Mrs Balvinder Kaur Legah

Chestnut Lodge Residential Home

Inspection report

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Tel: 01215513035

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 November and 01 December 2016. After that inspection we received concerns in relation to the safety of the home and the areas of improvement that we had identified at our last inspection. As a result we undertook a focused inspection to look into those concerns and to assess the safety of the home. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chestnut Lodge Residential Home on our website at www.cqc.org.uk. At this inspection, we found that the registered provider had taken some action to improve the safety of the support people received, however the systems in place to ensure people were safe were not always robust and people did not always receive consistently safe support that was to their satisfaction.

The home is registered to provide personal care and accommodation for up to 15 older people. At the time of our inspection, there were ten people living at the home and four people having a respite stay at the home.

The registered provider had registered with the Care Quality Commission. The registered provider was not required to have a registered manager in place and they had chosen to manage the service as a 'registered person'. 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 and relatives told us that they were safe at the home. We observed that most people were at ease and comfortable around staff and others, although some people expressed a lack of confidence in the support they received from some staff.

Staff were not consistently able to fully explain how they would recognise and report safeguarding concerns to promote people's safety. We were informed that refresher safeguarding training had been planned to address this shortfall in staff knowledge.

People's risks were not consistently managed safely and care plans did not always equip staff with a full understanding of the people's individual risks and associated support needs. Incidents were not always addressed and investigated in line with the registered provider's processes. Opportunities were missed to help minimise risks and future reoccurrences of incidents.

People were supported by sufficient numbers of staff at the home. People were supported to access the support of other health professionals to address concerns and changes to their care.

Improvements had been made in respect of medicines management at the home and people received safe support with this aspect of their care. The registered provider was making ongoing improvements to the health and safety of the home and had ongoing plans to continue to improve the quality and safety of the support people received.

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 consistently safe.

People and relatives told us that they felt safe living at the home, although some people expressed dissatisfaction with some aspects of the service.

People's risks were not always monitored and managed safely over time. People were supported to access further healthcare support to address concerns and changes relating to their support needs.

People were supported by sufficient numbers of staff.

People were supported to take their medicines safely and as prescribed.

The registered provider had taken some steps to improve the quality and safety of the home, although systems and processes were not robust to achieve safe, consistent practice in line with people's needs.

Chestnut Lodge Residential Home

Detailed findings

Background to this inspection

We undertook an unannounced inspection of Chestnut Lodge Residential Home on 02 May 2017. The inspection was prompted in part by information of concern that we had received about the safety of people living at the home. We also assessed the registered provider's progress to address safety concerns identified at our last comprehensive inspection on 30 November and 01 December 2016. This inspection was conducted by one inspector. The team inspected the service against one of the five questions we ask about services: is the service Safe? We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

As part of our inspection, we reviewed the information we already held about the provider and information we had received from commissioners of the service. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During our visit, we spoke with four people living at the home about their care and observed the care of other people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection, we gathered feedback from four visiting professionals and four relatives of people living at the home. We spoke with three members of staff and the registered provider. We sampled three people's care records, two staff files and records maintained by the service about risk management, staffing and the quality and safety of people's care.

Requires Improvement

Is the service safe?

Our findings

People and relatives that we spoke with told us that people were safe and we observed that most people and relatives were at ease and relaxed at the home. One person told us that they had no worries at the home. Another person commented, "The carers are good, they look after us properly." A relative told us, "They are looking after [my relative] well. [My relative] seems better, happier in themselves... It's home from home and what [my relative] likes." A staff member told us, "People are safe… There are no worries here, I love this place and the residents."

Further improvement was required however to ensure that people living at the home could always be confident in the care and support they received and we received mixed feedback about this. Feedback we received informed us that five out of ten people lacked confidence with aspects of the support they received from some staff and we observed that staff did not consistently adopt a proactive, positive approach when providing support. One staff member we spoke with could not provide a clear explanation as to how they would recognise signs of abuse and act on safeguarding concerns. Two staff members who confirmed they had received training in this area demonstrated a clearer understanding of their responsibility to recognise and report safeguarding concerns. The registered provider told us that safeguarding training had been provided for most staff and was planned for all staff.

The registered provider ensured that people were supported to access healthcare support to promote their health and to address concerns or changes in respect of people's support needs. One visiting professional to the home told us that the service was, "Always very good, always very helpful." Our discussions with the registered provider and most staff showed that they were aware of the support people needed to manage their risks. We found however that care planning and guidance failed to direct safe and consistent care in line with people's needs and risks.
Guidance was not always available to support staff understanding of people's risks and to make clear the role staff had for monitoring people's risks over time. People's risk assessments were not always made relevant to the person to guide staff in terms of the person's preferences, risks, conditions and the specific actions required to help keep them safe and well. This was an issue that we had brought to the attention of the registered provider during our last comprehensive inspection. Our discussion with the registered provider showed that they recognised that this was an area of improvement for all care plans. This placed people at risk of receiving inconsistent care that did not meet their full needs.

Where one person's care records we sampled had provided clear guidance from a healthcare professional, we observed that these instructions were not followed in practice to help keep the person safe. This person received poor moving and handling support on two occasions and in the presence of the registered provider, who failed to challenge this unsafe practice. People's risks were not always managed safely and in line with their needs.

At our last inspection, we found that the registered provider had failed to monitor and report incidents to the appropriate authorities as necessary to help protect and ensure the safety of people living at the home. The registered provider had failed to take full action to prevent similar occurrences happening again in the

future and to help keep people safe. At this inspection, records demonstrated the registered provider's continued failure to report and investigate incidents in line with their own processes, although we identified some improvement and progress in this area. We could not be confident that the registered provider consistently took appropriate action to investigate and address incidents as planned to promote people's safety and to prevent the reoccurrences of such incidents in future.

Further improvement was required in respect of the environment to ensure that this was safe and suitable for people living at the home. A visiting professional we spoke with told us that they had raised concerns with the registered provider about the lack of space and privacy people had to move around the home safely and with ease. We brought our observations of this to the attention of the registered provider who told us that this would be addressed.
A relative told us, "The home is nice and clean." Staff had recently become responsible for conducting regular health and safety checks within the home and in relation to people's care. Our discussions with the registered provider showed that these recently introduced checks required further development to ensure that they were timely and robust. We found that the registered provider had recently arranged to have external guidance and consultation to continue their improvements in this area. We also found that some improvements had been made to fire safety checks at the home since our last inspection.

A person commented that there were enough staff at the home and told us, "If we fall, we've got the call buttons we can press and staff come." Call buttons were available at the home which people could use to seek assistance from staff. Our discussions with people, staff and relatives showed that they considered there to be enough staff at the home to meet people's needs. We observed that staff were often present in communal areas of the home. The registered provider told us that they had reduced staffing levels at the home recently in line with the corresponding needs and numbers of people living at the home. During our last inspection, the registered provider was able to demonstrate that people were protected by safe recruitment checks at the home to ensure that staff were suitable. Records were not available during our inspection to confirm that this practice continued for staff who had been recruited more recently.

At our last inspection, we identified concerns in respect of storage and record keeping of people's medicines. At this inspection, we identified improvements in this area. A person we spoke with told us that they received their medicines on time and we observed that this was done safely in practice. Staff we spoke with described how they supported people with their medicines as planned and prescribed. Staff had recently received training about safe medicines practice from the local pharmacist. An external audit of medicines management at the home had been conducted by this pharmacist four days in advance of our inspection. This had found that the registered provider was meeting requirements in respect of medicines management at the home. The registered provider told us that they had introduced internal monthly medicines audits as of March 2017 and that their audit at this time had also confirmed no errors or concerns. Records we sampled showed that staff guidance in relation to people's medicines support was clear. People were supported to take their medicines safely and as prescribed.