

Bertinaley Care Limited

Angel Lodge

Inspection report

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South Croydon
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Tel: 02086579046

Date of inspection visit:
27 September 2017

Date of publication:
18 January 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

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

We inspected Angel Lodge on 27 September 2017. The inspection was unannounced. Angel Lodge is registered to provide personal care for a maximum of five adults. At the time of our visit there were four adults living in the home with mild learning disabilities and/or mental health conditions. Angel Lodge is located on a residential road in South Croydon close to local shops and good transport links.

At our last inspection in November 2015, we found the provider was meeting all the requirements and regulations we inspected.

At time of our inspection the service had a registered manager. Like registered providers, registered managers 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. The registered manager resigned soon after our inspection but will need to go through the process of deregistering. In the meantime, an experienced member of staff is managing the service with support from the provider.

People living in the home at the date of our inspection were independent and went out alone when they pleased. Staff encouraged people to maintain their personal hygiene, supported people to take their medicines and helped people prepare their meals.

People felt safe living in the home and in the way support was provided by staff. Staff had a good understanding of how to protect people from abuse. They knew how to identify abuse and the steps to take if they had any concerns about a person's safety. People and their relatives also knew how to report any concerns.

The provider had appropriate arrangements in place in relation to storing, recording and disposing of people's medicines. People received their medicines as prescribed. Staff supported people to maintain good health and liaised well with external healthcare providers. Staff effectively supported people to avoid the risk of dehydration and malnutrition. People were satisfied with the quality of their meals and had sufficient to eat and drink.

People told us there were enough staff working at the home to meet their needs. Staff respected people's

wishes and understood the importance of gaining their consent before providing support.

Staff training was not up to date. They had not received recent training in relevant topics such as, infection control and the Mental Capacity Act (MCA) 2005. Staff attended regular supervision and staff meetings which gave them the opportunity to express their views on working practices. Those who had been employed by the provider for more than one year participated in an annual performance review.

People's care plans did not always reflect their individual needs. Two people's care plans had exactly the same information in relation to their social needs and the support they required to access the community. From speaking to staff it was clear that the information in one of these care plans was inaccurate. There was no evidence that people were involved in their care planning. However people were supported by a consistent staff team who understood their routines from their day-to-day interaction.

Staff were recruited using an effective procedure which was consistently applied. People told us the staff were kind and caring. People were treated with respect and their dignity was maintained. People were supported to express their views and give feedback on the care they received. People knew how to make a complaint and there were appropriate arrangements in place to receive, record, investigate and respond to complaints.

There were systems in place to assess and monitor the quality of care people received. However, these systems were not always effective as they did not always identify areas which required improvement and where areas for improvement were identified action was not always taken promptly by the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the lack of staff training, the lack of person-centred care planning and the lack of effective systems to assess and monitor the quality of care people received.

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?

Good ●

The service was safe.

There were appropriate procedures to help ensure people received their medicines safely and these were followed by staff.
There were enough staff to meet people's needs.

People felt safe from abuse and staff knew about their responsibility to protect people from abuse and avoidable harm.

Staff were recruited using an appropriate recruitment procedure which was consistently applied. Appropriate checks were carried out on staff before they began to work with people.

Is the service effective?

Requires Improvement ●

Some aspects of the service were not effective.

Staff had not received training relevant to their roles and responsibilities which meant there was a risk of people receiving treatment which was inappropriate or unsafe.

Staff sought people's consent to care and treatment. Staff showed a good understanding of the Mental capacity Act (MCA) 2005.

People were supported to eat and drink enough and maintain a balanced diet.

People were supported to maintain their health, have access to healthcare services and receive on-going healthcare support.

Is the service caring?

Good ●

The service was caring.

People were satisfied with the quality of care they received.

Staff were kind and caring and treated people with respect.

Is the service responsive?

Requires Improvement ●

Some aspects of the service were not responsive.

The provider did not involve people in the care planning process and did not deliver person-centred care.

People were supported to express their views. There was an appropriate complaints procedure in place and people knew how to make a complaint.

Is the service well-led?

Some aspects of the service were not well led.

The systems in place to assess and monitor the quality of care people received were not always effective.

People and staff understood the management structure and how to escalate any concerns.

Requires Improvement 

Angel 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.

The inspection took place on 27 September 2017 and was conducted by a single inspector. The inspection was unannounced. Before the inspection we reviewed all the information we held about the service. This included statutory notifications sent by the provider of changes and events affecting people and the previous inspection report.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with two people living in the home, one staff member and the registered manager. We looked at four people's care files and three staff files which included their recruitment records. We reviewed records relating to staff, maintenance and management of the home, as well as a variety of policies and procedures.

After the inspection we spoke to a staff member, the provider and a representative of a local authority which commissions the service.



Our findings

Risks people faced were assessed and management plans were in place to minimise the risk of avoidable harm. The risk assessments covered areas such as the risk of abuse and the risks associated with being in the community alone. Care plans gave staff information on how to manage the risks identified. Staff knew the risks people faced and the staff team shared information regarding risks to individuals including any challenging behaviour during shift handovers. For example, we saw information in one person's risk assessment about the anxiety they felt when attending healthcare appointments. The staff rota indicated that additional staff were scheduled to work when that person had a healthcare appointment so they could be accompanied to the appointment.

People felt safe living in the home and receiving support from staff. Comments we received included, "I think I am safe here" and "I am safe. I have no problem with the staff." A relative told us, "I think [the person] is safe there."

The provider had policies and procedures in place to guide staff on how to protect people from abuse which staff were familiar with. Staff had been trained in safeguarding adults and knew how to recognise abuse and report any concerns. A safeguarding incident had been appropriately notified to the local authority. Accidents and incidents were recorded and monitored by the registered manager. Where appropriate care plans were reviewed and updated to help minimise the risk of the incident reoccurring. There were no unnecessary restrictions on people's freedom to come and go or to move around the home as they pleased.

We looked at the systems in place to order, store, administer and dispose of people's medicine and found the procedures were appropriate. This enabled staff to support people to take their medicine at the right time and in the correct dosage. Where people had medical conditions such as diabetes, the times they received their medicines and meals were coordinated. People's medicines were stored in a locked cupboard within a locked room. Medicines were stored at the correct temperature which was recorded and monitored. Protocols for 'as required' medicine were in place which gave guidance to staff on the type of medicines people required and when people needed to receive them. We found no recording errors on medication administration records we looked at and saw that there was a system to audit people's medicines which would help to identify any errors which might occur.

We saw evidence that appropriate checks were undertaken before staff began to work with people. These included criminal record checks through the Disclosure and Barring Service (DBS), obtaining proof of their identity and their right to work in the United Kingdom. Professional references were obtained from

applicant's previous employers which commented on their character and suitability for the role. This minimised the risk of people being cared for by staff who were unsuitable for the role.

There were enough staff deployed at the service to meet people's needs. The staff rota showed that at least one staff member was on duty at any time. When people needed support to attend healthcare appointments an additional staff member was deployed from a bank of staff who regularly worked at the service and knew people well.

The home was of a suitable layout and design for the people living there. Some parts of the home were not well maintained. The base of one person's bed was broken which meant that it sloped to the floor and the toilet seat in the downstairs cloakroom had come off its hinges. We raised these issues with the registered manager who told us the provider had been made aware of the necessary repairs three weeks earlier. Since our inspection the provider has notified us that the bed and toilet seat have been replaced. We will check the standard of maintenance at our next comprehensive inspection.

The utilities were regularly inspected and tested. The home had procedures in place which aimed to keep people safe and provide a continuity of care in the event of an unexpected emergency such as, a fire or boiler breakdown.



Our findings

Staff were not appropriately supported by the provider to effectively meet people's needs through relevant training. We asked for evidence of staff training and the registered manager handed us a blank sheet which he said was the training matrix for 2016/2017. It was the provider's policy that staff must receive annual training in topics such as first aid, infection control, medicine administration and safeguarding. We asked the registered manager why staff had not received this training. He was not able to explain why staff had not received training but told us that it would be completed by 27 October 2017. People living in the home had learning disabilities and/or mental health conditions as well as a variety of other health conditions including epilepsy and diabetes. Staff had not been trained in these areas, mental health awareness or in how to deal with challenging behaviour which meant there was a risk of people receiving treatment which was inappropriate or unsafe. The provider did not have a system in place which enabled staff where appropriate to obtain further qualifications appropriate to their role.

The provider's failure to support staff through relevant training or to obtain further qualifications appropriate to their role is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18.

Staff had received an induction, quarterly supervision and an annual performance review. This gave staff the opportunity to develop skills through reflecting on their practice and the exchange of information.

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 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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager knew when an application should be made and how to submit one.

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. Mental Capacity Act assessments had been conducted. Two people lacked capacity to make certain decisions for themselves. A framework and procedure was in place to deal with situations where people lacked capacity to make specific decisions. In these circumstances, family members who had the legal authority to do so were involved in making

decisions in people's best interests. Staff had not received training in the MCA but had a good understanding and awareness of their role and responsibilities in respect of the MCA and DoLS.

People made their own breakfast and staff prepared their lunch and supper. People were happy with the quality of the food and were protected from the risk of poor nutrition and dehydration. Records showed that staff assessed people's nutritional needs which took account of their healthcare conditions as well as their specific preferences for food and drink. Staff used this information to support people to plan meals which met their needs.

People were supported by staff to attend their healthcare appointments. A relative told us, "I know [the person] goes to see their GP and dentist." Staff proactively engaged with health and social care agencies and acted on their recommendations and guidance to maintain people's health. For example, we saw that a person had regular tests to monitor how well controlled their blood sugar levels were. Appropriate referrals were made to other health and social care services when required such as, psychologists and psychiatrists.



Our findings

People were satisfied with the quality of care they received. They told us staff were friendly and helpful. People commented, "I like living here" and "I get on with all the staff. They help me if I need it."

There was a calm atmosphere in the home. Our observations of staff interacting with people were limited because three people living in the home went out during our inspection before lunch and one person stayed in their room. Of the interactions we observed the staff approach was friendly and respectful. People seemed happy and relaxed. Staff were patient, polite and encouraging. They supported people at a pace that suited people and addressed them in the way they preferred. Staff had a positive attitude to their work and spoke about people in a caring way. They told us, "I like working here" and "I enjoy my job."

Staff respected people's privacy and dignity. Staff respected people's decision to spend time in the privacy of their room and did not disturb or enter people's rooms without their permission. People told us staff knocked their door and asked permission before entering. One person commented, "My room is my personal space and the staff respect that." The two people's bedrooms we went into were personalised and contained items which reflected their age, gender and interests. People were supported by staff to maintain their personal appearance which helped to maintain their self-esteem. The three residents we saw were neat and well dressed.

Staff encouraged people to maintain important relationships with their relatives and friends. There were no restrictions on visitors and people were able to entertain their visitors in the communal lounge or their rooms if they wished. People were encouraged by staff to maintain their independence. People were able to tidy their own rooms and help with the preparation of their meals if they chose to. One person told us that they liked to make sure that the dustbins were emptied and we saw the person doing this before they went out.

People made their own decisions about when they woke up and went to bed, what they ate, what they wore, whether they assisted with household chores and how they spent their time each day. This helped people to feel valued and that their choices were respected.

People felt they were listened to and that their views were acted on. The provider supported people to express their views by holding residents' meetings. One person told us, "I attend the meetings and we talk about what food we would like and things that have happened." Each person had a designated key-worker. A key-worker is a member of staff responsible for ensuring a person's care and support needs were being

met and also someone they can go to if they have any concerns. People knew who their keyworker was and we saw evidence that people met with their keyworker to discuss their care.

People's personal and confidential information was appropriately protected. Their records were securely stored and only accessible by staff. Staff understood their obligation to respect people's confidentiality at all times. A staff member told us, "It's important that we don't give out information on people without their permission."



Our findings

There was no evidence on people's care files that they had been involved in the care planning process. The people we spoke with could not remember participating in the process. People's care plans were not person-centred. We saw identical information in two people's care plans which was not relevant to either of the people concerned. The care plans were generic and did not take account of people's specific needs, abilities and preferences. They did not include information about the level of support each person required to have their needs met, as well as how they preferred staff to provide their care. We saw minimal information about people's interests and how they preferred to spend their time. It was evident from speaking to staff that they needed to know more about people in order to provide person-centred care. A relative told us, "They're not meeting [the person's] needs. It's not what we expected."

More could be done to engage those people who did not like to go out. Records indicated that one person spent most days alone in their room unless a relative took them out or they left the home to attend a healthcare appointment. We raised this with the registered manager. He told us that the person preferred to spend all day in their room but accepted that they had not fully explored whether there were any activities the person would like to participate in; that this could lead to social isolation and they needed to find ways to avoid this.

The provider's failure to work with people in carrying out an assessment of their needs in order to design care and treatment which was appropriate, met their needs and reflected their preferences is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9.

People were independent and went out when they pleased. One person told us, "I like going shopping and I get the bus into Croydon." Another person told us they were going out to lunch at a place they visited regularly. People were supported by a consistent staff team who understood their routines through their daily interactions.

The provider supported people to understand the care and treatment choices available to them. The provider gave people information on how to protect their rights by having a "theme of the month". Each month staff would put information on a noticeboard about a particular topic relevant to people in the home. At the time of our visit the theme was the deprivation of liberty safeguards. Previous topics included safeguarding. These measures assisted people to make decisions about their care.

There was an appropriate procedure in place to record, investigate and respond to complaints. Complaints

made were acted upon and learnt from with care and support being adjusted accordingly. Staff were aware of their responsibility to enable people using the service to make complaints or raise concerns. People told us they were aware of the complaints procedure and how to use it. A relative had made a complaint and we saw that appropriate action had been taken by the provider to investigate the complaint and refer the matter to an external agency as was required. The provider used learning from complaints and incidents as an opportunity to improve the service. We saw that the staff rota was reviewed and revised after an incident. There was a whistle-blowing procedure that staff were familiar with and said they would be comfortable using.



Our findings

Some aspects of the service were not well managed. There were arrangements in place for checking the quality of the care people received. Audits were conducted at registered manager and provider level in areas such as staff training and supervision, infection control and medication. However, where the audits identified areas which required improvement these were not always made or followed up. For example, there was a system in place to check that staff training was up to date. The system identified that staff had not received their annual training in essential topics such as infection control but this remained unchanged month after month.

Three weeks before our visit the registered manager had recorded and notified the provider that a person's bed was broken. No effective action had been taken to remedy this and we found that the person's bed had not been replaced on the day of our visit. People were not always as involved in the care planning process as they were able and therefore did not always receive person-centred care. Some of the information in two people's care records was inaccurate. This had not been identified by the provider's audits.

This meant the provider did not establish and operate effective systems or processes to assess, monitor and improve the quality and safety of the service provided. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested a variety of records relating to people, staff and management of the service. These were promptly located and well organised although in some instances as mentioned above, the information was inaccurate. The provider's policies and procedures were up to date and regularly reviewed. Staff working practices were in accordance with the provider's policies and procedures.

There was a clear staff and management structure at the home which people living in the home and staff understood. People knew who to speak to if they needed to escalate any concerns. Staff knew their roles and responsibilities within the structure and what was expected of them by the management and people living in the home.

The registered manager held regular meetings with people and staff. The registered manager told us they used the staff meetings to discuss any issues or concerns about current working practices and any changes within the home that staff needed to be aware of. People used their meetings to help devise the menus and give their views on how the home was run.

The provider was aware of their role and responsibilities particularly with regard to CQC registration requirements and their legal obligation to submit notifications of events or incidents at the service. This was important as we need to check that the provider took appropriate action to ensure people's safety and welfare in these instances. Our records showed that since our last inspection the provider continued to notify us appropriately of any reportable events or incidents at the service. The registered provider ensured the service's current CQC ratings were clearly displayed within the service and on their website in line with legal requirements.

The registered manager had been in post for five months prior to our inspection and it was clear that he was still in the process of establishing relationships with people and staff. People had mixed views on whether the service was well managed and the registered manager did not feel supported by the provider. Shortly after our inspection the registered manager resigned. An experienced member of staff who is currently working at the service will manage the service.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider did not involve people in an assessment of their needs; or design care or treatment with a view to achieving their preferences.</p> <p>The care and treatment people received did not meet their needs or reflect their preferences.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not establish or operate effective systems to assess and monitor the quality of care people received.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>Staff did not receive appropriate training to enable them to carry out the duties they were employed to perform.</p> <p>The provider did not enable staff to obtain further qualifications appropriate to their work.</p>

