DK Care Limited

Camber Lodge

Inspection report

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Camber
East Sussex
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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 25 October 2016, was unannounced and was undertaken by one inspector.

Camber Lodge provides accommodation and care for up to eight adults with learning disabilities. At the time of our inspection there were six people living in the home. There was a registered manager in post.

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 did not always receive care and support from sufficient numbers of staff. Staffing levels at night were not consistently sufficient to ensure that people received safe care.

People's did not aways have their risks assessed and care plans were not in place to mitigate known risks. People's plans of care had not been reviewed appropriately and were not reflective of their current care and support needs. However, staff knew people well and provided the care that they thought people needed.

Staff had not received all of the training required to equip them with the skills and competencies to provide safe care to people. A formal system of supervision had not been implemented and staff did not always receive the support that they required to work effectively in their role.

The provider had failed to implement an appropriate system of quality assurance audits in order to identify and address short falls in the service. When shortfalls had been identified timely action to rectify these was not always taken by the provider or registered manager.

People received their prescribed medicines safely and staff knew what action to take if they felt people were at risk of harm. Safe recruitment practices had been followed to ensure that the staff employed by the provider were of a suitable character to provide people with care and support.

People's health and well-being was monitored by staff and they were supported to access relevant health professionals in a timely manner when they needed to. People were supported to have sufficient amounts to eat and drink to help maintain their health and well-being.

People received care and support from staff that knew them well. Staff provided people with dignified care and support in line with their preferences. People were supported to pursue their interests and hobbies and partake in activities of their choice.

The registered manager was a visible role model in the home and motivated staff to provide person centred

care and support.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and one regulation of the Care Quality Commission (Registration) Regulations 2009. The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not sufficient numbers of staff to provide people with safe care and support.

Risks to people had not been assessed or appropriate documented plans of care implemented to mitigate the risks to people.

People were supported to take their medication as prescribed.

People were kept safe because the provider had systems in place to recognise and respond to allegations and incidents.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have access to appropriate training to equip them with the skills and competencies that they required to provide safe care and support.

There were procedures in place to ensure the Mental Capacity Act was fully implemented and where possible people provided consent for their care.

People were supported to maintain adequate nutrition.

Is the service caring?

Good

The service was caring.

People were supported to make choices about their care and staff respected people's preferences.

People were always treated with respect and dignity.

People, or their representatives, were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual plans of care were not always person centred or reflective of their current care and support needs.

People were supported to complete activities of their choice that reflected their personal preferences and interests.

There was a system in place to manage and respond to complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were not in place to monitor the quality of the service. Shortfalls were not being identified or addressed appropriately.

The provider had failed to submit the appropriate statutory notifications to the Care Quality Commission.

The registered manager was approachable and was a visible role model in the service.

Camber 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 took place on 25 October 2016 and was unannounced. The inspection was undertaken by one inspector.

Before the inspection we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR) which we reviewed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with four people living in the home and four members of staff including the registered manager of the service.

We spent time observing the care that people living in the service received to help us understand the experiences of people living in the home. We reviewed the care records of three people and the recruitment records for three members of staff. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that sufficient numbers of staff would be available to provide care and support to them in a safe way. A number of people living within the home required support with their mobility and one person had been assessed as requiring support from two members of staff with moving and handling because they were cared for in bed. The registered manager had assessed the need for two members of staff to be deployed at night in order to provide people with their care and support safely. However, we found a number of occasions when only one member of staff was working at night. This meant that there was a risk people would receive care and support that was unsafe. People could not always be assured that there were sufficient numbers of staff available to support them with their moving and handling needs safely or to respond to their care needs at night. We raised this with the registered manager who told us that they would ensure that two staff were deployed to provide people with their care at night with immediate effect.

The failure to consistently provide a sufficient number of staff to provide people with their care safely at night constituted a breach of Regulation 18 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

The provider did not have sufficient systems in place to assess the risks to people or implement guidance for staff to follow in order to mitigate these risks. Although people received care from staff that were knowledgeable about providing care and had adapted care to meet people's needs there were no reliable systems in place to formally assess people's risks. For example one person was cared for in bed, staff told us that they supported this person to reposition every two hours to protect their skin from pressure ulcers. However; this person did not have any form of assessment in relation to the risks associated with them developing pressure ulcers or plan of care to mitigate the risks associated with their skin integrity. One persons' moving and handling risk assessment showed that they required support from one member of staff to transfer. However, staff told us that this persons' needs had changed and they now required support from two staff with the help of a stand aid to transfer; their risk assessment had not been reviewed and the care plan did not reflect their current needs. Another person had a risk assessment in place providing guidance to staff on the actions to take to support them in the event that they had a seizure. The risk assessment stated that staff should administer an emergency medicine to manage the symptoms of a seizure however, this person was no longer prescribed any emergency medicine for staff to administer. People were at risk of not receiving care that met their needs as risk assessments and care plans did not always provide adequate direction for staff to mitigate the risks associated with changing needs.

The failure to implement a system to regularly assess people's risks and to ensure that adequate and consistent control measures and guidance for staff was implemented constituted a breach of regulation. This was a breach of Regulation 12 (1)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

People received their medicines as prescribed and were protected by the safe management of medicines. One person told us "I always get my tablets from the staff, they give them to me every day." Another person told us "The staff tell me what medicines I'm having and give them to me." We observed staff administering

medicines, the member of staff checked each individuals Medication Administration Record (MAR) sheet before dispensing medication and ensured that people received the right medicines at the right time. Staff told us and records confirmed that staff had received annual training in relation to the safe administration of medicines. Medicines were stored safely and records in relation to the storage and administration of people's medicines were accurate and audited regularly.

Staff were knowledgeable about the steps to take if they felt people were at risk. All staff had received training in how to safeguard people from harm and were confident in applying the learning from this training. One member of staff told us "If anyone was ever at risk here I'd report it straight to the manager or the provider. If I had to I could tell the Council or CQC too."

Appropriate recruitment practices were in place to ensure that staff were of a suitable character to provide people with care and support. Records showed the appropriate checks and references were in place. These included two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring checks on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that they would receive care and support from staff that had received all of the appropriate training they required to enable them to work effectively in their role. We found examples of staff administering insulin to one person in the home for diabetes without having their competency to administer insulin assessed by an appropriate healthcare professional. The administration of insulin to manage people's diabetes is a task that requires the formal delegation of duty from a nurse or suitably qualified medical practitioner. Staff had not had their ability to administer this medicine assessed and the provider had not ensured that staff administering this medicine were competent to do so. We addressed this with the registered manager of the home who made contact with this person's GP in order to arrange for District Nurses to administer this person's insulin until staff had been assessed as competent to do so by an appropriately trained clinician.

There were no systems in place to enable staff to access formal supervision. The registered manager regularly worked on shift within the home and told us that she provided supervision to staff on a day to day "on task" basis. The registered manager told us that she operated an "open door policy" and encouraged staff to approach them at any time to raise any issues or queries that they may have. Staff gave us mixed feedback in relation to how supported they felt in their role. One member of staff told us "The manager is always available and is very supportive. I'd feel able to approach her at any time." However, another member of staff told us "The manager is always about but we don't have supervisions so don't have a proper way to raise any issues or to discuss problems. Having a time to have supervision would be useful." We brought the lack of formal supervision to the attention of the registered manager who told us that they would introduce a system of formal supervision.

This is a breach of Regulation 18 (2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

Staff had received training in other areas that was relevant to their role such as nutrition, pressure area care, moving and handling, safeguarding and medicines. Training records showed that staff had accessed training regular basis and that the provider had a plan in place to ensure that people's training was updated periodically. Staff were able to describe how they applied their training on a day to day basis. For example one member of staff said "I think that the training here is good. We get plenty of training, like epilepsy training. I didn't know all of the signs and different types of seizures before but I am more vigilant now."

People were able to choose their meals and to help prepare them if they wanted to. One person told us "The food is nice here. They ask us what we like and we make that." People had a menu available within the dining room showing the planned meals for the week. People had access at any time to snacks and drinks within the home. Staff were aware of people's dietary needs and food intolerances and ensured that appropriate meals were provided.

People at risk of not eating or drinking enough had been assessed and actions taken to address this risk. Staff referred people to their GP and dietician for further guidance when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate

food and drink safely. For example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed or thickened their drinks to help prevent choking.

During this inspection we saw that people were asked to give consent for their care and support and staff were knowledgeable about their responsibilities in relation to the Mental Capacity Act 2005. 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 application 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. We found that the manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking capacity to be able to consent to their care.

People had regular access to healthcare professionals and staff were vigilant to people's changing health needs. One person said "When I am ill, they take me to the doctor." Staff liaised closely with people's GPs and reported any changes in their health or wellbeing in a timely manner to ensure that appropriate medical intervention was provided. For example, staff had arranged a home visit by one person's allocated GP because they had noted that they were unwell.

Good

Is the service caring?

Our findings

People had developed positive relationships with staff. People knew staff well and were treated with respect and compassion. One person told us "The staff are nice. We go out together and do jigsaws. We have a laugh." People were relaxed in the company of staff and had developed positive caring relationships.

People were encouraged to express their views about the home and make choices about their day to day care. We observed staff interacting with one person who was unable to communicate verbally; staff supported them to make choices about what they would like to wear, eat and drink by using objects of reference and showing them a number of choices and encouraged them to point at the option they wanted. Another person was in the process of having their bedroom decorated, they told us "I'm having new carpet next week. It's my favourite colour. We chose it on the internet together."

People were encouraged to make decisions about their care and their day to day routines and preferences. One person told us that they were encouraged to choose what they would like to do in the day. One person was cared for in bed, staff ensured they spent time interacting with them in their room, one member of staff told us "We sit with [person] even if its just to watch television together or talk about their bear." We also observed staff asking people whether they required any help throughout the day and encouraging people to choose the activities and trips they would like.

People were able to choose where they spent their time. Some people enjoyed spending time in the communal areas of the home and other people preferred to remain in their rooms. One person told us "I like watching TV but sometimes prefer to watch it on my own in my room." People who had chosen to spend time in their rooms told us that this was their choice and said the care staff respected their decision. People's bedrooms had been personalised with people's own belongings, such as photographs, ornaments and mementos to help people create their own personal space.

Staff knew people well and were able to tell describe people's life histories, preferences and dislikes and used this information to tailor the care and support that they provided to people. For example, staff told us that one person enjoyed knitting and showed us photographs of a Christmas scene that they had supported the person to knit. Staff continued to support them to make a patchwork blanket using lots of different colours. This person told us "The staff are helping me to knit a blanket for my bed."

People's dignity and privacy was supported by care staff; we observed that staff ensured that people's bedroom doors were closed when providing care. Staff understood the need to maintain confidentiality, we saw that staff ensured conversations about people's care and support took place where others would not overhear.

The registered manager had links with local advocacy services. An advocate is an independent person who is not connected with the home but who can support people to express their views. The staff in the home knew how to contact the advocacy services if an individual required support to make choices about their lives or to express their wishes about their care. At the time of our inspection there was nobody who

required the services of an advocate to act on their behalf.

Requires Improvement

Is the service responsive?

Our findings

Staff provided people with person centred care and support in line with their preferences. However, systems had not been implemented to provide guidance for staff on meetings people's assessed care needs in a consistent way. Although staff knew people well and people received care and support according to their preferences, people's plans of care had not been updated to reflect their current care and support needs.

The information contained within people's individual plans of care was inconsistent and was not always sufficiently detailed to enable people to receive consistently personalised care and support. Some documentation gave good descriptions of how people should be supported and were clear in instructing of how staff should respond to people in particular situations. However, other care plans lacked detail and were not person centred. For example, one person had episodes of behaviour that challenged others; their care plans stated that staff should be aware of the triggers that caused challenging behaviour to avoid further instances. However, this person's care plan did not describe what the triggers were; we found that staff relied upon their personal experiences of supporting this person, which differed between each member of staff, and staff provided care based on these experiences. This meant that staff did not provide consistent care as there was no record of the person's triggers.

People's individual care plans were not reflective of their current care and support needs. One member of staff told us "People have lived here for a long time and their needs have changed. Their care plans haven't changed to reflect that though." Another member of staff told us "We learn what care people need by supporting them. I'm guided by my experience because the care plans are out of date."

One person's care needs had changed, they required two members of staff to provide all mobility and personal care. Staff were providing what they believed was best to support their needs.There was no personalised plan of care available that reflected this person's needs to ensure that care was provided consistently. Staff told us the person enjoyed the view from their bedroom window and they moved their bed during the day so that they could look out of the window. This information was not present within the person's care plans to direct staff to provide this support consistently. We raised this with the registered manager who told us that she would review people's plans of care and ensure that these were updated to reflect people's current care and support needs.

The lack of sufficiently detailed guidance for staff or care plans meant that people were not not consistently receiving care that was appropriate to meet their needs and reflect their personal preferences. This is a breach of Regulation 17 (2)(c) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to moving into the home to make sure that their care and support needs could be met effectively. During this inspection the registered manager met with one person who was interested in moving into the home to provide them with a tour of the service. The registered manager told us that prior to any person moving into the home they would visit them at their current home in order to complete a full assessment of their care and support needs. This was to ensure that these needs could be met by the staff working in the home and that the person was compatible with the people already living at

Camber Lodge.

People were supported to take part in a range of activities according to their individual preferences. We observed people taking part in a cooking activity and choosing to partake in trips into the community. People were encouraged to help plan and provide feedback about the activities available in the home. There was a schedule of activities on display in the home and people were able to suggest additional activities to those shown on the planned schedule.

People knew how to make a complaint and had confidence that if they did complain this would be managed appropriately. There had not been any complaints received. The registered manager was aware of the provider's policy in relation to managing complaints and encouraged people and their relatives to provide feedback about the home.

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to ensure that the appropriate notifications of incidents such as safeguarding and notifications of authorisation to deprive an individual of their liberty were made to the Care Quality Commission (CQC). We found examples where the provider had received authorisations to deprive an individual of their liberty however, had not submitted the appropriate statutory notification to CQC.

This is a breach of Regulation 18 (2) (b) (e) of the of the Care Quality Commission (Registration) Regulations 2009 (Part 4), Notification of other incidents.

There was insufficient monitoring of the quality of the service. The provider and registered manager had completed a range of audits however, they were not effective at identifying or addressing shortfalls. People's risk assessments and individual plans of care were not reflective of their current care and support needs. The providers care planning audit completed in August 2016 had failed to identify that people's care plans were not accurate and that this posed a risk of people receiving inconsistent care and support. The provider's medicines audit completed in June 2016 had failed to identify that staff responsible for the administration of insulin had not had their competency assessed to ensure that they had the skills to administer this medicine safely.

Where the registered manager had identified shortfalls in audits action had not been taken quickly enough to address these to protect people from potential harm. For example we found a radiator in one person's bedroom which had been pulled and was hanging loose from the wall. This person mobilised on their hands and knees on the floor and pulled objects to help them move. The registered manager told us that they were aware of the damage to this person's radiator however; they had not ensured that it was repaired or made safe in a timely manner. The radiator posed a risk to this person because there was a risk that it may fall on them. We asked the registered manager to take urgent action to ensure that it was repaired.

We also found examples whereby the fire doors to people's rooms and communal areas were kept open by devices that were designed to activate and close these doors in the event of the fire alarm sounding. We observed that two of these devices were not working and that staff had resorted to using wedges to keep fire doors open. The provider's environmental audit had failed to identify these shortfalls.

This is a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

The registered manager was visible within the service and staff told us that they were approachable and motivated to provide people with personalised care and support. One member of staff told us "We can approach the manager at any time and they will always listen to us." Staff meetings took place to inform staff of any developments to the service and for staff to contribute their views on how the service was being run. Staff meetings had focussed upon the individuals receiving care and support and reinforced a positive person centred ethos. Staff meetings supported staff in enabling people to achieve their individual goals and aspirations.

Policies and procedures to guide staff were in place and had been updated when required. Staff demonstrated a good understanding of policies which underpinned their job role such as safeguarding people and confidentiality.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to submit the appropriate statutory notifications to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not implemented a system to assess the risk to people living in the home and to ensure that adequate steps were taken to mitigate the risks to people. (12 1a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans and guidance lacked sufficient detail to ensure people were receiving care and treatment appropriate to meet their needs and reflect their personal preferences. (172c) The provider had failed to implement an effective system of audits to assess, monitor and improve the quality and safety of care and support provided to people. (17 - 1 and 2a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed at night to provide people with their care safely. (18 1)

Staff had not accessed appropriate training or had their competency to administer insulin assessed by an appropriately qualified clinician. (18 2a)

Staff did not have access to appropriate supervision to support them to work effectively in their role. (18 2a)