans. For example, it was documented that one person preferred to eat alone, and we saw they were supported to eat after others had finished their meal.

People could choose where to spend their time in the home. One person told us they often chose to spend time alone in their room while others said they liked to spend time in the lounge with others. Another person told us they didn't like to eat alone, and we saw that staff ensured they ate their meal with others in the dining room.

People told us they had good relationships with staff and we observed that people were relaxed with staff and readily approached them for assistance throughout the day. Staff showed people kindness, patience and respect and told us they enjoyed supporting the people at Gable Lodge. We observed staff speaking with people who became distressed in a sensitive, compassionate manner, sitting with them and using touch appropriately to reassure them. We also saw that staff carried out personal care in a respectful, dignified way for example by ensuring bedrooms and bathrooms doors were closed.

The manager sought people's views and ensured they were involved in decisions about their care as far as possible. People and their relatives were consulted as part of the pre-assessment process and were involved in care plan reviews where appropriate. One relative described the pre-admission process, which involved the manager, them and their family member. They told us, "We asked each other lots of questions" in drawing up the care plan.

People were supported to maintain their independence. We observed staff involving people folding napkins and engaging in other household tasks. Staff told us how they encouraged people to do as much as they could for themselves when supporting them with personal care.

Each person had a member of staff allocated to them as their keyworker. This was a designated member of staff who met with them regularly to ensure their needs were being met and to encourage them to express their views on their care. They also took a lead role in their care, for example, ensuring they had all the clothing and toiletries they needed.

Relatives told us they could visit at any time. One relative told us, "I often drop in and the standards are always the same when they are not expecting me." Another said, "We can go in any time and that puts my mind at rest."

Good

Is the service responsive?

Our findings

People were positive about the service and said they received support that met their individual needs. One person told us, "I get [the newspaper I want to read] every day." Relatives were very positive about the service. One relative told us, "They seem to care for [people who use the service] individually. Some like to get up early, others later and that's fine." Another relative said, "My [relative] has very high needs and they are supporting [my relative] very well. The staff know what they are doing."

People's records included detailed information on their health conditions and backgrounds which enabled staff at the service to support them appropriately. People's needs were also regularly assessed, recorded and reviewed. Care plans showed that each person had a number of ongoing regular assessments to check whether their needs were changing. These included malnutrition, falls and pressure ulcer prevention, as relevant to each person.

People had access to activities that were important and relevant to them and people were offered activities according to their individual needs. We saw that the activities people liked to do were listed in their care plans and people told us staff catered for these preferences. There was an activities officer who provided a programme of group and individual activities, such as quizzes and trips to local places of interest. During keyworking sessions and residents' meetings the activities people liked to do were reviewed and planned. Some people clearly expressed they wanted to do activities by themselves, such as reading and watching TV, and several told us they preferred not to participate in group activities. People's individual wishes were respected. Several people told us they liked to read the paper and magazines, and these were provided daily.

The manager encouraged and supported people to develop and maintain relationships with people that matter to them and to help avoid social isolation. Several people chose to spend much of their time in the lounge and we observed people having conversations with each other, and with staff, throughout the day. Visits from relatives were encouraged and relatives told us staff always made them feel welcome. Relatives also described how the manager always kept them up-to-date with how their family member was. One relative said, "[The manager] always calls me if there are any problems." Another said, "When I visit, [the manager] is usually there and will always come and talk with me and tell me what's being going on. If she's not there then the staff will."

The service was responsive to the views and suggestions of people's relatives and the healthcare professionals who supported them. The service had recently sought feedback from people's relatives and healthcare professionals through an annual survey. One relative told us, "We have made suggestions and there is nothing they won't do."

There was a complaints procedure and this was displayed in a communal area so people using the service and their representatives had access to it. People and their relatives told us they knew how to complain and would do so if necessary and believed the manager would deal with any complaints in a fair manner.

Requires Improvement

Is the service well-led?

Our findings

People, staff and relatives described the manager as being warm, caring and open. One person using the service told us, “The manager is wonderful, the best thing about the home!” A staff member told us, “The manager is lovely. If you have a problem she will listen.” Another staff member said, “The manager is very caring and she always encourages us to do further studies.” Records showed the manager frequently attended training courses relevant to the running of the home.

There were quality assurance systems in place to monitor various aspects of the service, however, these had not identified the issues we found in relation to care and welfare, DoLS and safety of the premises. This meant they were not effective in ensuring the home was well-led and people received the necessary standards of care and support.

However, the quality assurance systems in relation to other areas, such as recruitment, medicines, cleanliness and some areas of health and safety, were adequate. Each staff recruitment file had an index indicating that an audit had been carried out to ensure all the necessary pre-employment checks had been carried out before staff started work. Regular medicines stock balance checks were carried out to verify people had received their medicines as prescribed. The senior care workers carried out daily checks to ensure the home had been cleaned to a high standard and paperwork had been completed, and also carried out regular health and safety and fire audits.

There was a management structure in the home which provided clear lines of responsibility and accountability. The registered manager was also the proprietor and had overall responsibility for the home, with a deputy manager assisting them. Both the manager and deputy took an active role in the running of the home, being continually present and involved in direct care and support. There were several senior care workers who supported and supervised care workers and an activities officer.

There were systems in place to share information and seek people’s views about the running of the home. There were regular meetings for people who lived at the home and staff. In the reception area there was a suggestion box for people to make anonymous suggestions if they preferred this to raising issues directly with the manager. Each year the manager carried out surveys of relatives and healthcare professionals to gather their feedback and ideas for improving the service. All comments received in the survey so far were positive. One relative had written, “Very good individual, attentive care.” Another relative had commented, “Our relatives are very well looked after.” Staff told us they felt listened to and the manager had acted on suggestions they had made, such as reviewing the rota to ensure shift allocation was fairer. Staff meetings were held monthly and staff told us they were encouraged to share their views about 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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used services were not protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care to meet people's individual needs and ensure their welfare and safety, reflecting published research evidence and professional guidance. Regulation 9(1)(b)(i)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for establishing, and acting in accordance with, the best interests of people using the service. Regulation 18(2).