Chelcare Limited

Doddington Lodge

Inspection report

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14 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6, 7 and 14 September 2017 and was unannounced.

At this inspection, we found the registered provider was in breach of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we identified during the last inspection. These shortfalls in the service are described throughout all sections of this report.

Doddington Lodge provides accommodation and personal care for up to 41 people, some of whom are living with dementia. At the time of our inspection, there were 30 people living at the home.

There was not 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 and associated regulations about how the service is run.

People were exposed to harm, both in terms of their physical environment as well as the care they received. Action had not been taken to address areas that required it which placed people at risk of injury and harm. A fire escape route identified as being obstructed did not get cleared at the time it was identified. People remained without hot water for over two months with no clear plan in place to remedy the situation.

People's risk assessments were not followed, which resulted in unsafe care and treatment. People's skin health was compromised due to guidance not being followed. The provider had not taken action where risks had been identified by staff and brought to their attention.

People's nutritional dietary needs were not always identified or followed and people were not provided with the support they needed to eat and drink enough. People were at risk of malnutrition and of dehydration with people's needs and abilities not routinely reviewed.

Complaints were not always appropriately responded to and lessons were not learnt

People were not always treated with dignity and respect. Care did not always centre on people as individuals. People's care reviews were not completed and people's preferences were not known by staff.

People were unable to enjoy their individual hobbies and interests. Staff were not always available to support people with the things they enjoyed doing. Professional and medical guidance was not followed, which meant people's health needs were not always met.

There was no effective governance and oversight of the service. The provider and the manager did not have understanding of where they were failing to meet people's needs. The provider had not identified the concerns we highlighted during the course of our inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

Some equipment was unsafe and placed exposed people to harm and risk of injury from an unsafe and hazardous environment.

Risk assessments were not followed, both in relation to people's care needs and the physical environment.

Is the service effective?

Inadequate

The service is not effective.

People were not supported in way that met their needs effectively.

Professional and medical guidance was not always followed and their dietary and nutrition needs were not met.

Is the service caring?

Requires Improvement

The service is not very caring.

People were not always treated with dignity and respect and not always involved in decisions about their care.

Is the service responsive?

Inadequate

The service is not responsive.

People did not receive care and support that was individual to them. They were unable to enjoy their individual hobbies and interests and staff did not always respond promptly to people's needs.

Complaints were not always appropriately responded to.

Is the service well-led?

Inadequate

The service is not well-led.

The provider did not have effective systems in place to monitor, identify and drive improvements in the service and had not acted on significant risks to people's health, safety and welfare.

There was no registered manager in post.

Doddington 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. We brought this inspection forward due to concerns that we had received from health professionals and members of the public.

We made an unannounced comprehensive inspection on 6, 7 and 14 September 2017. The inspection team consisted of two Inspectors and one 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. They had knowledge and experience of care for older people.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

We asked the local authority if they had any information to share with us about the care provided by the service. We also asked the local Health watch for information relating to people's experiences at Doddington Lodge. Health watch are the independent national champion for people who use health and social care services.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with six people who lived at the home. We spoke with the manager, the provider, and eight members of staff. We also spoke with three health professionals who included two district nurses and a social worker. We looked at the records of six people, which included medicines, mental capacity assessments, nutrition, risk assessments, care plans and assessments of people's needs. We also looked at

the systems for monitoring the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

We looked at how the risks associated with people's individual care and support needs were managed. Before our inspection visit, we received concerns about the quality of pressure area care provided by staff. We looked at one person's risk assessment regarding their skin health. This person was assessed as being at high risk of developing skin damage from pressure areas, in August 2017. It stated that the person required regular two hourly repositioning to control the risk of skin breakdown. Monitoring charts for 3, 10 and 13 September 2017 showed that no repositioning took place between 2pm and 12 am on each day. Staff could not tell us why the person did not get repositioned as regularly as identified in the assessment and care plan. This person continued to have frequent episodes of skin breakdown, for example notes written by district nurses following their visits showed that the person had broken skin in March, April and May 2017.

One person had remained in their bed for over 12 months. The person's profile in their care records stated that previously they had Deep Vein Thrombosis (DVT). The National Institute for Clinical Excellence (NICE) state in their guidelines for managing DVT to avoid dehydration and encourage people to mobilise (NICE, clinical guidelines 92 (2016)). The person had not mobilized since August 2016 and fluid intake was not consistently monitored. There were no risk assessments in place for managing the DVT and staff were unaware of the risks.

At the time of our inspection on 6 September 2017, staff told us that they felt some of the wheelchairs in use were unsafe. One member of staff told us how they had recently 'nearly tipped a person out.' We raised this with the manager and we were told that the person responsible for maintenance would carry out checks on the wheelchairs to make sure they were safe for use. We found a schedule of work undertaken by the maintenance person during the month of June 2017 and this said, '11/6/17 – No legs on wheelchairs or some just has the one.' An entry on 12/6/17 states, 'wheelchair legs.' Marks against the entries indicated that work had been done to attempt to rectify the faults.

On 7 September upon our arrival the maintenance person told us they carried out regular checks on wheelchairs and this had been completed. We checked the wheelchairs and found two wheelchairs being used, were unsafe. The first wheelchair had a footplate missing. This meant that people who sat in the wheelchair would have their feet unsupported when being moved which left people at risk of injury. The other wheelchair did not have a working brake. An attempt to repair the wheelchair had previously been undertaken as there was sticky tape holding sections of the brake together. Staff confirmed that they were using these wheelchairs to support people to move around the home. The maintenance person told us that they would repair them immediately. At the end of the visit we went with the manager to where maintenance to the wheelchairs had been carried out. The two wheelchairs previously identified as being defective had been sprayed with oil and placed ready to go back into the home, however we found they were still not working. We asked that they were no longer used and the manager condemned them immediately.

On our return visit on 14 September 2017, we found a further three defective wheelchairs. All three appeared to have been heavily used and did not offer any back support to people, were too small to transport people

safely and also tipped backwards with only slight pressure being applied onto the handles at the rear of the wheelchairs. When we pointed this out to the provider they were in agreement that the wheelchairs were unsafe to use, however they had failed to take timely action or ensure that they were unused by staff. The provider had continued to fail to ensure the safety of their equipment.

People had individual risk assessments which included nutrition, moving and handling and pressure area management. However three of the risk assessments we looked at had not been reviewed and did not reflect the people's current risks and needs. For example one person's health condition had deteriorated and this had an impact on their mobility and increased the risk of falling. When we looked at the person's care records, they had not had a review for over two years. What staff told us did not reflect what was written in the person's care records. Staff told us that the person was at an increased the risk of falling.

The provider had failed to maintain an environment that was safe. For example a hoist and three wheelchairs were being stored in a corridor that was designated as a fire escape route. A health and safety assessor present on the second day identified that this meant that the fire escape route was not clear so that in the event of a fire, people's path to a safe exit would be impeded. At the time of inspection visit, the manager was unable to identify an alternative storage area for the hoist and when we returned for the third day, we found that the hoist was still in a place that obstructed the fire escape. We discussed this with the provider and by the end of the day the hoist had been moved to another area.

The lift had been out of order for two weeks prior to the inspection visit and a date for the work to be completed to the lift had not been arranged. This had meant that hoisting equipment and people had to be taken through the outside car park to access parts of the building including the bathroom. Staff told us that this meant a delay in the availability of the hoist for people at times through the day.

There was no hot water in areas of the home and this had not been fixed for over two months. At the time of inspection two bedrooms and a communal toilet were without water.

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

People told us that there were enough staff to give them the support they needed. One person told us, "Ask and they [staff] will come." Some of our observations supported this view, for example we saw a person use their call bell in their room and staff responded. However other observations did not support this view. For example we carried out a SOFI in a lounge area for 25 minutes, and during this time we observed four people that needed assistance with some food that they had been given. One person had dropped their food and was unable to pick it up and staff did not help them. Another person was not given the support they needed to have a drink that had been prepared for them even though a member of staff walked past the person during our observation. Staff told us that while they felt there were enough staff to keep people safe, there were not sufficient staff to allow them to spend individual time with people.

Staff we spoke with, did not feel that there were sufficient staff during the night to always ensure people's safety as they felt there were not enough staff to respond quickly to people through the night. We were told that a total of three carers provided night time cover in the home. Staff said that through the night some people were up and that at times it was difficult to ensure that both areas of the home were staffed suitably though the night. We discussed this with the provider following the inspection and they told us that they would review the night time cover as soon as possible.

Staff told us that checks were made to make sure they were suitable to work with people before they started

to work at the home. These included references, and a satisfactory Disclosure and Barring Service (DBS) check. DBS helps employers make safer recruitment decisions by preventing unsuitable people from working in care. Staff told us they undertook a structured induction programme, including shadowing experienced staff members, until they were confident and able to carry out their roles effectively.

We found that people had the support they needed to take their medicines safely. One person we spoke with told us, "I get my tablets when I need them." Medicines were only administered by staff that had received training in the safe management of medicines. We observed how medicines were administered and found staff to be organised and focused on giving the right medicines at the right time to the right person and accurate records of medicines were kept. We found this to be carried out safely and effectively. Medicines were stored safely and appropriate systems were in place for the ordering and disposal of medicines.

Staff told us what they would do if they suspected abuse and had a good understanding of the different types of abuse. They also told us what they would do and who they would contact if they suspected abuse. There were systems in place to protect the people that lived in the home and to make sure that the relevant authorities were informed and action taken to keep people safe.

Inadequate

Is the service effective?

Our findings

People did not have their dietary and nutrition needs met effectively. Staff including the kitchen staff were unaware of people's eating and swallowing needs. There was no understanding of the correct preparation of food to meet people's individual needs which left people at risk of choking and malnutrition. For example, one person's deterioration in their Parkinson disease meant that their ability to swallow was being effected. Staff had told us that at times the person; "Struggles to eat". Food amounts were not being monitored for this person and between July and August 2017 the person had an unplanned weight loss of 1.7kg. There had been no care or medication reviews for this person and advice from the GP or specialist health professionals had not been requested. When we spoke with staff they were unaware of the implications of the progression of the person's Parkinson disease.

Some people were having their intake of food and fluid recorded on a fluid monitoring chart. The daily recommended amount for an adult is 1200ml or 6- 8 glasses a day (British Nutrition Foundation 2016). However, we found that recorded fluid intake fell well below this recommendation which placed the person at an on-going risk of dehydration. For example, one person was recorded to have only had 200ml of fluid on one day and 630ml of fluid the day before. Staff told us that this was not unusual for this person but there was no evidence that action had been taken to review this or that staff had taken the necessary steps to ensure their hydration needs were met. The handover sheet completed at the end of a shift by the senior member of staff stated on both of these days that the person had; 'Ate, drank well' and they had 'no concerns'.

Staff told us one person had received support from the Speech and Language Therapy (SaLT) team for their eating and drinking. However, when we looked at this person's care records, there was no guidance contained in their care plan. The only nutrition information was a nutrition care plan dated 10 March 2016. This stated the person was to be given a fortified diet as they were underweight. We spoke with the cook, who was unaware of this care plan and told us that the person did not receive fortified meals. The monthly weight monitoring chart showed this person had lost 3.2 kg between April and June 2017 and had lost 0.8kg between July and August 2017. The person's care plan indicated that there had been no reviews of this person's nutrition needs since March 2016.

We found that there was no consistent monitoring of people's food or fluid intake. Information communicated between staff was contradictory and where food or fluid intake was low, no remedial action had been taken.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt they had adequate training and support to carry out their roles safely and effectively. Staff said that they had regular supervision and good levels of support from the manager with their roles. However, we found that staff were unable to demonstrate an understanding of important aspects of people's conditions. For example the kitchen staff had not received any training in how to

prepare food for people with complex health conditions. Also staff did not have any awareness of Parkinson's disease and how to manage the condition. The provider did not have an approach to training that took account of people's roles and the complexities of people's health conditions. When we discussed this with the manager they told us that they would look at increasing the training opportunities for staff.

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 told us that could make choices and their wishes were respected by staff. We saw examples where people were involved in day to day decision making where they chose what they wanted to eat and drink and when they wanted it. We discussed with staff what needed to happen if people could not make certain decisions for themselves. What they told us demonstrated that they had knowledge of the principles of the MCA. All staff told us that they had received training about the MCA and were confident in their knowledge of its principles and use.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider 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 for some people their mental capacity to make decisions had been assessed and appropriate DoLS applications had been made. The provider had invited people, for example social workers and family members, to be involved in meetings to discuss decisions to be made in the person's 'best interests'. These had been documented and confirmed the person themselves had been involved in this process. However there was a person who had spent over 12 months in their room and staff told us this had not been the choice of the person themselves. The manager told us that the person lacked capacity to make the decision to stay in their room for themselves. We would expect under these circumstances that a best interests meeting and an application for a DoLS would have been made, but we could not find evidence that this had taken place. We discussed this with the manager and they assured us that this would be actioned.
This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We found that people were not always treated with dignity and respect. Staff followed bathing rotas which meant that people could only have a bath or shower on an allocated day. Staff told us that this was done to make sure that people had a weekly bath or shower, and if in the event that someone needed a bath or shower urgently, they would swap with another person on the rota. One senior member of staff when we discussed the bathing rota said, "Do you expect people to have a daily bath or shower then?" This did not reflect an approach that afforded people dignity and respect.

While we could see that staff were patient when giving people choices, there were no mechanisms in place to involve people in reviewing their care or to identify things that they would like to do. People's individual preferences were not routinely recorded in people's care records and staff could not demonstrate to us an understanding of people's individual wishes and preferences.

We heard a person ask a staff member if they could go to bed at 7 pm.. The staff member told them that they would try but, "Could not guarantee it." The person told the staff member that they were disappointed, the staff member said, "I know you're fed up with not being able to go to bed when you want." This member of staff told us this person always asked to go to bed at 7pm. They said that only occasionally do they get to go to bed at this time. They told us that this was due to the pressure on staff to get other things done. This shows that people were not involved in the decisions about how they were cared for.

We found soiled clothes in a communal area where other people were sat. We saw that people sat in a dining area later in the afternoon with items from the lunchtime that had not been cleared away. Records containing people's personal information were in communal areas where they could be accessed by anyone coming into the home. When we spoke with staff about this we were told that this was to encourage staff to fill in the relevant records for people. However, this also meant that people's personal information was accessible to people that lived there as well as any visitors and did not respect people's right to privacy.

This was a breach of Regulation 10 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People's care records and what staff told us did not demonstrate that the care and support was person centred. One person had been confined to their room because specialist equipment was needed, but was not available, specifically, a particular wheelchair. Staff confirmed this person was not able to mobilise without this equipment and so had not left the bedroom for this period of time. This inaction had compromised the person's quality of life and wellbeing. The manager and staff told us that this was a sociable person and could not give us any clinical reason why the person had remained in their room for over 12 months. Whilst the manager told us they were in the process of sourcing this equipment, no action had been taken for a period of 12 months.

There were no regular assessments or reviews of people's needs. Where people's individual health conditions had deteriorated the relevant professionals had not been involved and staff were unaware of the implications of the progression of specific health conditions.

People told us they were not able to pursue their individual hobbies and interests and their preferences were not always taken into account. We found that people's hobbies and interests had not been assessed or recorded and this meant that people were unable to pursue those interests. There was no provision for people to access items of interest independently. Staff were busy carrying out essential tasks, such as addressing people's personal health needs and this had an impact on the ability for staff to spend time with people to do the things people enjoyed.

We looked at how people's individual health needs were responded to. We asked people whether they saw health professionals when they needed to. People told us that if they felt unwell they would be supported to see a doctor. However we found that where people's conditions had shown signs of deterioration, suitable support or advice from health professionals was not always sought or followed appropriately. One person had an ear condition, which the care records said affected their balance. Advice written in the care notes by a district nurse following a visit on 10 August 2017 said, "[Person] should have the olive oil put into his ears for another week." A subsequent entry on 7 September said, "Came to syringe [person's] ears, said wax too hard. We should be putting olive oil into [Person's] ears." A district nurse we spoke with said that this had not been happening. When we spoke with staff and the manager they confirmed it not been attempted, but could not give reasons as to why this was the case. Accident analysis records showed that the person had four un- witnessed falls during August 2017 and this showed an increase in falls to previous months with two un-witnessed falls recorded for June 2017. Staff had not followed the instructions given by the district nurse and a lack of action may have contributed to the person falling more than necessary.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system in place to handle complaints and we found that a recent complaint had received an initial response from the provider within the provider's identified timeframe. However the initial response to the complainant did not indicate that the concerns raised were being fully investigated. There was a failure

to identify key actions from a recent complaint that detailed significant concerns of the care of a person who had since passed away. The initial response to this complaint from the provider was not sufficient or appropriate to the concerns raised. Concerns were raised about the lack of appropriate food preparation for the person, signs of health deterioration being missed and not acting in a timely manner when health concerns arose. Evidence of similar concerns for people currently living in Doddington Lodge had been gathered and shared with the manager and provider during this inspection.

Inadequate

Is the service well-led?

Our findings

The provider has been rated as requiring improvement or inadequate in the key question of is this service well led, since September 2015. There was no registered manager in post and the deputy manager had been the acting manager for 2 months. The provider told us of the intention of the manager to become registered with CQC, but no application to register has been received.

There was no effective governance or oversight of the care and support in the home. Although there were audits and checks such as gathered information on the frequency of people falling and people's weight loss, nothing was done with this information to improve the care and support for people. The provider and manager did not have knowledge of and in some instances were totally unaware of the areas of concern we identified during the inspection visits. Where we did point out areas for improvement, this was not attended to in a timely way, so was still requiring attention when we returned.

Where there was an awareness of improvements needed, for example reviews of people's care needs, no reviews had taken place, and no action to ensure people's needs were met. People's care records were contradictory, unclear and used inconsistently, which meant that crucial information about people's health, safety and wellbeing was not documented, communicated or shared.

Handover records of staff's communication between shifts, did not contain information about a person's poor fluid intake giving the impression that the person had eaten and drunk well even when they had been asleep for most of the day. Action was not taken to maintain an overview of people's current health needs. For example, where a person's health condition had deteriorated, no care reviews had been arranged and relevant professionals had not been contacted.

There was no proactive approach to reduce risks to people. For example, one person had lost over 3kg in weight over three months. Care records showed that there had been no review of their nutrition since March 2016. Whilst there were systems in place to monitor areas such as accidents /incidents and weight and diet and nutrition; poor recording and a failure to capture concerns had led to people being placed at risk of not having their health and welfare needs met appropriately.

Lessons had not been learnt from incidents, complaints or identified risks. Concerns that had been raised with the provider had continued to have an impact on other people such as the continuing issues around nutrition and pressure area care. These areas had been identified as areas of risk by other health professionals and discussed with the provider and manager, but there had been a failure to act to address these concerns.

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

During the inspection visit dates, we became aware of incidents that had occurred that had resulted in people receiving injuries. Whilst they had referred safeguarding concerns to the local authority they had not informed CQC of incidents that we needed to be aware of. Providers are required to inform CQC of

safeguarding concerns, serious injuries or accidents and this did not happen consistently.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).