Chitimali Locum Medical Limited

Whitworth Lodge

Inspection report

52 Whitworth Road
London
SE25 6XJ

Tel: 02082399906

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 31 August 2017 and was unannounced. At our last announced comprehensive inspection of this service on 9 June 2015 we rated the service 'good'.

Whitworth Lodge provides care and accommodation for up to six people with a learning disability, some of whom also have autism. Some people had behaviours which challenged the service in various ways. There were six people using the service at the time of our inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not always enable bodies, including CQC, to carry out their regulatory duties in monitoring the service provided to people. This was because the provider did not always notify external bodies of significant events as required by law. The provider did not have systems in place to ensure all relevant information about accidents and incidents were consistently recorded as they had no template in place. The provider had systems in place to assess, monitor and improve the service, although these had not identified the issues we found during out inspection.

Staff understood their responsibilities to provide care to people in line with the Mental Capacity Act (MCA) 2005. However, the provider had not always recorded their assessments for significant decisions to evidence they followed the code of practice. In addition, the provider did not always formally record discussions held with family members and others involved in people's care in relation to best interests decision making, in accordance with the MCA. The provider told us they would review their processes in relation to MCA as soon as possible. People were only deprived of their liberty when this was required as part of keeping them safe and authorisation was granted from the local authority.

Risks to people were mitigated because the provider identified and assessed risks and put suitable management plans in place for staff to follow in caring for people safely.

People were safeguarded from abuse and neglect by the provider as staff received relevant training and understood how to identify and respond to allegations appropriately.

People lived in a service which was maintained by the provider. Staff and external contractors carried out regular checks relating to the safety of the premises. The provider agreed to contract a specialist to carry out a risk assessment to further mitigate the risks of Legionella accumulating in the water system.

The provider recruited staff following robust procedures to check they were suitable to work with people. In addition there were enough staff deployed to meet people's needs. Medicines management was safe and

the provider carried out sufficient audits to check medicines safety.

People received care from staff who were supported with a suitable programme of training, support and supervision. People received the support they required in relation to eating and drinking and the provider supported people to access the healthcare services they needed.

People were treated with kindness, dignity and respect by staff. Staff understood the needs of the people they were caring for as well as their interests, preferences and the best ways to communicate with them. Staff supported people to maintain their independence. People were involved in decisions about their care and were supported to maintain relationships with people who were important to them.

People were cared for in a way that was responsive to their needs. In addition people were involved in planning and reviewing their care. People were supported to access activities they were interested in. The provider encouraged feedback from people and their relatives. Although people and relatives were confident any complaints would be dealt with well, the complaints policy required an amendment to clarify CQC do not investigate complaints which the registered manager told us they would make as soon as possible.

People, relatives and staff were confident in the leadership and management of the service. The registered manager had been in post for four months and had a good understanding of their role and responsibilities. The provider had open and inclusive ways of communicating with people, their relatives and staff.

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 remains good.

Is the service effective?

Requires Improvement

The service was not always effective. People were at risk of not receiving care in line with the Mental Capacity Act as the provider did not always record their assessments that people lacked capacity.

Staff received appropriate support, supervision and training from the provider.

People received the right support in relation to eating and drinking and in relation to their healthcare needs.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had not always notified external organisations, including CQC, of significant events as required by law. Systems were in place to assess the quality of the service people received but these had not identified the issues we found. Systems were not in place to record accidents and incidents consistently.

People, relatives and staff were positive about the registered manager who was recently registered with us. The registered manager understood their role and had inclusive ways of communicating with those involved in the service.

Whitworth 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 checked 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 was a comprehensive inspection. The inspection took place on 30 August 2017 and was unannounced. The inspection was carried out by an inspector.

Before our inspection we reviewed information we held about the service. This included our previous inspection report and statutory notifications received from the provider since the last inspection.

During the inspection we spoke with three people using the service, a senior care worker, a care worker and the registered manager. We looked at a range of records including three people's care plans, three staff files, medicines records and other records relating to the management of the service.

After the inspection we spoke with one relative via telephone and a social worker via email. We also reviewed two audits carried out by separate departments within the local authority in April and May 2017 which looked at many aspects of the service.

Good

Is the service safe?

Our findings

Risks to people, staff and others were mitigated well by the provider. This was because the provider identified and assessed risks well and put suitable management plans in place for staff to follow in supporting people. For example, the provider identified risks to a person relating to their lack of road safety awareness and put management plans in place to ensure they only accessed the community with staff support. As another example, the provider identified and assessed risk relating to some people's behaviour which challenged. The management plans in place to mitigate the risks included training staff to recognise the signs individuals were becoming agitated and how to support them to relax. The provider also trained staff in how to deescalate situations and risk management plans included ways for staff to keep themselves and others safe. The provider reviewed risk assessments and management plans annually or more often in response to incidents or changes relating to risks. This meant information and guidance for staff to follow in mitigating risks remained current.

People were safeguarded from abuse and neglect by staff. People told us they felt safe and relatives were in agreement the service provided a safe environment. Staff understood the signs people may be being abused and how to respond to keep them safe. The provider trained staff annually in safeguarding adults at risk to keep their knowledge current.

People lived in a service which was maintained safely by the provider. Staff carried out regular checks of hot water temperatures to reduce the risk of scalding, fire safety and environmental hazards. In addition the provider contracted external professionals to carry out regular checks of fire safety systems, gas safety, electrical installation and portable electrical appliances (PAT testing). The provider contracted an organisation to test the water for Legionella twice a year. Legionella is a bacterium which can increase rapidly in water systems if sufficient precautions are not taken and can be harmful to people. However, the provider did not have a risk assessment in place to check they were taking sufficient precautions to prevent Legionella accumulating, as stipulated by Health and Safety Executive (HSE). When we discussed this with the registered manager they told us they would arrange for a suitably qualified professional to carry out a Legionella risk assessment as soon as possible.

People were supported by staff who were recruited via robust procedures to check their suitability. The provider checked the employment history of candidates and obtained references from former employers. In addition they carried out criminal records checks and checked candidates' identification, proof of address and their right to work in the UK. Staff completed a health declaration so the provider could identify any reasonable adjustments to people's roles to accommodate any health conditions. The provider also checked the suitability of candidates to work with people via an interview process.

There were enough staff deployed by the provider to meet people's needs. People and relatives told us there were always enough staff to provide care. One relative told us, "The times I've visited there have been enough staff… I feel they have staff to cover the shifts." The registered manager told us staffing levels varied according to each day's schedule. For example, more staff were booked to work when people required support on activities outside the home. We viewed rotas for four weeks and saw staffing levels were

sufficient, with additional shifts being covered as overtime by permanent staff or by bank staff.

People's medicines were managed safely by staff. A person told us staff always administered their medicines on time, after breakfast. The provider stored medicines safely. Our checks of medicines stocks and medicines records indicated staff administered people's medicines as prescribed. Staff recorded medicines administration appropriately with no omissions. The provider put in place clear guidance for staff to follow in administering 'as required' medicines to people, such as medicines to help people to relax when they were feeling agitated. Records showed the provider limited usage of medicines to managing behaviour which challenged. The registered manager confirmed they used other techniques to help people manage their behaviours which challenged in the first instance, and used medicines as a last resort. Staff recorded the reasons why they administered 'as required' medicines to people, as well as the quantity of medicines administered where this was variable to ensure a clear audit trail. The provider only allowed staff who received training in medicines management to administer medicines to people. Although the registered manager carried out informal checks of staff competency to administer medicines they did not record these and they did not follow a set format to ensure they assessed all staff in the same ways. When we discussed this with the registered manager they told us they would introduce a formal competency assessment for all staff as soon as possible.

Requires Improvement

Is the service effective?

Our findings

People were at risk of not being cared for in line with the Mental Capacity Act because the provider did not always make records relating to people's capacity to consent or agree to the services provided. 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.

The provider did not record whether people had capacity to consent to all aspects of their care, as indicated in the MCA code of practice. The provider noted in some people's care records they lacked capacity to manage their medicines and their day to day finances. However, the provider did not keep records to evidence they followed the principles of the MCA in assessing people lacked capacity in relation to these significant issues. The provider consulted with family members to make decisions in people's best interests when they determined people lacked capacity in relation to managing their medicines and overseeing their day to day finances. However, they did not record discussions held with family members, plus the views of others involved in people's care to evidence the decision making process was in people's best interests. When we discussed these issues with the registered manager they told us they would improve processes as soon as possible.

Our discussions with staff showed they understood their requirements in providing care on a day to day basis in relation to the MCA, such as obtaining consent before providing personal care. The registered manager confirmed MCA training was delivered to staff annually to keep their knowledge current. The registered manager had a good understanding of the principles of carrying out an MCA assessment and told us an example of when they successfully challenged an MCA assessment carried out by an external professional as they had not carried this out in accordance with the act. The lack of records meant the provider could not be assured about the robustness of their mental capacity assessments and best interests processes. The registered manager told us they would review their mental capacity assessment processes and hold best interests meetings where necessary at people's forthcoming annual reviews.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider made appropriate applications for DoLS authorisations when these were required as part of keeping people safe. Staff understood the conditions of people's DoLS authorisations and cared for people in line with these.

People were supported by staff who received appropriate support from the provider, with a suitable programme of induction, training and supervision. New staff followed the Skills for Care induction, the 'care certificate'. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant staff were reaching the expected

standards of care workers during their induction period.

Staff training records showed staff were trained in a range of topics including courses specific to the needs of people using the service. These courses included autism awareness, working with people with learning disabilities and managing behaviour that challenges. The provider also supported staff to complete more in depth courses such as diplomas in health and social care. The registered manager had completed a level 5 qualification in health and social care management and the senior care worker was completing a qualification in team leading. In addition staff recently completed a year-long programme in supporting people in planning and delivering their end of life care, in association with a local hospice and the local authority.

Staff were supported with supervision every two months. Records showed during these meetings staff could discuss any issues of concern, receive feedback on their performance and receive guidance on the best ways to care for people. The registered manager told us appraisals were scheduled for January 2018.

People received the support they needed relating to eating and drinking. People who could give us verbal feedback told us they enjoyed their meal when we observed lunchtime. A relative told us, "[My family member] has actually lost weight [due to support from staff]". We observed those who could not talk and saw they also appeared to enjoy their food. People told us they received food of their choice and staff confirmed this. Staff also told us they usually cooked food from scratch and promoted healthy eating. People were provided with food to meet their cultural and ethnic backgrounds such as jollof rice and ackee and saltfish. The provider monitored people's weights to identify concerns. Staff were successfully supporting two people to lose weight. The registered manger had liaised with the GP and dietitian for two people who were overweight and staff followed their guidance.

People were supported to access the healthcare services they needed by staff. One person confirmed staff supported them to visit the GP when they were ill and that staff encouraged them to visit the dentist and other healthcare services. A relative told us, "If [my family member] has an appointment they tell me and they tell me the outcome." Staff understood people's individual healthcare needs. People had health action plans in place to ensure their healthcare needs were recognised and met. Health action plans were developed during annual reviews with a learning disability nurse. Staff understood people's healthcare needs and people were supported to attend regular appointments with GPs and other medical professionals.

Good

Is the service caring?

Our findings

People received care from staff who were caring, treated them with dignity and respect and respected their privacy. A person said, "Staff are alright". A relative told us, "I'm happy with the care [my family member] receives… staff are very approachable, they're always smiling". We observed staff interactions with people and saw they took care to listen to people and respond to their questions and requests. Staff also used appropriate touch to calm a person who was becoming agitated. Staff spoke about people in a respectful way and it was clear they enjoyed their roles in caring for people. Staff told us they ensured they shut doors and drew curtains when providing personal care. We observed staff discreetly advise a person to change their clothes when they became soiled, so that no others would overhear. People were supported to dress well, in clean, matching clothes in accordance with their personal or cultural style. Most staff were dignity champions as the manager encouraged this. Dignity champions are people who sign up to a campaign run by the National Dignity Council, pledging to challenge poor care, to act as good role models and to educate and inform all those working around them.

People were supported by staff who knew them well. One relative said, "Staff know [my family member well] as [my family member] has been there for [many years]". Our observations showed staff had developed good relationships with people. We observed people were comfortable around staff and approached them freely for conversations or assistance. Staff spent the majority of their time interacting with people in various ways and care was provided in a person-centred, not task-based way.

People were supported to maintain relationships with those who were important to them. One person told us they would visit a close family member very soon and would travel independently. Other people visited their family regularly with staff support. A relative told us they often visited and, "I don't give notice, it's always unannounced". The registered manager updated relatives regarding any significant events in, including changes to their health, accidents and incidents and changes to their care plans.

Arrangements were in place for people and their relatives to be involved in decisions relating to people's care. One person told us, "I sat in the garden all day yesterday" and told us how this was their choice to do so. During our inspection people chose where and how they wished to spend their time. Each person had a keyworker. A keyworker is a member of staff who works closely with a person to check their care is meeting their needs. We reviewed records of keywork meetings and saw they were used to check whether people were happy with their care and to identify how improvements could be made. Staff also helped people plan what activities they would like to do as well as plan their meals. Staff celebrated people's birthday's in the ways they wanted. One person told us, "On my birthday I saw [a family member] and went out for a meal. [Staff] cooked me a birthday pie." Only staff of the same gender provided care to people where they had shown a preference or their family had requested this. The registered manager also supported people to access advocacy service regarding some decisions.

People were supported by staff to maintain and develop their independent living skills. One person told us, "I do shopping [for the house], it's my job…I get newspapers [for other people in the service]. One person told us how they had helped to bake an apple pie the previous day. They told us they were often involved in

cooking as well as other tasks such as laundry and cleaning their room. People's care plans indicated how staff should support people to do certain tasks themselves as far as possible.

Staff understood the different ways people communicated their needs and preferences. We observed staff understood people whose speech was sometimes unclear very well. Staff adapted their speech depending on the person they were communicating with to help people understand them better. Staff understood the body language and gestures of people who were non-verbal. The registered manager ensured people had communication guidelines in place to inform staff about the ways people communicated and the best ways to communicate with them.

Good

Is the service responsive?

Our findings

People were cared for in a way that was responsive to their needs and preferences. People's care plans were 'person-centred', focusing on the person as an individual with them at the centre of their care. People's care plans contained information and guidance for staff on how to care for people in relation to their learning disabilities, autism and other conditions such as epilepsy. Care plans also including information about people's likes and dislikes, hobbies and interests and their backgrounds including their family networks. Staff told us they read people's care plans and our discussions with staff and our observations showed they knew people well and provided care in accordance with people's care plans.

People and relatives were involved in planning and reviewing people's care. The registered manager ensured people's care plans were reviewed regularly so the content remained reliable for staff to follow in caring for people. Staff met with people as part of the review process to find out about their views and whether they would like any changes to their care. The provider also reviewed people's care each year in meetings led by social services. People and relatives were invited to these annual reviews of people's care to ensure they were involved as much as possible. The registered manager sent one person's relative copies of their care plans when these changed as they had requested these and their family member was in agreement.

People were supported to do activities they were interested in. During our inspection one person requested to sing karaoke and staff duly supported them to do so. A person told us they enjoyed snooker and watching a particular genre of movies, and they explained staff supported them to explore their interests as often as possible. We observed staff encouraged people to do various activities throughout the day to occupy themselves, such as reading a newspaper, writing letters and arts and crafts. Each person had an activity programme in place. On the day of our inspection one person was supported to attend a day centre. Other people attended horse riding lessons and a gardening project for people with a learning disability. One person told us they were going on holiday to a British seaside resort the following week. Staff told us they arranged regular day trips at least twice a month, with holidays at least once year. Day trips and holidays were arranged in small groups so staff could better meet people's individual needs and preferences.

People and their relatives were encouraged to feedback to the provider. Besides keywork meetings, people also met monthly with staff in 'house meetings' where they were asked to share their views of the service. In addition people and relatives were requested to complete annual questionnaires to find out views and suggestions for improvements.

People and relatives told us they had confidence the provider would respond appropriately if they had reason to complain. A relative told us, "I complained in the past and some things were put into place." The provider told us they had not received any complaints since our last inspection. The provider had a complaints policy which they made people and relatives aware of. However, the complaints policy misled people as it incorrectly stated complaints should be forwarded to CQC if the complainant was not happy with the response of the service. CQC does not investigate individual complaints and instead complaints should be raised with the Ombudsman if the service is unable to resolve this. When we discussed this with

the registered manager they told us they would ensure the complaints policy was updated as soon as possible.

Requires Improvement

Is the service well-led?

Our findings

The provider did not always enable external bodies, including CQC, to carry out their regulatory role in monitoring service provided to people. This was because the provider had not notified CQC of important events at the service, such as police incidents and authorisations to deprive people of their liberty. However, the provider had notified us of a serious injury in the past 12 months, as required by law. In addition, the provider did not make a RIDDOR report (reporting of injuries, diseases, and dangerous occurrences) to Health and Safety Executive (HSE) in relation to an incident at work even though a member of staff was signed off work for more than seven days, as required by law. When we raised our concerns with the registered manager they confirmed this was an oversight and they had not been in post when the regulatory reporting was required. However, the registered manager completed the necessary reporting before the end of our inspection.

People could be at risk of not receiving the right care in response to accidents and incidents. Records relating to accidents and incidents were not always robust as the provider did not ensure all the necessary information was captured. Although the registered manager ensured staff recorded accidents or incidents, there was no standard template to ensure consistency. Staff wrote incident reports freely and information such as the time and location incidents occurred, along with details of any witnesses were not always recorded. In addition, records of the action taken in response to the incident were not always recorded and there was no record made to evidence reports had been reviewed by the registered manager. However, the registered manager confirmed they reviewed all reports submitted to them. The registered manager told us they would review how they recorded accidents and incidents and introduce a standard form to ensure all necessary information was captured as soon as possible.

Systems to monitor the service were not always robust as they had not identified the issues we found during our inspection. Although the operations manager visited the service frequently to check the quality of service they did not record their findings and so there was no audit trail of any issues they found with action plans to resolve them. The registered manager oversaw other internal audits which included checks of medicines management, care plans, risk assessments and health and safety. The local authority had recently completed two separate audits of the service. Where suggestions for improvements had been made the registered manager confirmed they were taking appropriate action in response. The pharmacy had audited medicines management in the last year and confirmed medicines systems were robust.

Although we identified some issues relating to the governance of the service, people, relatives and staff were all very positive about the management. One person told us, "[The registered manager is] a lovely lady!" A relative told us, "[The registered manager] looks into things, she's very good." Staff told us the registered manager was supportive and always listened to them. The registered manager registered with us in May 2017 and had been promoted to the position from their previous role as team leader. The registered manager was a visible leader within the service as they spent much of their time in communal areas interacting with people and supporting staff. The registered manager knew the service well and had a good understanding of their role and responsibilities, as did staff. The registered manager had completed the level 5 diploma in leadership and management in healthcare services. They also attended forums and

training courses for managers run by the local authority and in these ways they were committed to constantly improving their knowledge and skills in their role.

The provider had open and inclusive ways of communicating with people, their relatives and staff. A relative told us, "[Staff] are very good at communicating things to me." The provider met with staff and people using the service separately in monthly meetings to gather their views and involve them in running the service. In addition the provider sent quality assurance surveys to people and their relatives and the registered manager had reviewed and responses. We found responses were positive and there were no recommended actions.