Gemini Care Limited

The Lodge

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 15 June 2015. This was a comprehensive inspection.

The service had a registered manager who had been at the service several years. 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.

The Lodge is registered for 44 people living with dementia. When we inspected on 15 June 2015 there were 38 people living in the service.

We found that the staff were generally caring and observed some compassionate interactions between staff and people who lived at this service. We also found room for improvement with regards to dignity and respect. People who live at the Lodge were satisfied with their choice of home. Relatives had mixed feedback about the experience they received for their family member. One raising concerns that we asked the manager to address directly with the family.

Summary of findings

This service was not clear about their vision and purpose. They did not have a model of dementia care that they subscribed to. The environment was not specifically designed for people living with dementia and staff had not received enhanced training about supporting people with dementia based upon a chosen model.

Assessments were completed before people came to the service. The service used an assessment and care plan that is based upon a nursing model that does not readily take account of behaviour that may be present in stress situations for a person living with dementia.

We found that staffing levels were satisfactory but staff were not as well organised and designated as efficiently as they may be. This was particularly noticeable at lunch time, which was disordered and confusing for people.

There was a high incidence of falls, accidents and urinary tract infections noted from the service's own records. We also found that people at the service may be at risk from other people's distress reactions to situations that arise. Recording of incidents were not routinely used to develop a strategy of management and prevention of further incidents. Individual risk assessments were in place but these were not informative and effective.

Management of the service did not have a defined overview to use data to improve governance and the safety within the service for people. People told us that the management within the service was friendly and approachable.

We fed back our findings to both the registered manager and the provider at the end of the inspection. Both were keen to develop this service and make significant changes.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 was not safe.

We found individual risk assessments were in place but these were not informative and effective. There was a high incidence of falls, infection and aggression from people living with dementia. Recording of incidents were not routinely used to develop a strategy of management and prevention of further incidents.

There were sufficient staff employed on a daily basis, but lunchtimes were not effectively managed and some people had a poor experience because of staff unavailable to support them.

Medicines were safely managed and people received their medicine as prescribed.

Is the service effective?

Requires improvement

The service was not always effective.

Staff and the service did not have a comprehensive knowledge of decision making and Deprivation of Liberty Safeguards that was underpinned with guidance and training.

People enjoyed the meals provided, but this was not supported by thorough assessment and action for those people who had lost weight.

People did have access to healthcare for maintenance of their health, but knowledge and practice at the service was not based upon a preventative model.

Is the service caring?

Requires improvement

The service was not consistently caring.

Most staff showed polite and caring interactions and responses to people. A small number of staff did not always show respect and understanding of people living with dementia.

Choice was offered on a day to day basis, but people and their families were not involved as much as they should and could be.

Is the service responsive?

Requires improvement

The service was not always responsive.

The assessment system and care plans in place were not totally suited for people living with dementia. Care plans were not effectively reviewed and individualised.

Summary of findings

Recorded complaints at the service were kept to a minimum and were not routinely used to develop and inform practice within the service.

Is the service well-led?

Requires improvement

The service was not consistently well led.

A lack of systems and processes could not assure the service was operating effectively. There was a lack of monitoring and mitigation to ensure the health, safety and welfare of people using the service.

The service was open and approachable, but lacked a known vision and purpose in their model of dementia care.

The Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 June 2015 and was unannounced.

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.

Information was gathered and reviewed before the inspection. This included information we hold, statutory notifications from the provider (a statutory notification is information about important events which the service is required to send to us by law) and information from the local authority that included safeguarding referrals.

During this inspection we talked to four people using the service, six visitors, four staff, the registered manager, and the provider. We reviewed a variety of documents including four care plans and associated care records, seven sets of recruitment records (including training, supervision and appraisals), policies and procedures and other records related to the running of the service.

We observed how care and support was provided to people throughout the day, including during the midday meal. We 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 may not be able to verbally tell us about their experiences of the service.

Following the inspection we spoke with three health and social care professionals to gather further information about their involvement and experience of the service.

Inadequate

Is the service safe?

Our findings

Risks to people were not effectively managed to protect people. One visitor was concerned that their relative had had another fall. Another visitor was concerned about the number of recurrent infections their relative had. There was a high incidence of falls, accidents and urinary tract infections noted from the service's own records. Records showed that one person had 16 falls since January 2015 another had 24. Action had not been effectively taken to reduce risk to people's health and wellbeing and therefore risks remained high for some people. Since our visit health and social care professionals involved with the service told us that more could be done to diagnose and prevent occurrences. These professionals were actively involved and willing to support changes within the service.

We also found that people at the service may be at risk from other people's distress reactions to situations that arise. During our visit the expert by experience was assaulted by a person living at the service. In one person's care records we saw that they had assaulted 10 others since 1 March 2015. No definitive action was recorded on their plan, but the risk assessment had been reviewed in April 2015 detailing staff to 'protect others, note possible triggers and leave the person to calm down'. This review had not involved professionals or relevant others and had not effectively managed the risk to the individual or others. In conclusion we found individual risk assessments were in place but these were not informative and effective. Recording of incidents were not routinely used to develop a strategy of management and prevention of further incidents.

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

There were sufficient numbers of staff on duty. Staff we spoke with thought there was sufficient staff employed. One staff member said, "I think we have enough staff, we can sit down and talk to the residents." Another said, "I think that we have enough staff most of the time, but this is dependent on people's needs on the day." One visitor said, "It's nice that my relative has the consistency of the same staff." However another visitor said, "I'm concerned whether there is enough staff to give my relative full attention".

We looked at staffing numbers employed and their designation. We found there were sufficient support staff employed in roles such as housekeeping, catering and maintenance. The manager said that he was mindful of dependency levels and numbers of people and therefore had a ratio of one care staff to six people using the service. We found there were six carers and one senior carer on duty between 7am and 9pm each day. At night there were three waking night carers. The manager determined that with 38 people resident all of whom were high dependency then seven care staff were sufficient to meet their needs. We concluded that these numbers of staff were adequate, but the meal time experience was chaotic due to the deployment of people and the extra activity and support needed during that time.

During this time people's experience was not consistently good. One person ate their meal from their knife. This made it more difficult for them to consume the meal as they were not supervised. Another person had their meal placed in front of them and there was no staff available to support them to eat it promptly therefore it went cold. The person was supported to eat a cold meal. Another person was seated by staff, but then left unattended and they repeatedly moved from place to place as they were unsure what was happening without staff to guide them. Other people did have staff to support them throughout their meal and therefore their experience was positive. We fed back our findings on the deployment of staff during mealtimes and management agreed to take steps to review mealtimes and look at staggered timings to ensure there are sufficient staff available to support people.

There was safe recruitment of staff. We reviewed seven staff member's personnel files in relation to the recruitment process. Each staff member had a completed application form, which provided information relating to any gaps in employment, a health declaration, photograph identity, criminal convictions declaration and contact information for two references. The provider had obtained a criminal records check, received two satisfactory references before new recruits were allowed to commence employment.

People's rights were protected and people told us they felt safe. One person said, "I feel safe here and have settled in very well". A visitor told us, "The staff are all lovely. I've never seen anything that is not right".

We spoke with staff who each told us they had received training to enable them to safeguard adults from abuse.

Inadequate

Is the service safe?

The training was updated regularly. Staff were able to demonstrate what constituted abuse and what they would do if they were told, saw or suspected that someone was being abused. Staff would raise concerns with the manager or senior carer straight away and were aware of the local authority's role and that of CQC. The staff we spoke with were aware of the whistleblowing policy. Following recent investigation the service was working with the local authority to improve safety for people at the service.

People received medicines as prescribed. We observed two staff administering medicines at breakfast time, they explained to people that it was time for their medicines; they ensured that each person had a drink of their choice to take the medicines with. A member of care staff confirmed that they always stayed with people to ensure they had swallowed the medicines that had been administered.

Records were appropriately completed for the ordering, receiving and safe storage of medicines. We reviewed the medicines administration records for 10 people for the last three weeks and saw that there were no unexplained gaps in the records. There was a clear audit trail of medicines received, administered and returned to the pharmacy for both the controlled drugs and any other prescribed medicines.

Controlled drugs were stored in an appropriate locked medication cabinet that was securely fixed to the wall in the medicines room. Regular audits were completed to ensure that quantities tied up with the quantities entered within the controlled drugs register. Two people signed the register every time medicine was administered. This ensured the service met its legal obligation with the use of controlled drugs.

The medicines room and fridge temperatures had been taken daily and were within the prescribed temperatures. Bottles of liquid, creams and eye drops were dated on the day of opening which was to ensure that they are disposed of when required in line with the manufactures instructions.

Requires improvement

Is the service effective?

Our findings

Consent for day to day decisions was sought by staff informally with people as required. Staff were able to describe how they promoted people's independence and encouraged them to make choices. One staff member said, "We encourage people to choose what to eat, drink and what to wear". On the whole this was what we observed throughout our day at the service. However, the legislation and current guidance for staff in supporting people with wider and more complex decisions were not fully understood by the staff we spoke to. Relatives said they had not been involved in any decisions about their relative's care. They all said that the staff would always talk to them about their relatives and would always tell them if there been any problems. One visitor said, "They would tell me if my relative had had a fall or anything".

The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had not been fully implemented which meant that care planning and formal recording of capacity and decision making was not comprehensive or clear. One person had blank documentation and another had documentation completed that concluded that they lacked capacity. But this did not say what professional had completed this nor to what decision within life this related to. We spoke to the relevant professionals within the local authority. They told us that they had visited the service recently. They had not received any applications relating to DoLS. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom of movement and liberty these are assessed by appropriately trained professionals. The manager confirmed they had application form given to them by the local authority and that these would be completed for people living at the service.

We found that external doors had controlled entry and exit. We observed one person repeatedly asked to go out and tried to leave on several occasions. A staff member was on a break on the other side of the locked door and the person asked why the door was locked. The staff member replied, "Yes it is locked. I do not know why it is locked". The staff did not have the skills to support this person. This made the person cross. We saw that the person had a risk assessment in place to prevent them from leaving. It instructed staff to reassure the person and to take their mind away from what they were thinking at the time. This assessment and plan did not relate to any guidance or legislation or refer to any trained professional with regards the decisions in place.

This demonstrated a breach of Regulation 13 (1(7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors told us that the staff were competent. One person said; "I'm sure they know me as a person and understand my needs. They're very, very helpful". A visitor said, "The staff seem to have the skills and I'm sure they know my relative as a person".

On the day of our visit several staff were undergoing refresher training in moving and repositioning and first aid. One staff member said, "The refresher training is very thorough". Staff we spoke with told us that they received regular training updates. Staff had received an introduction to dementia, a small number of staff had further training and had completed the virtual dementia training. They told us had led to a deeper understanding of what it felt like when unable to express needs and understand others clearly. Staff had also received training in safety matters such as fire safety, infection control and health and safety.

There was not a training plan in placed based upon the needs of people using the service. Training was not fully effective as we had seen examples of staff member's interactions that included the inability to support people with their distress, meal times, and people wanting to leave the premises and an overall lack of understanding on falls prevention.

New staff had an induction and during this time they read the policies and procedures, care plans, risk assessments and they shadowed experienced members of staff. One staff member said they had three shadow shifts and that, "The seniors and staff were very supportive during my induction". We did not see that the induction was comprehensive or that it related to the new Care Certificate.

Staff had not received regular supervision over the last year. Most had two occasions to share their views and seek support in the role that they performed. This lack of frequent support could impact upon the manager's ability to check competence and training required. No one had an

Requires improvement

Is the service effective?

annual appraisal in the last 12 months. The manager said the annual appraisals were planned to take place in July and August 2015 as it would be a year since the new provider took over.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the meals on offer, but we were not assured that everyone had a positive experience to ensure that they had enough to eat and drink. One person said, "The food is very good". Another said, "Yes, there's enough to eat, you've only got to ask and they will give you something or other". A visitor said, "I have had no complaints from my relative about the food. The food looks OK and the staff seem to make the choice for them". Another relative said, it could be better but they were comparing it with their own food at home.

We observed lunch time in three areas of the service. In two areas we observed members of staff gently encouraging people to eat their lunch. They were heard asking people if they had enjoyed their meal and if they had had enough to eat and drink. They were heard offering people a choice of drink and asked people if they required any assistance with cutting up their food and where asked they carried out the task sensitively. Where people were fully supported to eat this was done with care and consideration. A soft diet was provided for those who needed it and it was presented well.

Other people were in a dining area and the main lounge area. This experience was less organised. Staff were needing to access equipment and drinks during the meal and therefore were unable to supervise people and they then became distracted by other matters such as the large television that was showing a police drama unfold. People were not settled and therefore left their meal before staff eventually resettled and supported them.

In people's care plans we saw that people had a malnutrition universal screening tool (MUST) completed. In three plans we saw that people had lost weight. This was between eight and 12 pounds in five months. We could see that referrals to a dietician had been made with build-up drinks being prescribed. However we could not see that records underpinned or confirmed action taken by staff because people did not have their food and drink monitored and recorded, nor in one case was the action plan in the risk assessment completed. This lack of comprehensive information could lead to inappropriate treatment. Staff we spoke to said that they would record food and drink if they thought people's appetite was low. However this should be based upon guidance and assessment to ensure a comprehensive approach. The chef knew people well and was aware of specific dietary needs such as a diabetic diet and the advice given by the dietician

People had support to maintain their health. Visitors told us that their relatives had access to medical services when needed. The local GP surgery supported the service on a weekly basis with a visit by a GP to the service. Care staff prepared a list for the GP of people who needed a consultation. District nurses visited when required. Feedback we received was that the service supported people with complex needs, but that more could be done in preventative care if changes were made. We found that the service used the GP to access all other referrals such as the dietician and the falls prevention. The service had a visiting optician and chiropodist in place.

We recommend that the service finds out more about health care preventative interventions for falls, maintaining nutrition and infections based on current best practice, in relation to the specialist needs of people living with dementia.

Requires improvement

Is the service caring?

Our findings

People at this service did not get a consistently good experience that was always compassionate, involving of people and respectful at all times. Feedback conflicted with the observations we made.

People told us that they experienced a service that was caring. People residing at the home spoke highly of the staff and their relationships with them. All said that they were kind and considerate. One person told us, "They're very friendly and they look after you very well. We're well looked after by these people, they've always been very polite". A relative said, "I'm impressed with the care, I can't find fault with it. My relative came in for respite, liked it straight away and stayed".

We observed staff talking with people who used the service, most were polite and respectful. We heard a staff member use a person's favoured name. This member of staff gently encouraged the person to eat their meal and had a calm way about them. The effect had a positive impact on the person.

However, during the main meal of the day, we also observed two staff members drag a chair with a person seated from one position at the table to another side of the table. Staff did not explain what was happening and the individual accepted what had happened. This was to discourage the person from touching another person's meal. They themselves did not have their meal yet. One same member of staff then supported three people to eat their meal. This was not done respectfully or with dignity as the staff member went between the three people, standing over each person as they placed the food in each person's mouth.

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

Privacy was respected. One person told us, "The staff treat me very well". We did see staff knock on people's bedroom doors before entering. Doors were closed during personal care tasks to protect people's dignity. We observed staff discreetly and sensitively asking people if they wished to use the bathroom facilities.

During the day we observed staff engaging with people who used the service. We observed staff offering choices of drink to people throughout the day. We observed some staff sitting with people who used the service and they spoke with people and knew them well. Visitors felt welcomed by the staff and said there were no restrictions on visiting during reasonable hours. We heard from some relatives that they all felt able to talk to the staff and discuss their relative's condition or needs. But we also heard from another relative that felt the service did not always listen to their views and respond appropriately to their relatives care. We saw little evidence in care plans that people and their families were involved in the development or review of care plans. When asked about resident or relatives meetings to involve people, the registered manager said that this had previously been tried, but no one was interested. We were given minutes of the last meeting that was held in April 2010. This lack of involvement of people in the service does not allow for development or innovation on how best to meet peoples changing needs.

Requires improvement

Is the service responsive?

Our findings

Staff told us that they knew people's needs well, saying the care plans had enough information in them to help, such as the time people like to get up go to bed and their likes and dislikes. We found that the assessment system and care plans in place were not totally suited for people living with dementia. The specific care needs that present for someone with dementia could not easily be captured on the assessment or care plan format used. This was based upon a nursing model that does not readily take account of behaviour that may be present in stress situations for a person living with dementia. People's history and meaningful connections of their past were not able to be captured. Where this was indicated on the documents, there was either scant or no information in the care plans. Each person had approximately eight different plans in place to support them with their daily needs, but these were not based upon robust risk assessments. The instructions then given to staff for individuals was quite generic. An example being, 'observe and give support when necessary'. Or more descriptive such as for one person, 'able to walk around, but refuses to use stick'. Care plans were not individualised or specific enough to guide staff and therefore placed people and staff at risk of inappropriate care.

Most relatives told us that people were well cared for and we observed that people were appropriately dressed and well groomed. The daily recording of care and support given was appropriate and we were able to see that people had been supported with their personal care and bathing on a regular basis. Care plans had generally been reviewed and updated, but we did not see involvement of people, their relatives or professionals had always been consulted. We also question the effectiveness of these reviews as in three cases there was repeat incidents that did not trigger in-depth review and change to plans. Therefore people had been placed at on going risk with no action taken to mitigate this.

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

People were supported to follow interests during the day. We were told that these were organised five times a week. A relative said, "Activities include craft work, colouring, music and entertainment and in the summer I can take my relative out into the garden". We saw that activities on offer were displayed for all to see. As advertised, in the afternoon ice-cream making was taking place, with several people participating in chopping fruit and mixing. People were visibly enjoying themselves.

The majority of people we spoke with had never made a complaint. People said that they knew how to complain and doing so would cause no problems. One person said, "I would tell the staff or my family if I was unhappy about anything". A visitor said, "I've never had to complain but I feel quite able to so because they are so approachable," and, "I've not had reason to complain but I would have no problems in approaching the manager". In the case of one relative we spoke with, they had concerns about the care and welfare of their relative. They told us they had brought these to the attention of management, but that matters had not improved. We fed back to the management and they agreed to look into the concerns again and respond directly to the family using the home's complaints procedure that was in place.

The manager told us that there had not been any complaints made to the service since the service was last inspected (May 2014). We were unable to find that the service used concerns and complaints to develop and drive improvements as there were no records of matters raised except the one shared with us on the day of our visit.

Requires improvement

Is the service well-led?

Our findings

The service was open and had a positive culture but was unclear as to its vision and model of care for older people living with dementia. This service had a registered manager in place. People we spoke with told us that the management were approachable and were supportive of them. Both the owner and manager were present on the day we inspected. They both appeared to know the staff and the people living at the service as people were comfortable in talking to them.

Staff said they were happy in their jobs. Staff told us that the managers were supportive and readily available. One staff member said, "The managers are very helpful, you can talk to them and ask for advice" Another said, "The managers help out when it gets busy." Another said, "They ask for our views and listen to staff". Whilst staff were supportive of the service they were unclear as to the vision and approach of this service to the people living here. The information on the website and written information about the service was not clear as to the aims and model in place for supporting people living with dementia. The environment whilst accommodating people with a physical disability in its layout was not specific to people living with dementia. Appropriate signage, visual memory aids, lighting and use of colour to support people living with dementia had not been used to full advantage.

We recommend that the service seek guidance from a reputable source on dementia models and then base their approach, day to day running, environmental factors and training of staff on this vision.

We asked to see all the systems in place that ensured a quality service for people. The service was starting to seek the views of people using the service and had developed a quality assurance tool for relatives. There had not been any meetings with people using the service or their relatives since 2010. There had been no complaints from people using the service since our last visit. Therefore in terms of developing a quality service based upon feedback from people using the service little information could be gleaned. We saw that staff meetings had been conducted since the new owner took over. One was in October 2014 to introduce the new owner and 28 staff attended. This discussed areas for improvement within the service and staff matters such as training and supervision. The other was in May 2015 where medication and record keeping was discussed. This showed us that staff were involved in the running of the service and were informed of the expectations and developments planned.

In terms of development and preventative approaches based upon clinical governance, the manager was unaware until after our visit that other staff collated information on accidents and falls. This data information could have been used to develop an approach to drive improvement. The manager was open to this suggestion and agreed to develop this along with a falls prevention strategy for the service.

We did find an audit of staff personnel files that had recently been conducted. Where shortfalls had been identified the manager had identified the actions required to address the issues. In addition medicine records seen confirmed that regular audits had been conducted. This was to check that medicines were safely handled by staff and that people received medicine as prescribed. What the service lacked was a framework of systems that checked the quality of service provision. An example being that care plans were generally reviewed, but were not checked for effectiveness of risk assessments and care delivery. If this had been in place the incidents of aggression and assaults on people may have been detected and been preventable.

This lack of overall systems and processes demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not provided with a collaborative assessment of need that was appropriate, then developed into a plan to ensured people's individual needs were met. Regulation 9 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use the service are not treated with dignity and respect at all times.

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 were not protected from avoidable harm because risks to health and safety were not effectively assessed. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established to restrict service user's liberty of movement. People were not protected from improper treatment.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance A lack of systems and processes could not assure the service was operating effectively. There was a lack of monitoring and mitigation to ensure the health, safety and welfare of people using the service.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff at the service were not appropriately trained and supervised to support the care and welfare needs of older people living with dementia.