Care Unlimited Group Ltd

Chipstead Lodge Residential Care Home

Inspection report

Hazelwood Lane
Chipstead
Coulsdon
Surrey
CR5 3QW

Tel: 01737553552
Website: www.careunlimited.co.uk

Date of inspection visit:
22 September 2017

Date of publication:
12 October 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on the 22 September 2017 and was unannounced. Chipstead Lodge is registered to provide residential care for up to thirty six people. The service is set up to provide care for people who have mental health diagnosis and also provides care to people who are elderly. On the day of our inspection 26 people lived at the service.

The registered manager was on annual leave on the day of the inspection. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Instead we were supported by a senior carer and a director of the service.

We carried out a comprehensive inspection of this service on 21 July 2017. After that inspection we received concerns in relation to the safety of people that lived at the service. We received information from the provider that there had been a fire at the service and that one person had left the service without staff being aware. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chipstead Lodge Residential Care Home on our website at www.cqc.org.uk"

People were not always safe as the provider had not ensured that all identified risks were mitigated. There were people that had left the service unnoticed by staff. Despite the risk of this happening being known by the provider appropriate steps had not been taken to ensure that people were protected. One person left the home for six days until they were found by Police. We are making further enquiries about this incident with the provider.. There had been another two incidents since June 2017 where people have left the service without support.

In the event of an emergency information that related to people's whereabouts and what support they needed was not up to date or accurate. Handover sheets and the service fire risk register were not completed accurately and did not always account for people that were not at the service.

Personal evacuation plans (PEEPs) had not been updated to reflect that one person had passed away, two people were not at the service and one person that was at the service did not have a PEEP. The PEEPs did not contain information around the risks of the people that may leave the service without staff being aware.

The provider notified us after the inspection that actions had been put in place to ensure that people were regularly checked to ensure that they were present in the service.

All appropriate actions had been taken by staff in relation to the fire that was started at the service. The provider informed us that the fire service had commended staff on their swift action to ensure that people

were evacuated safely.

The service was last inspected on the 21July 2017 where breaches of regulations were identified in relation to the overall environment and the lack of person centred care, lack of mental capacity assessments, lack of robust governance, lack of training for staff and the lack of supervisions for staff. At the inspection on the 21 July 2017 the service was rated as requires improvement.

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

The service was not always safe.

There have been three incidents where people have left the service without support.

There were not appropriate plans in place to ensure people's safety where they were at risk of leaving the service unnoticed by staff. Staff were inconsistent of their knowledge of the risk of people leaving without support.

Emergency evacuation plans for people were not accurate. Staff had not carried out checks on people's whereabouts. Records that related to people's whereabouts were not always accurate.

Chipstead Lodge Residential Care Home

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. We carried out an unannounced comprehensive inspection of this service on 21 July 2017. After that inspection we received concerns in relation to the safety of people that lived at the service. We received information from the provider that there had been a fire at the service and that one person had left the service without staff being aware. As a result we undertook a focused unannounced inspection on the 22 September 2017 to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chipstead Lodge Residential Care Home on our website at www.cqc.org.uk".

The inspection team consisted of two inspectors. Prior to the inspection we reviewed the information in relation to the incidents the provider notified us of. This included information regarding a fire that had been started by a person that used the service and information regarding a person that had left the service unnoticed by staff.

During the visit we spoke with a director of the service and five members of staff. We looked at a sample of three care plans of people who used the service, accidents and incident report, evacuation procedures for the service and records that related to the checks that staff were undertaking to ensure that people were safe.

The service was last inspected on the 21July 2017 where breaches of regulations were identified in relation to the overall environment and the lack of person centred care, lack of mental capacity assessments, lack of robust governance, lack of training for staff and the lack of supervisions for staff. The service was rated as requires improvement.

Requires Improvement

Is the service safe?

Our findings

People were not always safe as the provider had not ensured that all identified risks were mitigated. According to their accident and incident reports in June 2017 one person had left the service unnoticed by staff. This person required staff with them to access the community and the incident report stated that 'All staff aware that he was at risk of going out.' The person was found and brought back to the service by a member of the public soon after they had left. Despite the person leaving the service there was inconsistency from staff about their knowledge that this person was at risk of leaving the service without support from staff. One member of staff told, "[The person] has left somewhere else." Four of the staff we spoke to were unable to tell us that the person was at risk of leaving. In August 2017 we were notified that another person had left the service without staff noticing. The person was found safe and well and brought back by Police. In the person's pre admission assessment it stated, 'Any opportunity he will go out the door.' Despite this knowledge this person was still able to leave the service unnoticed by staff which put them at risk.

We were notified that a third person had left the service unnoticed by staff on the 15 September 2017. This was not noticed by staff until the following morning. No checks had been undertaken on the person since they had gone to their room the night before. The person had left without their medicine or any access to funds. The person was missing from the service for six days until the Police found them. On reviewing the person's care plan there was evidence that this risk was known. Deprivation of Liberty Safeguards (DoLS) applications had been submitted to the Local Authority in 2015 in relation to the person leaving the service unsupported by staff. This was because there had been a history of the person leaving the service without staff knowledge. In March 2016 there was a letter from the mental health trust stating, 'High risk of absconding.' A more recent document dated April 2017 from the local authority stated, 'Risk of absconding from [person's name.]' There was a risk assessment dated August 2017 that stated that the person was a risk of leaving the service without staff knowledge. Despite having this knowledge there were no appropriate plans in place to ensure that the person was monitored sufficiently to stop this happening. Staff told us that although they were aware the person left the service years before they did not believe that this was a risk now. When asked, one member of staff still did not believe that this was a risk despite the person having just been returned to the service without staff knowledge. We are making enquiries with the provider in respect of this incident.

In the event of an emergency information that related to people's whereabouts and what support they needed was not up to date or accurate. The 'senior handover sheet' that was completed each morning and evening was inaccurate. It stated on the morning of the 16th September 2017 that the person (who had already gone missing from the service) 'slept well no concern.' The person had not been checked in their room by staff so this information was inaccurate. Had staff checked in their room they may have been alerted sooner to the person's absence. The service 'Residents fire register' that had been completed by staff stated that one person (that was known to have been admitted to hospital on the 16 September 2017 and not returned to the service) was ticked as present at the service up to the 21 September 2017. We were informed by the provider that another person at the service was at risk of leaving the service without support from staff. There was no mention of any risk of them leaving the service in any support plan or risk

assessment. This put them at risk and led to staff having inconsistent knowledge of risks to people.

In the event of an emergency such as a fire each person had a personal evacuation plan (PEEP). These were left in the office area and could be accessed quickly and easily if needed. However PEEPs had not been updated to reflect that one person at the service had passed away, two people were no longer living at the service and one person that was at the service did not have a PEEP. The PEEPs did not contain information around the risks of the people that may leave the service without staff being aware.

As appropriate actions had not been taken to protect people from known risks this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All appropriate actions had been taken by staff in relation to the fire that was started at the service. The provider informed us that the fire service had commended staff on their swift action to ensure that people were evacuated safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected against known risks.

The enforcement action we took:

We have issued a warning notice in relation to this regulation.