Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 6 April 2016. Breaches of legal requirements were found. We issued warning notices to the registered provider for the breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment and Good governance.

We undertook this focused inspection on 2 August 2016 to confirm that the provider had met the requirements of the warning notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eden Lodge Residential Care Home on our website at www.cqc.org.uk.

The inspection was unannounced. Eden Lodge Residential Care Home provides accommodation for up to 60 older people. On the day of our inspection 22 people were using the service. This was because the provider is only currently using one section of the service.

The service had a registered manager in place at the time of our 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. There was a manager in post and they had submitted an application to register with us.

Although people felt safe in the service, people were not always protected from risks in relation to their care and support and medicines were not always managed safely. Information was shared with the local authority safeguarding vulnerable adult's team when needed and safe recruitment practices had been implemented.

Governance processes had been implemented and although this was identifying issues and leading to improvements, the issues we found had not all been identified. People felt the registered manager was approachable.

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?

Requires Improvement

The service was not always safe.

People felt safe in the service and knew who to speak with if they had any concerns. However, risks in relation to their care were not always assessed and planned for appropriately.

Medicines were not always managed safely.

People were supported by staff who were suitable to support them as safe recruitment processes had been implemented.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor and improve the service had been implemented and this was bringing about some improvements in the service. However the issues we found had not been identified by the systems in place to monitor the service.

The management team were approachable and people were involved in giving their views on how the service was run.

Eden Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out an unannounced focused inspection of Eden Lodge Residential Care Home on 2 August 2016. This inspection was undertaken to check that the improvements to meet legal requirements planned by the provider after our 6 April 2016 inspection had been made.

The team inspected the service against two of the five questions we ask about services: is the service safe and well led. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with six people who used the service. Some people who used the service lived with a dementia related illness and were not able to share their views with us so we also relied on observations and spoke with the relatives of two people who used the service.

We spoke with three members of support staff, the cook, the deputy manager, the registered manager and the registered provider. We looked at the care records of five people who used the service, medicines records of fifteen people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the manager.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 6 April 2016 we found there were improvements needed to ensure people received their medicines as prescribed and in relation to the way medicines were managed. We told the provider they must make these improvements by 26 May 2016.

During this visit we found some improvements had been made but there were further improvements needed. We saw the registered manager had implemented systems to audit the medicines to ensure people were receiving their medicines and that they were stored safely. We found that in general people were receiving their medicines as prescribed, however on the day of our visit we observed one person was not supported to have a medicine prescribed to help with their breathing.

This person had a health condition. We observed they appeared to be unwell and suffering some discomfort and distress. Staff checked on the person frequently and offered regular drinks, all of which the person refused. We asked the deputy manager about this and they informed us that the person did not seem well but had seen the doctor recently. The deputy manager told us that they would arrange for the doctor to visit again. We looked at this person's care plan which showed that they had a health condition for which they were prescribed 'as required' medicines; however there was no guidance telling staff when to give this medicine. We observed this person throughout the morning and they were not offered this until at 11.45am when we intervened to recommend that the person was given their medicine. After the person had their medicine they appeared more comfortable, less distressed and immediately had a large drink. This person should have been offered their medication sooner to relieve their distress and discomfort. The person's GP visited in the afternoon and confirmed that the person had an infection, which was a known risk in relation to their health condition.

The last time we inspected we had concerns about one person who was taking a certain medicine which required them to avoid certain food. We were concerned that the cook did not know about this. Following the inspection the registered manager put in place information for the cook to ensure they knew to avoid this food but when we spoke with the cook they again said they were unsure of what food the person needed to avoid. Additionally eight people who used the service had risks in relation to a health condition which needed to be managed by their diet. Staff had received training in relation to this condition since we last inspected but again the cook displayed a lack of understanding of how to support these people with their diet. This posed a risk that people would not be given a diet which was appropriate to their health conditions.

We looked at the medicines systems and we saw the registered manager had put in place audits to assess if medicines were being administered as prescribed and were managed safely. However we found staff were not always following safe practice in relation to medicines and were not always recording medicines administration appropriately. We saw the medicines of four people had not been signed for on one occasion. Some people were on medicines which were to be given as required, when the person displayed symptoms such as pain or behaviour which might challenge staff or may present a risk to other people. There was a lack of protocols in place for three people which would inform staff of when they should

administer these medicines. This meant there was a risk people may not be given their medicines when they needed them.

Additionally, records were being kept of the temperature of the fridge containing medicine and we saw that on four occasions the temperature of the fridge had risen above the recommended safe temperature for medicines. No action had been taken to seek advice from the pharmacy to make sure the medicines would still be effective.

We saw staff were following safe protocol in relation to keeping a tally of boxed medicines which created an audit trail for the registered manager to assess. They were also ensuring any handwritten entries were signed and witnessed to reduce the risk of errors and were ensuring medicines bottles were dated upon opening to ensure they were kept within their shelf life. Staff had received training in the safe management of medicines since we last inspected. The registered manager was carrying out observations of staff and was in the process of commencing formal competency assessments to ensure staff were following safe practice.

When we inspected the service on 6 April 2016 we found there were improvements needed to ensure people received safe care and treatment in relation to how risks to their health and wellbeing were managed. We told the provider they must make these improvements by 26 May 2016.

When we visited on 2 August 2016 we found that the registered manager had been working to implement new care plans for people who used the service which included new risk assessments and details of how staff should care for people. However we found that there were still risks in relation to the care of some people and these had not been properly assessed or planned for.

The last time we inspected the service we had concerns about the risk in relation to one person who had been assessed by the Speech and Language Therapy Team (SALT team) as being at risk of aspirating fluids and needed to have a thickening agent in their drinks to a 'syrup consistency'. We had found this was not always adhered to by staff and the person was placed at risk of choking on their drinks. We observed the care given to this person again at this inspection and found that although the register manager had implemented a care plan for this risk, staff were not always adhering to it. The care plan stated that one scoop of thickening agent needed to be added to 200ml of fluid. We observed the person being given a drink and the drink was not of the consistency detailed in the care plan. We spoke with staff about this and there was a lack of understanding of what the consistency should be. This meant the person was still being placed at risk of aspirating fluid.

Additionally the last time we inspected the service the SALT team had placed this person on a special diet which needed to be a soft diet due to their risk of choking. During this inspection we observed the person was not given the soft diet and when we spoke with staff they told us the person was much better now and did not need the soft diet. However, the SALT team had not been contacted to ensure the person was appropriately assessed to see if they were safe to eat a diet which was not soft. This meant the person was placed at risk of choking. In order to keep this person safe we ensured the deputy manager contacted the SALT team whilst we were in the service and asked for a re-assessment of this person and we ensured the soft diet was re-instated until the assessment was carried out.

This person was also at risk of retaining urine and we had concerns about the way this was monitored the last time we inspected. This time when we visited we saw the registered manager had put in place a risk assessment and care plan and had implemented charts to monitor the persons fluid intake and output. However staff were not tallying the amount of fluids and so there was no analysis of whether the person was retaining any fluid.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people felt there were enough staff working in the service to provide them with support, the provider did not have contingency systems in place to ensure that people were provided with appropriate support from staff in the event of an emergency. We received information that one person had been admitted to hospital in an emergency situation and due to staffing levels the service had been unable to provide a member of staff to accompany the person. We saw in the person's care plan that they had a fear of hospitals which had in the past led to the person using their behaviour to communicate. The person also had an assessment in their care plan which stated they would not be safe to be outside of the service alone due to a lack of understanding of risk. This had caused undue distress and suffering and had also put the person and staff working at the hospital at risk.

Some areas of the service had malodour during the morning of our visit. We found the source of this odour was from plastic pressure ulcer prevention mattresses in the rooms of some people. We spoke with the housekeeper who told us the mattresses were cleaned when beds were changed or more frequently if needed. However the mattresses were not included on the cleaning schedules so it was unclear how frequently the mattresses were cleaned.

People we spoke with told us they felt safe in the service and would feel comfortable raising concerns if they needed to. One person told us, "I just always feel safe." Relatives we spoke with also told us they felt their relation was safe in the service. One relative told us, "The staff are first class they're faultless, never seen such patience."

Staff we spoke with were aware of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the registered manager and escalating concerns to external agencies if needed. One member of staff told us "I would mention it to the senior, chat to the person, take it on board and tell the manager. Another member of staff said "I would report any abuse to the senior or I would go to the next level if I needed to." We saw the registered manager had shared information with the local authority when required. This meant there were systems in place to protect people from the risk of abuse.

We saw that recommendations which had been made by a community nursing team for one person who had been assessed as high risk of falling and injuring themselves had now been adhered to. This included regular checks of the person and equipment put in place which reduced the risk of the person falling and injuring themselves.

Risks in relation to people developing a pressure ulcer had been properly assessed and planned for to reduce the risk of pressure ulcers developing. Two people who used the service were at risk of developing pressure ulcers and this was being regularly assessed and steps taken to reduce the risk, such as supporting them to reposition regularly.

During our last inspection we found that where people communicated with their behaviours staff did not always have a good understanding of how to support people in the least restrictive way possible and this was not clearly detailed in care plans. We told the provider to make changes in this area to ensure people's rights were protected.

During this visit we saw that information about people's behaviours, triggers and how staff should respond had been added to people's care plans. Staff we spoke with had a good understanding of how to support people in the least restrictive way possible. We observed improvements to the way one person was

supported and this was having a clear impact on the person's wellbeing. This person spent more time in communal areas socialising with others and staff we spoke with told us that there were fewer occasions of potentially risky behaviours. Staff were recording occurrences of behaviour and this confirmed that that there were fewer instances of the person using their behaviours to communicate. We discussed with the registered manager the need to specify that any medicines prescribed for this type of behaviour should include instructions for staff that the medicines were a last resort if other less restrictive interventions failed and she agreed this would be included.

When we inspected the service on 6 April 2016 we found there were improvements needed to ensure people were kept safe from staff who may not be suitable to care for them. We gave the provider a deadline of 20 June 2016 to make these improvements.

When we visited on 2 August 2016 we found that the registered manager had taken steps to protect people from staff who may not be fit and safe to support them. A System had been implemented to ensure all checks were carried out before staff were employed in the service. We looked at the records of staff employed since we last inspected the service and saw the registered manager had carried out all the required checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

The recruitment files for all staff had been checked to determine if the required checks had been made and the files had been organised so that it was easier for the registered manager to produce evidence of the checks being carried out. This meant the required steps had been taken to protect people from staff who may not be fit and safe to support them.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service on 6 April 2016 we found there were improvements needed to the systems in place to monitor the quality of the service and ensure people received safe care. We gave the provider a deadline of 20 June 2016 to make these improvements.

When we visited on 2 August 2016 we found there had been some improvements but more improvements were needed. We discussed this with the registered manager and the registered provider. They told us they had recognised there were more improvements needed in the service and they were in the process of engaging external agencies to get support and advice on areas such as care planning. The registered manager told us, "I'm here to get people a better quality of life and a better service."

The registered manager had implemented systems and processes to monitor and improve the quality of the service; however these were still not always effective in identifying areas for improvement. The newly implemented systems included a range of new audits which covered areas such as infection control, care planning and staff training and any issues that were identified had actions to improve. However these audits had not picked up all issues identified during our inspection such as missing information in care plans or a lack of effective risk management for some people.

The registered manager had implemented a new system for reviewing and analysing accidents and incidents however when patterns were identified, actions taken to reduce the likelihood of future incidents were not clearly recorded. For example one person had suffered two recent falls and although these incidents had been audited by the registered manager actions taken were not recorded. We spoke to the registered manager about this who informed us that action had been taken to reduce the likelihood for future accidents and we saw records in the person's care plan that external health professionals had been consulted. The registered manager informed us that they would be improving their audit of accidents and incidents to clearly show what action had been taken when patterns had been identified.

Since our last inspection a monthly audit had also been implemented for the registered provider to complete and this looked at the same areas as the registered manager was assessing. This audit had been effective in identifying some issues that we had picked up on our inspection, for example we identified a maintenance issue and saw that this had also been picked up by the providers audit and a note had been left for the maintenance person. The providers audit had also picked up the concern about the lack of protocols for 'as required' medications. However the issues we found in relation to care planning had not been identified and so the systems were still not robust.

During our last inspection water temperatures were above the recommended level which put people at risk of scalding. We told the provider they must make improvements. During this visit we saw that some improvements had been made in this area but further improvements were still needed. Records showed that some water temperatures were still above the recommended level. We talked to the registered manager about this who told us that they check the water temperature records on a weekly basis and then get an external contractor to bring the water temperatures back into a safe range. However we saw that the

registered manager had not audited the water temperatures for two weeks, no action had been taken which meant people may be at risk of scalding.

During our last inspection we found that clear records were not kept, for example in relation to when people had been offered or given a bath or shower. We told the provider to make improvements in this area. During this visit we found that although a bath and shower rota had been put in place it had not been fully completed by staff. For example there was no record of one person having had a bath or shower for over three weeks. Staff we spoke with told us that people normally got a bath or shower weekly, but sometimes they forgot to record this. This meant there was still a risk that people may miss their weekly bath or shower without staff knowing.

We saw that improvements had been made to some of the care plans and records had been implemented for more areas of care and support. However the care plans were still complex and hard to navigate and we found that important information was not always easily accessible. We spoke to a visiting health professional who told us it was sometimes difficult to find information in care plans. Staff we spoke with told us that they did not always refer to the care plans intended to guide them in supporting people. A recently recruited member of staff told us they had not read any care plans and relied on learning from other members of staff. Another member of staff told us "I've not had time to look at all the new care plans yet."

Staff we spoke with felt that their main challenge was too much paperwork which had an impact on the amount of time they got to spend with people using the service. We saw that record keeping was complex with some records being duplicated and this would cause unnecessary record keeping for staff. For example one person had a fluid intake and output chart in place and staff were recording fluid intake on this and were also recording the same information on another chart for fluid intake. We spoke with a visiting professional and they told us they often found staff in the dining room completing records. This meant the systems in place for record keeping was complex for staff and taking them away from supporting people who used the service.

This was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager had notified us of some events in the service, they had failed to notify us of some safeguarding incidents within the service. A notification is information about important events which the provider is required to send us by law. We spoke with the registered manager about this and they assured us that they were now aware of their responsibilities to notify us of these incidents.

During our last inspection we found that there were no systems in place to protect people from the risk of legionella. Legionella is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. We told the provider to take action to protect people from this risk to their health. During this visit we saw that improvements had been made in this area. We saw records that infrequently used taps were flushed regularly. The registered manager told us that shower heads were deep cleaned regularly, however this was not clearly recorded. We discussed this with the registered manager who told us that they would take action to ensure that this was clearly recorded.

People who used the service and relatives told us they felt the registered manager was approachable and listened to them. One person told us, "You can make a comment to the Manager and they will usually sort it out." Another told us, "Mostly everything runs smoothly, it's (any issues) usually taken up by management and people in charge." A relative told us, "I wouldn't change anything it's a well-run home, well looked after and well managed. I've never had any concerns about anything." Another relative told us, "The owner

checks things are all right and speaks to us."

People who used the service and their relatives were supported to have a say in what happened in the service. We saw that regular meetings were being held for people who used the service and their relatives. One relative told us, "I don't go to residents meetings because everything I think is already happening I visit every day so I know exactly what's happening and how it's happening." The registered manager had also nominated a volunteer to be a 'family link person' to be a representative for people who used the service and their relatives, discussing their wishes and liaising between staff and management to build communication links.

Staff we spoke with felt supported by the management team and felt there had been improvements in the service. All of the staff we spoke with told us they felt they could approach the registered manager and one member of staff told us, "I get good support and I am treated fairly." Staff had a clear understanding of the management structure and told us that they would go to the senior staff in the absence of the registered manager. Both the care staff we spoke with told us they would feel comfortable whistleblowing on poor practice. One member of staff told us, "If I saw anything I would tell [the registered manager] and she would do something." Staff we spoke with said that they had noticed some improvements since the previous inspection. The housekeeper told us, "Things are logged better and staff work together better." Another member of staff we spoke with said, "the paperwork is now up to date, the bathrooms have been refurbished and the atmosphere has changed slightly."

People were supported by staff who got regular supervision and support. One member of staff told us, "Yes I get supervision and appraisal. We talk about concerns with residents and other staff, problems and my goals." Another member of staff we spoke with had not been working at the service long and so had not yet had supervision but felt that they could go to the registered manager if they needed anything.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable care because of inadequate systems to assess the quality of the service. Regulation 17 (1) (2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care and treatment was not being provided in a safe way for service users. Regulation 12 (1)(2)(a)(b)(g).