Mr & Mrs P Chellun

Gate Lodge

Inspection report

1 Upper Woodcote Village
Purley
Surrey
CR8 3HE

Tel: 02086687286
Website: www.gatelodgecarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 13 September 2018. At the last inspection in December 2016, the service was rated good. At this inspection we found, overall, the service requires improvement.

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

Gate Lodge is located in a quiet residential road in Purley close to good transport links. Gate Lodge provides accommodation and personal care for up to 21 people. At the time of our inspection 18 people were 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.

Staff demonstrated a good understanding of safeguarding and whistleblowing procedures and knew how to report concerns. Incidents and accidents were recorded and the records showed that actions were taken to minimise the risk of recurrence.

Improvements were required to ensure that people were protected from the risk and spread of infection. People received their medicines as prescribed. However, the arrangements in place for storage of people's medicines were not always safe.

We were concerned that there were insufficient staff at mealtimes and at night particularly in the event of an emergency. Staff performance was effectively monitored. Staff received supervision and training to ensure they had the skills to meet people's needs.

The premises were not adequately maintained to ensure people's safety. We have made a recommendation that the provider seeks guidance on good practice in meeting the needs of people living with dementia.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes. People had a sufficient amount to eat and drink. Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

Systems were in place for monitoring the quality and safety of the service. However, they were not always as effective as they needed to be and when areas were identified as requiring improvement, the provider did not always take prompt action.

We found a breach of the of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 in relation to the provider's failure to provide safe care and treatment. You can see the action we have asked the provider to take at the back 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

Some aspects of the service were not safe.

Some parts of the home were not adequately maintained to ensure that the people living there were safe. Improvements were needed to minimise the risk and spread of infection.

Staff were recruited using a safe recruitment procedure. There was not always sufficient staff to meet people's needs.

People received their medicines as prescribed. However, people's medicines were not always stored safely.

Accidents and incidents were reported, recorded and action taken to minimise future risks.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The systems in place to assess and monitor the safety and quality of care people received were not as effective as they needed to be.

The registered manager was approachable and responded appropriately to feedback.

People's care files and records relating to the management of the service were well-organised, accurate and up to date.

Gate 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.

We undertook a comprehensive inspection of Gate Lodge on 13 September 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by an inspector 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.

Before the inspection visit we looked at the information we had about the home. The provided had completed a Provider Information Return (PIR). This is a form that asks the provider for key information about the service, what the service does well and the improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us by law.

During our visit we spoke with seven people who lived at the home and one relative. We observed the way staff interacted and engaged with people. Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with the provider and registered manager. We looked at five people's care records. We also looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with people and staff, and other records relating to the monitoring and management of the home.

Requires Improvement

Is the service safe?

Our findings

There were infection control and cleaning policies and procedures in place to protect people from the risk of infections. Staff understood the importance of good hand hygiene and the need to wear personal protective equipment (PPE) when supporting people. We observed that staff followed infection control protocols. However, during our inspection, we observed areas of the premises were not hygienically clean. Some communal areas of the home had a strong and unpleasant odour. There were clumps of dust on some of the radiators and ground-in dirt on skirting boards in the communal areas. Chairs in the communal lounge were dirty and stained. Four chairs were not covered in impermeable material which meant there was a risk of cross infection. The regular cleaning of these chairs was not included on any cleaning schedule. The carpet in the room where people's medicines were stored had a large patch of sticky ground-in dirt. Records demonstrated that the registered manager had previously identified that the home required a deep clean. However, this had not been done. We raised this with the registered manager and provider who assured us that a deep clean of the home would take place and that a new cleaning schedule would be devised.

Some areas of the home were not safe. We were not able to go into all the bedrooms because some people were resting but in two people's bedrooms on the first floor there were no window restrictors in place. This posed an obvious risk to people of falling from a window. We raised this with the provider who immediately arranged for the maintenance person to fit window restrictors. However, the provider was not aware of the relevant health and safety guidance in relation to preventing falls from windows in a health and social care setting. Therefore the provider could not be sure that the window frames and restrictors fitted were sufficient to mitigate the risk of someone falling from the window. Maintenance checks did not include checking that safety fixtures and fittings were functioning effectively as recommended by health and safety guidance. Although on the day of our inspection it was warm and sunny, the emergency exit stairs were wet and covered in leaves. This would make any emergency evacuation hazardous, particularly at night.

People told us they received their medicines when they were supposed to. We looked at people's medicine administration records (MAR) and checked the balances of their medicines. These records were up to date and accurate. There were safe systems for administering and monitoring of controlled drugs. However, we saw that some steroid creams were kept in people's rooms. This meant there was a risk of people applying the creams inappropriately and causing long-term damage to their skin. We raised this with the registered manager who confirmed that people were not responsible for applying these creams themselves and therefore the creams should not be in their room. The steroid creams were immediately removed and placed in a locked room where people's medicines were kept.

These issues amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Although people did not express concerns about the staffing levels, we observed that at times there were not enough staff on duty to meet people's care needs in a timely or appropriate manner. During lunch we saw that one staff member was helping two people who required support to eat at the same time. The activities co-ordinator was also assisting people who required support although this was not part of their

role. We were also concerned that two members of staff were on duty at night to support 18 people, the majority of whom were living with dementia. We were particularly concerned about how two staff would manage to support 18 people to a place of safety in the event of an emergency such as fire. The home had an up to date fire risk assessment in place. We saw records confirming that the fire alarm system was tested and fire drills were regularly carried out at the home. However, at the last fire drill six people became agitated or refused to leave the home. The provider did not have a plan in place to deal with what staff should do to ensure people's safety if this happened in a real emergency which meant that people were at risk.

People told us they felt safe and that staff treated them well. They commented, "I am safe here" and "I think I'm safe." A relative told us, "I'd be quite happy not coming in to check on my mum as I know they look after her."

Records showed that risks to people (excluding the risks mentioned above) had been assessed when they first moved in to the home and reviewed regularly thereafter. The risk assessments were personalised. Care plans gave staff detailed information on how to manage identified risks and keep people safe. This covered such issues as how to minimise the risk of falls and what to do in the event that a person had a fall. Staff knew the risks people faced and how to manage those risks.

The provider had procedures in place for protecting people from abuse. Training records confirmed that all staff had received safeguarding training. Staff demonstrated a clear understanding of the types of abuse that could occur. They told us the signs they would look for and what they would do if they thought someone was at risk of abuse. They said they would report any safeguarding concerns to the registered manager. Staff knew they could report concerns to the local authority safeguarding team or the CQC. The provider had a whistle-blowing procedure and staff told us they would use it to report poor practice if they needed to.

The registered manager showed us the provider's system for monitoring and investigating incidents and accidents. They told us they monitored accidents and incidents to identify any trends. Where trends had been identified the registered manager had discussed them with staff and taken action to reduce the likelihood of the same issues occurring again.

An appropriate recruitment process and relevant checks were conducted before staff started to work with people. This included obtaining employment references, health declarations, proof of identification, criminal record checks and eligibility to work in the UK. These measures helped to ensure that staff employed were suitable for their role.

Good

Is the service effective?

Our findings

People continued to receive effective care from staff who had received relevant training and support to carry out their roles. People told us, "The staff seem to be well trained" and "They are good." We observed that staff appeared comfortable carrying out their role. Staff told us they felt well supported by colleagues and the registered manager.

Newly recruited staff completed an induction programme and then shadowed colleagues to gain practical experience. The induction programme incorporated essential training designed to ensure staff had the skills and knowledge to provide an appropriate standard of care and support. Staff had regular supervision meetings. In addition, staff employed by the provider for more than one year received an annual performance review. The training records showed that staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding and dementia awareness.

People's needs were assessed. Care plans contained nutritional assessments and staff ensured that people's nutrition and hydration needs were met. People who required support to eat and drink got the assistance they required. People had sufficient to eat and drink and were satisfied with the quality of their meals. People commented, "I enjoy my lunch", "The food is ok" and "I have no complaints about the food." People were given a choice of meals and if they did not like any of the meals on offer they could have another meal of their choice. A relative told us, "The cook will always do something different for my mum when she doesn't like what's on the menu."

People were supported to maintain good health because a variety of checks were conducted regularly and recorded. People had access and were referred appropriately to external health professionals. Records showed that people had been visited by a range of health professionals including GP's, nurse practitioners and social workers.

Staff were aware of the importance of seeking consent from people when supporting them with their needs. One member of staff told us, "I would not force any resident to do anything if they didn't want to do. I always encourage people to do as much as they can for themselves."

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. Care plans we looked at showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements

of the MCA. Where people had capacity or fluctuating capacity to make decisions we saw this was documented. We saw that applications had been made to local authorities to deprive people of their liberty where this was assessed as required. Where these applications had been authorised, we saw that the appropriate documentation was in place, they were kept under review and conditions of authorisations were complied with by staff.

Gate Lodge advertises its service as specialising in short and long stay care for elderly people with dementia. People living with dementia can become disorientated in time and space which can make it difficult for them to find their way around without support. At our previous inspection of the service in 2016, the provider had a business development plan which included plans to develop the home to be "dementia friendly". We saw that in the communal lounge there was furniture, decor and objects which encouraged reminiscence. Reminiscence is widely accepted as being beneficial to people living with dementia. However, insufficient action had been taken to make the environment "dementia friendly". Given that the majority of people at Gate Lodge are living with dementia, more could be done to ensure the environment meets their needs.

We recommend that the provider finds out about appropriate adaptations, based on current best practice in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People felt respected by the staff who were kind and considerate. People commented, "They are lovely", They are as good as gold" and "They are a nice bunch. They're very good to me." A relative told us, "The staff seem to go out of their way to help people."

Throughout our inspection we observed many instances of positive interactions between people and staff. We observed staff speaking to people respectfully and treating people in a dignified manner. During our inspection, one person became very agitated. We observed that the person responded quickly to the staff member's calm and reassuring approach. People appeared comfortable and relaxed with staff and did not hesitate to ask for their support when they wanted this.

People were consulted about their care and support needs. People's choices were respected. People told us they chose when to get up and to go to bed, how they received their personal care and what they wore. Staff knew people well; they told us about people's individual needs and how they preferred their care to be provided. Care was delivered by staff in a way which met people's needs. For example, during meal times we saw staff listening to people and encouraging them to communicate their needs. People and their relatives were provided with appropriate information about the home in the form of a service user guide. This included details of the services they provided and ensured people were aware of the standard of care they could expect.

Staff respected people's wishes for privacy by knocking on doors before entering their rooms and we observed staff respected people's choice for privacy as some people preferred to spend time in their room alone. Staff told us how they ensured people's privacy and dignity was respected whist personal care was provided. They told us they closed people's doors and curtains when supporting them with personal care. Staff maintained people's independence as much as possible by supporting them to manage the aspects of their care that they could by themselves.

People were supported to maintain relationships with family and friends. Staff made visitors feel welcome. These measures helped to avoid people becoming socially isolated.

Good

Is the service responsive?

Our findings

Before people moved into the home they were assessed by the registered manager to make sure their care needs were known and could be met. Care plans were based on these assessments and were designed to reflect individual needs, choices and preferences. They included details of people's life histories as well as their physical, mental, emotional and social needs. Care plans were added to and updated once people moved into the home and their daily routine was clear. People who wished to do so had contributed to planning their end of life care. There was guidance for staff on what to do if the person's health deteriorated and who to contact. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. Where people did not want to be resuscitated, we found DNAR forms had been completed and signed by people, their relatives [where appropriate] and their GP. This helped to ensure staff were clear about people's end of life care wishes so that their wishes would be respected.

Staff understood people's communication needs and made appropriate adjustments to help people to express their views. For example, we saw that staff adjusted the volume, tone and pace of their speech depending on who they were talking to, in order to aid effective communication with people. They did so in a way which was unpatronising and respectful.

People's care plans were regularly reviewed with their input as far as this was possible. People were satisfied with the quality of care they received. One person told us, "I'm happy here. I get everything I need." A relative told us, "We are really pleased with the home."

Activities were provided which reflected people's age and interests. The provider employed a part-time activity co-ordinator. The weekly activity programme included arts and crafts, quizzes, reminiscence activities and sing-a-longs. On the day of our visit, people were participating in a sing-a-long to popular songs from the past which they were clearly enjoying. The activities co-ordinator adapted this activity to people's needs so that everybody who wanted to could take part. For example, those who could not remember the lyrics to a song were encouraged to hum the song. People were satisfied with the quality and variety of activities on offer within the home but two people told us they would like organised activities more often. There were limited opportunities for people to do anything outside the home. Two people told us they would like to go out from time-to-time. One person told us, "I would like to go out sometimes." Another person told us, "I have not been out since I moved here." We raised these issues with the registered manager who informed us that a trip had been arranged to a local garden centre and that organised trips out would be arranged quarterly. The registered manager also planned to improve the activities available by arranging for an external entertainer to visit monthly and increasing the number of hours the activity co-ordinator worked.

The provider continued to have an appropriate complaints procedure in place. A relative commented, "When things aren't as I want they respond really quickly." The registered manager took opportunities to make improvements and make sure lessons were learned. For example, the process for handling people's laundry was changed after people complained that their clothing was going missing.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to assess and monitor the quality of service that people received. We saw that regular audits had been carried out by the registered managers in areas such as medication, infection control, health and safety, incidents and accidents, care files, staff training, supervision and appraisal and complaints. These audits were not always as effective as they needed to be as the issues we found regarding safety of the premises and storage of steroid creams had not been identified by the provider's audits.

Actions were taken when shortfalls or areas for improvement were identified. For example, following a fire safety report the provider devised and implemented an action plan to improve fire safety. Additionally, on receipt of our feedback the provider took immediate steps to remedy some of the shortfalls identified. However, action was not always taken in a timely manner. For example, months before our inspection the registered manager had identified that the home required a deep clean. At the time of our inspection this had not been done. The provider's auditing systems require improvement.

There were many aspects of the management which were good. People and their relatives spoke positively about how the home was managed. People knew who the registered manager was and felt comfortable approaching her to discuss any concerns. Comments from people included, "The manager is lovely. She always says hi as she is walking through" and "The owner is super and the manager is lovely." A relative said of the manager, "If I need to, I pop up and speak to the manager, she is very serious about things." All the staff we spoke with told us they enjoyed working at the home and felt well-supported by the manager.

The registered manager was knowledgeable about their responsibilities with regard to the Health and Social Care Act 2014. Statutory notifications were submitted to the CQC as required and in a timely manner. Statutory notifications are important as they allow us to monitor the risks associated with the service and help us to plan our inspections. The registered manager responded to our requests for information promptly and in a way which indicated that the provider's internal systems were well organised.

People's views and those of their relatives were sought as part of the quality assurance process to make improvements to the service. There were a variety of ways in which they could give feedback. These included annual surveys, residents' meetings, care reviews and through the complaints process.

We requested a variety of records relating to people, staff and management of the service. People's records were appropriately stored to protect their confidential information. They were comprehensive, accurate and up to date. All the records we asked for were well-organised and promptly located.

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 The provider did not provide care and treatment to service users in a safe way by ensuring the premises used by service users are safe; by ensuring the proper and safe management of medicines or by assessing the risk of and preventing, detecting and controlling the risk of infection. Regulation 12 (1) and (2) (d) (g) and (h).