Mr S N Patel

Deer Lodge

Inspection report

22 Sandy Lane
Teddington
Middlesex
TW11 0DR

Tel: 02089433013

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We Inspected Deer Lodge residential care home on 28 August 2018. The inspection was unannounced which means the provider was not told that we were inspecting.

At the previous inspection of February 2016, the provider was meeting all the standards and was rated "Good". During this inspection we found that improvements needed to be made regarding the management of the service in order for it to be well-led.

Deer Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Deer Lodge provides accommodation and support with personal care for up to 14 older people, including people who are living with dementia. The home accommodates people over two floors, with common lounges and garden. At the time of inspection there were 12 people living in the home.

The service 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.

At the time of inspection the registered manager was on holiday and the home was being managed by the deputy manager.

At the previous inspection in February 2016 the provider and registered manager had expressed their plans on how to improve the service. These plans included the addition of a deputy manager, modernising the record keeping processes and developing staff training to go beyond basic mandatory training, better alignment of staff personal skills and interests with both their own professional development and introducing new activities with people.

During this inspection we found that there had not been much development in these areas and that this lack of development had contributed to the service not being as well-led as it could be. The role of deputy manager had been established and was working well with regard to ensuring care plans and other documentation was well managed. However, there was no clear boundary between the role of the registered manager and the role of the deputy manager which impacted on the management and supervision of staff and the team working between the Provider, registered manager and deputy.

Staff training was again managed well, but had not moved beyond the basic mandatory training, and there was still work to be done regarding monitoring staff professional development and how any training had had a positive impact on the care of people.

The quality assurance checks by the provider were carried out monthly, but were mainly cursory checks on areas of safety and speaking with the registered manager regarding staffing matters. The quality assurance system did not discuss any plan for the future development of the service, whether they related to any feedback from people who used the service or relatives, or review whether they were in line with the required standards.

The home's IT system was basic and did not enable the service to make use of IT for the benefit of staff or people living in the home.
Access to staff records was limited because of poor communication between the management team regarding the location of keys.

During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance. You can see what action we told the provider to take at the back of the full version of the report.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. People were familiar with the registered manager and deputy manager as well as the other staff. Staff had received training in safeguarding people from abuse and harm and the home had appropriate policies and procedures.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

There were enough staff on duty to care for people. The staff rota showed three care staff per shift with one waking night staff and one sleeping in staff. Staff had been trained to use specialised equipment, such as hoists, safely.

People told us that they were happy with the care they received and felt their needs had been met. People also told us that they could carry on with their day as they pleased. People had access to emergency call bells which were in easy reach of the person.

The provider ensured that people's independence and dignity was respected. People told us that they had been involved in making decisions and there was good communication between staff and themselves. We saw examples of positive interaction between staff and people which promoted choice and demonstrated good relationships.

Staff understood the requirements of the Mental Capacity Act 2005 and how to act in people's best interests. The management team had acted appropriately in respect of those who required a deprivation of liberty safeguards assessment and authorisation.

We saw that people's health, nutrition, fluids and weight were regularly monitored. There were well established links with GP services offering a single point of access for people.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences. Care records included details such as personal achievements, places visited and family relationships. Care plans and records had recently been updated.

Medicines were well managed, with designated staff having responsibility for medicines management and administration.

Staff told us that they felt supported by the management team. They were able to describe training they had received and how they were supervised.
The provider maintained regular contact with the registered manager to keep in touch with any issues at the home. The deputy manager was able to demonstrate sound knowledge and awareness of people's needs, and staff and people confirmed that they were regularly visible in the home and could be approached for help and support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People who lived at the home were protected from the risk of abuse happening to them.

People told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing.

There were clear policies and procedures in place relating to safeguarding and whistleblowing. Medicines were safely and securely stored in a locked medication cupboard.

Is the service effective?

Good

The service was effective.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

Staff received supervision and training, including training in the use of specialised equipment, such as hoists.

Staff understood the relevant requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences.

People's needs in respect of their age, disability, gender, race, religion and belief were understood by the staff and met in a caring way.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was reflected in their assessments and care plans.

People were enabled to maintain contact with family and friends.

The home had a complaints procedure that was understood by people. People told us felt confident that any problems or complaints that might arise would be dealt with by the management in a satisfactory way

Is the service well-led?

Requires Improvement

Some parts of the service were not always well-led.

Some aspects of the service were not fully developed, such as the roles of deputy manager and manager and duty officers.

Management plans to modernise the record keeping processes and develop staff training to go beyond basic mandatory training had not yet been completed.

A lack of communication between the management team had led to important records not being accessible.

People spoke positively about the management team, staff and culture of the home.

Deer Lodge

Detailed findings

Background to this inspection

We carried out this inspection of Deer Lodge residential care home 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 28 August 2018 and was unannounced. The inspection team consisted of one inspector.

Before the inspection we reviewed information we held about the service. We looked at notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern.

The provider was asked to complete a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with four people who used the service, three care staff, a volunteer worker and the deputy manager. We observed care and support being delivered in communal areas of the home and the interaction between staff and people.

We looked at the care files for four people using the service including care plans, risk assessments and care and treatment records. We reviewed the medicines administration procedures and looked at a sample of training records for staff. We saw examples of team meetings and checked various policies and procedures including adult safeguarding procedures. We reviewed quality assurance and monitoring systems at the service.

Good

Is the service safe?

Our findings

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the service and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. One person told us, "I can look after myself and would report anyone that gave me trouble." Another person said, "They're all very nice here but I would speak to [deputy manager] or [registered manager] if I was worried about anything."

We observed interaction between staff and people and saw that the behaviour between staff and people who lived in the home was mutually confident and friendly.

Staff were supported with information to guide them in the event of a safeguarding concern being identified. For example, we saw that the home had clear safeguarding policies and procedures which included whistle blowing procedures. Staff were knowledgeable about the different types of abuse and the signs which indicate abuse may have occurred.
Staff told us they had completed up to date training in safeguarding and records confirmed that training in safeguarding was a mandatory requirement in the home.

Risks to people's health, safety and welfare had been assessed and where appropriate a risk management plan had been put in place for aspects of people's care and support. Risk management plans covered aspects of care such as, nutrition, mobility and physical and emotional health and they formed part of the person's care plan.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible. Records showed that risks people faced were reviewed and updated on an ongoing basis.

People were free to move safely from one from one area of the home to another including an outdoor secured garden. The home was free of hazards and obstructions.

We saw that the entrances to the stairwells were clear and free from obstruction, which allowed full use of the stair lift chair. However, we recommend that the provider seek professional advice and carry out regular reviews of the second-floor stairways to ensure that people are not put at risk of falling accidentally.

The provider had a staff recruitment and selection policy and procedure. Recruitment procedures ensured that people were protected from having unsuitable staff working at the service. The recruitment process included details of previous employment, checks made under the Disclosure and Barring Scheme (DBS) and reference checks. DBS checks are checks which look at whether someone has criminal convictions which would bar them from working with vulnerable people. Staff confirmed that they had completed an application form, attended interview and underwent appropriate checks prior to starting work. This ensured staff were fit and suitable to work in a care setting.

There were enough staff on duty to care for people, with between two and three staff on duty at all times. The night care team consisted of one waking staff with one sleeping in staff. Staff could contact the manager on call if there was an emergency out of hours. We checked the staffing rota and found this reflected the staff on duty at the time of inspection.

Staff told us they had no concerns about care staffing levels but suggested that the recruitment of a domestic assistant would enable them to spend more time being with people. Care staff were required to ensure the cleanliness of the home as part of their responsibilities. These duties were included as part of the overall care hours, which meant that the numbers of staff on duty did not always reflect time actually spent with people or in monitoring their safety.

We recommend that the provider and registered manager review their staffing regularly to ensure that the number of care staff on duty can provide the care hours required to meet people's needs, and that staff involved in domestic duties are clearly stated on the staff roster.

Medicines, including controlled medicines were safely and securely stored in a locked medication cupboard. The medicines cabinet was locked and could only be accessed by a key which was held by the senior staff member on duty. There was a system in place for ordering and delivery of medicines in blister packs on a four-weekly basis by the local pharmacy. Medicines were disposed of safely with a system in place for counting, returning to the pharmacy and signing where medication needed to be disposed of. We observed medicines being administered and saw that this was done correctly.

Staff had been trained to use specialised equipment, such as hoists, safely. Specialist assessments had been completed in relation to complex moving and handling issues, for example, with the support of occupational therapists. This helped people and staff to feel reassured when using such equipment.

There were procedures and policies in place to control infection. We looked around the service and saw that all areas were clean and hygienic. Staff had received infection control training and records confirmed this.

Good

Is the service effective?

Our findings

People told us that they were happy with the care they received and felt their needs had been met. One person told us, "They are very helpful indeed. They come when I need them to and help me sort myself out." Another person said, "The staff are lovely. They always have a smile on their face and help you with getting around."

Staff told us they received sufficient training and felt very supported by the manager. We saw examples of training records which showed staff had received training in safeguarding, first aid, moving and handling, fire safety and dementia care.

Care staff confirmed they received supervision and on-going support through team meetings. Each shift had a "duty officer" who acted as shift leader.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made to the supervisory bodies at the time of the inspection, following a mental capacity assessment. Where DoLS had been authorised, the service was complying with any conditions applied to the authorisation. The service followed the requirements of the DoLS.

Staff we spoke with confirmed that they had attended MCA training and were able to tell us about the principles of the MCA, acting in people's best interests and how they applied these in their work with people. One staff member told us, "We are here to care for the residents. You have to ask them what they want and help them choose things."

Staff were aware of people's dietary needs and preferences. People could choose to eat in the main dining room or eat in their own rooms. A four-weekly menu was clearly displayed and staff once again offered choice at the time of the meal itself. People spoke positively of the quality of the meals.

Staff were knowledgeable about the needs of people who required support during mealtimes and supported people in a way that helped the person enjoy their meals. People's care plans and staff training records included references to the importance of nutrition and hydration. We saw that people's health, nutrition, fluids and weight were regularly monitored. There were well established links with GP services offering a single point of access for people.

Good

Is the service caring?

Our findings

People at the home were treated in a kind and compassionate manner which respected their privacy and afforded them dignity. One person told us, "They're very good. They're kept busy but always have a smile for you." Another person said, "I have no complaints. They help me when I need them and leave me alone when I don't."

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences. Each area of need, for example, mobility, or nutrition, was followed by a short description of what was required to support the person in a caring manner.

One staff member told us, "I have worked here for a long time and I feel I know the residents very well." Another staff member said, "I always try to think for the person and do things the way they want it done."

Staff gave people choices and respected their decisions. Throughout the day we saw that people had access to all communal parts of the home and their own rooms. Some people chose to spend time in their room, others chose to sit in quiet areas or move freely around the units. We observed staff carrying out regular checks on people who preferred to be alone and offered drinks and snacks. Staff ensured that people's call alarms were positioned close by for ease of access.

People told us they could choose how they spent their time during the day, what time they got up and went to bed. One person told us "I enjoy short bursts of company and then I like to get back to my room and my TV." Another person told us how they enjoyed reading in the morning and we saw that they had access to reading material.

Visitors were free to visit without undue restriction.

Staff respected people's dignity and privacy. For example; we saw people received personal care either in their own room or bathrooms with doors closed. During our inspection we observed how staff interacted with people who used the service and found it to be respectful and sensitive. For example, before entering a bedroom or bathroom, staff knocked and waited before opening the door. People and staff spoke together in friendly and respectful tones and staff responded promptly when asked a question and took time to explain their actions.

Good

Is the service responsive?

Our findings

The service responded to people's needs in a person-centred way.

We were told by people that the staff attend promptly when they rung the call bell during the day and night. We saw that people's requests for assistance throughout the day were responded to promptly.

People's needs were fully assessed prior to becoming resident in the home and at regular intervals thereafter. We looked at care records and saw that they contained assessments relating to weight, mobility, and healthcare including medicines, eating and drinking, behaviour and independence.

People said they could get up and go to bed at a time that suits them and were able to enjoy activities and interests that suited them. The home also supported people to maintain relationships with family, relatives and friends.

There was a programme of activities which included external visitors and entertainers such as musicians. Internal activities included games and exercise classes as well as ensuring people had access to music, books and newspapers.

The home's philosophy placed importance on ensuring that people who live at the home continued to lead as normal a life as they were able. Staff demonstrated a commitment to this philosophy by the way they spoke with and helped people and included them in the ordinary day to day life of the home and conversations about events, family life and the daily news.

The home had a complaints policy and procedure. The policy included timescales for responding to complaints and details of how people could escalate their complaint if they were not satisfied with the initial response from the service. People told us they knew how to complain if they needed to.

Care records contained information about the way people would like to be cared for at the end of their lives, if the person wished to discuss these matters and this included clear information about people's wishes in the event that they may need resuscitation.

Requires Improvement

Is the service well-led?

Our findings

Although the home was managed by a registered manager with the support of the deputy manager, it was not always as well-led as it could be.

For example, we found that there had not been much progress in areas identified for development two years previously by the registered manager, such as modernising the record keeping processes, developing staff training to go beyond basic mandatory training, better alignment of staff personal skills and interests with their own professional development, and introducing new activities with people.

A deputy manager had been in place for some time. However, there was no clear job role or boundary which described the respective roles of these two posts. This had an impact on the development of staff, for example in the areas of support, line management and supervision. Sometimes the registered manager would hold a supervision session with a member of staff, at other times she would delegate this to the deputy manager.

Similarly, the role of Duty Officer was given to certain members of staff which was based on their numbers of years of service rather than any particular qualification or skill, and there was no job description available for this role, since the Duty Officers were care workers at the same level as care workers who were not Duty Officers.

Staff training was managed well, but had not moved beyond the basic mandatory training, and there was still work to be done regarding how the provider monitored training and staff's professional development with a view to measuring how any training had had a positive impact on the care of people.

The quality assurance checks by the provider were carried out monthly, but were mainly cursory checks on areas of safety and speaking with the registered manager regarding staffing matters. The quality assurance system did not discuss any plan for the future development of the service, whether they related to any feedback from people who used the service or relatives, or review whether they were in line with the required standards.

The home's IT system was extremely basic and consisted of a shared laptop computer. The deputy manager was unable to describe how, or if, any data was backed up in case of emergency. Internet access for people in the home was not used in a proactive manner and did not enable the service to make use of IT for the benefit of staff or people living in the home.

Access to staff records was limited because of poor communication between the management team regarding the location of keys. The registered manager had gone on holiday and had mislaid keys to the cabinet which stored staff files. At the time of inspection the keys had been missing for over a week.

The lack of clarity between the job roles of the registered manager and deputy manager, the lack of clarity on the role of duty officer, the slow progress in moving beyond mandatory training, the basic nature of

monthly quality checks and the poor communication regarding the loss of a key to an important storage cabinet, indicated that the home was not as well-led as it could be.

The impact on the home was that it did not enable the provider to effectively assess, monitor and improve the quality and safety of the services provided in the home.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

On a more positive note people were very positive about the culture and atmosphere in the home. One person said, "I have been here for a long while and I love it." Another person told us, "The staff do their best to make us feel at home."

Staff told us that the deputy manager and registered manager were very approachable and that they could go to them with any queries. Staff had a good understanding of the ethos of the home and quality assurance processes were in place, together with policies and procedures that focussed on the rights of the individual person and were clearly written to enable staff to understand them and apply them.

There were regular quality assurance questionnaires sent to people and relatives and these were reviewed by the provider and registered manager.

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 The current management processes did not enable the provider to effectively assess, monitor and improve the quality and safety of the services provided in the home. (Regulation 17(1) and (2)(a)