

Chapel Lodge Care Limited

The Lodge

Inspection report

Hayfield Road
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High Peak
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Tel: 01298814032

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18 October 2016

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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 ●

Summary of findings

Overall summary

This inspection took place on 18 October 2016 and was unannounced.

There is a requirement for The Lodge to have a registered manager and there was a registered manager in place at the time of this inspection. 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.

The service is registered to provide nursing and residential care for up to 36 people, including some people living with dementia. At the time of our inspection 33 people were using the service.

Systems and processes to check on the quality and safety of services provided to people were not always effective at identifying shortfalls.

Medicines were not managed and stored safely in line with good practice. The provider could not demonstrate that people, whose fluid intake was monitored, received sufficient fluids. In addition, some people required repositioning at regular intervals to prevent and reduce the risks associated with pressure areas. The provider could not demonstrate these people were always repositioned at the frequency identified as required by the provider.

Policies and procedures were in place for the Mental Capacity Act 2005 (MCA). Applications for assessments using the Deprivation of Liberty Safeguards (DoLS) had been made when required. However care plans for people who lacked the capacity to consent to their care, did not contain a mental capacity assessment and best interest's decision to inform the provision of care and support.

People were supported to enjoy mealtimes and received sufficient food and drink. However, staff did not know one person had diabetic needs and not all lists in the kitchen included people's diabetic needs.

People were supported by staff who were compassionate and caring. Staff listened to people and respected their choices and decisions. Care and support respected people's privacy and dignity. People's independence was supported.

People received responsive and personalised care from staff who understood them and their interests. People were supported to engage in enjoyable interests and activities. People were asked for their views and people knew how to raise concerns or make suggestions.

The registered manager had taken action to recruit new staff to ensure they could provide sufficient numbers of staff to meet people's needs. Any risks to people were identified and assessed and monitored.

Staff were supported through supervision and training. Staff received training in areas that were relevant to the needs of people using the service. People were supported to access other health care services as required.

The registered manager was viewed as being open and approachable and involved in the day to day management of the service. The registered manager was supported in their leadership by motivated and supportive staff.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection visit. You can see what action we told the provider to take at the back of the full version 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?

The service was not safe.

Risks from medicines were not safely managed. Actions to reduce risks in other areas were not evident. Action had been taken to ensure sufficient numbers of staff were deployed and recruitment processes to ensure staff were suitable to work with people using the service were followed.

Requires Improvement ●

Is the service effective?

The service was not effective.

Mental Capacity Assessments and best interest decisions did not inform the care plans for people who lacked the capacity to consent. Staff were not aware of all people with diabetic needs. People received support from external health professionals when required. Staff received training and support.

Requires Improvement ●

Is the service caring?

The service was caring.

People were supported by compassionate and caring staff. Care and support was provided in a way that respected people's privacy and promoted their dignity. People's views and opinions were respected and people were involved in their own care.

Good ●

Is the service responsive?

The service was responsive.

People received personalised and responsive care and support and their preferences were understood and respected by staff. People were asked for their views and understood how to make a complaint or offer feedback.

Good ●

Is the service well-led?

The service was not well led.

Checks on the quality and safety of services were not effective at identifying shortfalls. The registered manager was approachable

Requires Improvement ●

and understood their responsibilities. The service had clear values and areas identified for development.

The 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 18 October 2016. The inspection was completed by one inspector who was accompanied by a specialist professional advisor.

We reviewed relevant information we already held about the provider, including the Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We also checked whether we had received notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about.

We spoke with four people who used the service and seven members of staff, including the deputy manager, regional manager, care staff and maintenance staff. We looked at six people's care plans and we reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records.

Is the service safe?

Our findings

We reviewed the medicines for one person who received their medicines as and when they needed them. We found one member of staff had not cancelled a GP's instruction to discontinue one of their medicines when a new medicine had been introduced. This resulted in the person having two sedatives available at the same time, to have, 'as and when required.' There was a risk the person could be administered both sedative medicines and as a result become over sedated. We discussed this with both the deputy and the registered manager. They confirmed although staff had not administered both medicines at the same time, an error had been made by the member of staff. This was because they had not discontinued the medicine as instructed.

We found other prescribed creams and eye drops were also not stored securely in people's bedrooms. Medicines should always be secured securely to reduce the risks associated with them. In addition, we found cream prescribed for one person in another person's bedroom. This posed the risk of cross infection and meant the provider could not be assured people were receiving their medicines, as prescribed. Creams found in people's bedrooms were not dated when opened. This meant the provider could not be assured they were disposed of, in line with any guidance. This demonstrated that the correct and proper guidelines for the safe management and storage of medicines were not being followed.

The provider could not demonstrate people who were at risk from dehydration received sufficient fluids. Records of people's daily fluid intake had not consistently been checked by nursing staff, as they were required to do by the provider. Records showed some people had taken reduced levels of fluids, however nursing staff had not reviewed the records to confirm the level of fluids taken by the person, was safe and appropriate for their health condition. The provider could not therefore be assured that people at risk of dehydration, had taken sufficient fluids. We discussed this with the registered manager who confirmed they would take immediate action to improve the records of people's fluid intakes.

We found people at risk from developing pressure areas were not always repositioned at the frequency identified by the provider, to prevent further deterioration of their pressure areas. For one person who required repositioning every two hours, we found there were regular occasions when they were not repositioned for four hours; and on one occasion they were not repositioned for over six hours. This meant people were at risk from deterioration in their skin integrity, as they were not being repositioned at the frequency determined by the provider to prevent and reduce risks from pressure areas.

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

People told us staff were busy. However, they also said staff were available to provide support when they needed it. One person told us, "I miss them [staff] to chat to, but they are busy." Families we spoke with shared the view there were sufficient numbers of staff available to meet people's needs. One family member told us, "It's always felt well-staffed; I've never seen buzzers go unanswered." Staff we spoke with told us they were very busy, however shifts were always covered. However on the day of our inspection, the deputy

manager told us there should have been six care assistants on shift, when there were only five. This was because a member of staff was ill. The deputy manager told us the activities coordinator would be covering some care shifts. Whilst we saw the activities coordinator assist people with their meals, they also spent time engaging people in activities. Staff told us the registered manager had recruited extra staff and they expected this to reduce the pressure when staff were ill or on holiday. During our inspection a newly recruited staff member visited the service to finalise some recruitment paperwork. Whilst the numbers of care staff had not fully met the levels required by the provider to meet people's needs, action had been taken to improve this situation.

People we spoke with were satisfied with the arrangements in place for the management of their medicines. One person told us, "[Staff] always ask if I need any paracetamol." One family member told us, "Staff manage [my relative's] pain well." We observed staff administering medicines to people. Staff checked people were available to take their medicines before preparing them and checked to ensure medicines were taken. We saw medicines administration records (MAR's) were updated after people had taken their medicines. Temperatures were monitored and were within the correct temperature range for the safe storage of medicines.

People were involved in assessing risks to their health and wellbeing. One person told us they, "Only use a [walking] stick in the garden," as they did not need one in the home. This meant actions identified to reduce risks still promoted people's freedom and independence. One relative told us staff always made sure their relative had the correct textured food and fluids to reduce the risks of choking. Risk assessments were in place for when people had been assessed from risks such as falls and weight loss. These actions helped to ensure any risks to people were identified and well managed.

People we spoke with told us they felt safe living at The Lodge. One person told us, "Oh yes, it's safe here." One person, who told us they liked to spend time on their own, told us staff checked on them regularly and would ask them if they needed anything. Families we spoke with told us they felt their relatives were cared for safely and staff also shared this view.

Records showed and staff told us, they received training in safeguarding. Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service. The provider had taken steps to reduce the risk of abuse to people using the service.

Is the service effective?

Our findings

Where people did not have capacity to make a decision the provider had a policy in place so that any decisions relating to their care followed the principles of the Mental Capacity Act 2005 (MCA). The 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 they are appropriately supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made 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). The provider had identified and submitted the relevant applications for where people required an assessment and authorisation for a Deprivation of Liberty.

However mental capacity assessments and best interest decision making processes for specific care decisions, other than for people's decisions to reside at The Lodge, were not always clearly recorded in people's care plans. We spoke with the registered manager about this who told us any decision where a mental capacity assessment might be needed, for example over the provision of personal care when the person could not consent to this, were included in people's DoLS. Whilst we saw that providing personal care was included in some people's DoLS, a DoLS does not allow for the authorisation of care and treatment. Therefore when a person cannot consent to their care and treatment, care plans need to demonstrate the principles of the MCA and best interest decision making have been followed.

Staff did not assure us they understood how the MCA and DoLS were relevant to their work. Staff we spoke with did not know how a mental capacity assessment would be completed. In addition, staff told us they were not aware of anyone with a DoLS. We were aware that some DoLS were in place and further applications for DoLS assessments had been made for other people. There was therefore a risk staff did not know what restrictions were lawful and appropriate to a person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always aware of people's dietary needs. For example, one member of staff told us a person was not diabetic. We asked the registered manager for more information on this person as we had noted their care plan referred to their diabetic needs. The registered manager confirmed they were diabetic. There was a potential risk that this person may not receive appropriate food and drink to meet their diabetic needs as staff did not know they were diabetic.

People told us they enjoyed their meals. One person told us, "By and large the food is pretty good; if we don't like something we're not served it and there's always a choice." A relative we spoke with told us staff would always ask people for their meal choices. We saw aids and adaptations were used to help people

maintain their independence when dining. For example, lidded cups were used for drinks where people found a tea cups or mugs could spill too easily. We observed people who required staff to support them with their lunchtime meal received this support. Staff encouraged people to have enough to drink; one member of staff said in a friendly way, "Shall we have a drink?" as they sat for a while with a person. People were supported to receive sufficient food and drink of their choosing.

People were asked for their consent about their care before staff provided assistance and support. We observed staff asking people whether they required any help and support throughout the day. For example, staff asked, "Do you want to stay here or go over there?" Staff checked people were happy to have support before they provided it.

The registered manager had taken action to ensure staff training records were up to date. We saw staff had either completed or had been booked in to complete training relevant to people's needs. For example staff told us they had received training in assisting people to mobilise and safeguarding.

Staff told us they felt well supported by the registered manager and other staff members. One staff member said, "I have supervision and it's definitely useful." Another staff member told us staff worked well as a team, they said, "All the staff get on well." Records showed regular supervision was planned with staff and staff confirmed they could approach the registered manager for support in between supervision meetings. In addition, staff meetings were held on a regular basis. This showed that staff were being supported to develop their skills and knowledge to provide care and support to people using the service.

We saw that external health and social care professionals were involved in people's care. One person told us, "I saw my doctor a couple of weeks ago and I've just had new hearing aids." One relative told us a health professional had been involved with their relative's care to help assess their swallowing needs. People saw a range of other health professionals as appropriate. This meant people received appropriate care and support for their health and care needs.

Is the service caring?

Our findings

People told us they felt staff were caring. One person said, "Staff are exceptionally patient," and, "[Staff] always speak when passing." Staff spoke with warmth and affection for the people they cared for. One staff member told us, "I treat the ladies and gents here just like my grandma and granddad."

Families told us they felt welcomed when they visited. One family member told us, "[Staff] know who you are when you go in." They also went on to tell us how a refreshment area had been developed for families and people to use when visiting.

Staff spent time with people and responded with care and warmth if people became upset. One staff member noticed a person was upset and went to sit with them; They gently asked, "What's the matter? Don't cry." A family member told us staff had phoned to let them know their relative had settled and gone to sleep well on their first night at the service. People were cared for by staff who were caring and compassionate.

Care plans were written with the involvement of people and where appropriate, their families. One person told us, "I've been involved; I've had an assessment of my care." One family member told us they had been involved, along with their relative and other professionals to help plan the person's care and support. People were involved in their care and support.

We saw staff asked people for their views throughout the day and these were listened to. Staff were heard to ask people, "Would you like the telly on?" or they asked people where they wanted to sit. People's views were listened to and respected.

One person told us, "I change my own bed; I take myself to the bathroom; You've got to use it or lose it!" A family member told us staff were mindful of respecting their relative's privacy and always ensured any support with personal care was given in private. Staff told us they would ensure towels were used to help promote people's dignity during personal care. People were supported to maintain their independence and their privacy was respected.

Is the service responsive?

Our findings

One person told us, "This is what I like doing," as they headed off to play a game of skittles organised by the activities coordinator. The people playing skittles shared laughter and conversation together as they played. The activities coordinator told us, "I ask people what they want to do and always encourage people to have a go." They went on to tell us they did different activities to suit people's different needs and abilities. For example, they told us they would sit and read to some people; take people to the shops or play board games with people in their own rooms if they preferred.

We saw people enjoyed their hair being styled by the hairdresser. Another person told us how they enjoyed pottering around in the garden, they said, "It keeps me happy." They also told us their suggestion of a blossom tree as an addition to the home's garden had been supported and arranged by the registered manager. People received personalised and responsive care and support.

Records showed people and their families had contributed details relevant to their care and treatment and that this information was used by staff to build relationships. For example, staff had recorded, "[Name of person] has enjoyed a chat about Morse Code." One staff member also told us how they would make sure one person's radio was on when their favourite football team were playing so they could follow the game. Staff built positive relationships with people and supported them to follow their interests.

The registered manager had asked people their views about the service. Questions had covered topics such as, dignity and privacy, staff attitude and activities. We saw that most responses were positive to the questions asked. We saw people and families had the opportunity to contribute their views and suggestions at meetings. In addition, a relative told us a feedback book had been introduced as an additional way for people to make suggestions. Where people had left feedback this had been reviewed by the registered manager and details of what actions had been taken were recorded. People received a personalised response to any issues raised.

Details on how to make a complaint were displayed at the service as well as included in a 'service user's guide' made available to people when they first started to use the service. The provider had a complaints policy and process in place to ensure complaints were processed to set timescales. One person told us, "I do complain; do they listen? – Yes." They told us they were happy to raise any concerns and make suggestions as they felt listened to and things had been changed as a result. Records had been made of any complaints received along with steps taken to resolve them. Families we spoke with told us they would talk with staff or the registered manager should they need to make a complaint. Procedures were in place for people to raise any concerns and people were able to share their views.

People told us they contributed to the assessment of their care and support. One person told us a staff member spoke with them, "Every month," to review the care and support they received. Care plans and risk assessments were up to date. Other records showed health professionals, such as GP's visited when staff noticed any changes in people's health. Care and support provided was responsive to people's needs.

Is the service well-led?

Our findings

Systems were not effective to ensure the quality and safety of services. The provider completed regular audits on the standards of care achieved in the service and their scores indicated a high level of compliance. However, audits had not been fully effective at identifying shortfalls in the service. This was because audits had recorded fluid charts were added up, balanced and had been checked by a nurse. However, we found this had not been completed on the fluid charts we checked. Nor had audits identified creams and eye drops had been left unsecured. In addition, audits had not identified medicines prescribed for one person had been found in a different person's bedroom. Audits had also not identified that the provision of secure storage in people's rooms, had not been large enough to accommodate all their thickeners, prescribed creams or eye drops.

We also found a shortfall in the records made to assure the provider cleaning had been completed as expected. This was because we found a cleaning chart at 10.55am and it recorded that a bathroom had been cleaned both in the morning and afternoon of that day. This meant the record of cleaning completed was incorrect. Systems were not effective at identifying shortfalls in the quality and safety of services and records were not always accurate.

Systems to record people with diabetic diet needs were not effective. This was because not all records used in the kitchen identified accurately the people who required a diabetic diet. We spoke to the registered manager about this and they confirmed they would review the systems used to make them more effective.

Audits had not identified where the coverings on bedside bumpers had perished. Perished fabric coverings present a risk from infections as they cannot be effectively cleaned. We discussed this with the manager who confirmed they had audited all bedside rails and ordered new bedside bumpers for any that had been identified as requiring replacement.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Lodge is required to have a registered manager and a new registered manager was in place. Providers and registered managers have responsibilities to send in written notifications when required to tell us about any important changes, events or incidents at the service. We found that written notifications had been completed as required.

The registered manager was clear about the values of the services being offered. The service user guide contained details of the service' philosophy of care. This included a commitment to the provision of individualised care, privacy and dignity, support for people's aspirations and to work in partnership with people. Staff also told us they felt the registered manager was open and approachable. Staff members told us, "[Registered manager] is approachable," and, "[Registered manager] is an amazing manager; the best I've had; they are always fair and there for the staff." The service was being led with an open and approachable leadership style.

Staff told us they enjoyed working at the service, some of their comments included, "I adore working here," and, "I enjoy working with the service users and enjoy how we all interact." The registered manager was supported by a deputy manager. In addition, one of the provider's clinical support managers provided assistance to the registered manager with audits and service developments. We spoke with the clinical support manager who told us about planned developments to the service's conservatory. Resources were being made available to support the maintenance and development of this area and the registered manager was supported by motivated staff.

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 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	The principles of the MCA did not always inform people's care planning and the care and treatment provided by staff. 11 (1) (3)
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Medicines were not always managed or stored safely. Not all steps were taken to mitigate risks. 12 (b) (g)
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Systems and processes were not always effective at assessing, monitoring, improving and reducing risks. records were not always accurate and contemporaneous. 17 (a) (b) (c)
Treatment of disease, disorder or injury	