Irvine Care Limited

Coombe Lodge Care Home

Inspection report

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Ratings

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

Overall summary

On the 18 and 19 March 2015 we carried out an unannounced comprehensive inspection of the service to follow up the four requirement actions. We found the improvements required at the service had not been made. We issued four requirement actions and four warning notices.

We undertook this focused inspection on 20 and 21 May 2015 to check the provider had improved and now met legal requirements of the warning notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coombe Lodge Care Home on our website at www.cqc.org.uk

This inspection took place on the 20 and 21 May 2015. It was an unannounced inspection.

During the last inspection in March 2015 we had concerns about the care and welfare of people, including whether their nutritional needs were being met. We also had concerns about the numbers of staff and the lack of support for staff by the provider. The local authority also

Summary of findings

has concerns about the service and have been monitoring and working with the service provider to improve the quality of care provided. Many of the concerns we found during this inspection reflected the same concerns raised by the local authority staff who had been visiting the service since our last inspection in March 2015. During this inspection we found some improvement had been made in some areas.

Coombe Lodge Care Home provides nursing care for up to 60 people, including people living with dementia. The service has two units which provide nursing and dementia care. The service is set over two floors. At the time of this inspection, 25 people were living at the home.

There was no registered manager working at the service. 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 home had a temporary peripatetic manager in place.

We found improvements had been made to the accessibility of most people's call bells. We found one person did not have their call bell accessible to them. Where people were unable to use the call bell staff checked their welfare regularly. Staffing levels had increased this resulted in more staff being available to observe people and to ensure their safety. The number of falls had decreased, and falls prevention technology such as alarm mats alerted staff to the whereabouts of people when they left their rooms. We found staff responded quickly.

We did not always observe good practice in the care of people. Staff were not always responsive to people's needs. One person was positioned in such a way that the risk of falling out of bed was high. Staff did not respond positively when we asked them to assist the person, stating they would only reposition themselves again.

One person's dentures were dirty, a staff member told us although they had tried to clean them without success they had placed them in the person's mouth. One person, who ate with their fingers, dropped food on the floor and ate it. Staff did not meet their need for support.

Staff were not always aware of people's wants and needs. They did not always engage with people in an appropriate or meaningful way. Whilst we did observe some positive interaction between staff and people, this was mainly when care was being provided. Staff told us they enjoyed working in the home, and some showed a caring and sensitive nature towards people.

Some activities were available to people but we did observe one person in bed all day without any music, television or stimulation. This meant their social needs were not being met.

Staff knew how to support most people with their food and hydration. Records showed people were eating well, and from our observations most people were encouraged to drink and eat to maintain their health and well-being.

Records related to the care being provided were confusing and difficult to locate. The provider was in the process of updating records and the systems used for care planning in order to streamline them. Care plans were not always up to date and accurate.

Staff told us they were being supported by the temporary peripatetic manager. In addition support was offered through training, coaching and meetings. Staff had also been given daily sheets to remind them of what the individual needs of people were; for example how often the person needed checking and how much support they needed with food and fluids amongst other things.

The provider told us they had made improvements since the last inspection but acknowledged the need for further improvements. They responded to our requests for information in a timely way.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We will report on the action taken at a later stage.

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?
We found action had begun to be taken to improve safety for the people who used the service. There were now enough staff to meet the needs of people.

We could not improve the rating for this key question from inadequate because to do so requires consistent good practice over time. We still have to follow up on all the requirements in the previous inspection, we will check this during our next planned comprehensive inspection.

Inadequate

Is the service effective?
Some aspects of the service were not effective, people's needs were not always responded to in a timely way. Improvements had been made to how people's nutritional needs were met.

We could not improve the rating for this key question from inadequate because to do so requires consistent good practice over time. We still have to follow up on all the requirements in the previous inspection, we will check this during our next planned comprehensive inspection.

Inadequate

Is the service caring?
Some aspects of the service were not caring. People's dignity and privacy was not always protected. People were not always supported to make choices.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time.

We still have to follow up on all the requirements in the previous inspection, we will check this during our next planned comprehensive inspection.

Requires improvement

Is the service responsive?
We did not look at this area during this inspection.

Is the service well-led?
We did not look at this area during this inspection.

Coombe Lodge 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. 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.

We undertook an unannounced focused inspection of Coombe Lodge Care Home on 20 & 21 May 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 18 and 19 March 2015 inspection had been made. The team inspected the service against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service caring? This is because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors. During our inspection we spoke with the peripatetic manager from the home and met with three other of the provider's managers. We looked at 12 people's care plans and associated care records. We spoke with ten staff including agency nurses, care staff and the chef. We spoke with three relatives and a friend of someone living in the home.

Before the inspection we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. The local authority shared information with us about concerns they had received about the service.

We observed how care was provided to people, how they reacted and interacted with staff and their environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection, we raised concerns about how people's needs were met as no call bell extension cords were in place for them to use. During this inspection we found one person whose call bell was out of reach, we brought this to the attention of the member of staff, who moved the bell to an accessible position for the person to use. We were told by one staff member that only one person on the ground floor could use their call bell. Regular hourly checks were completed and documented to ensure people were safe. We observed staff going in and out of people's rooms to assist with care, and we observed one staff member sat with a person whilst they watched television in their room.

During the last inspection we had concerns about the low numbers of staff employed to care for people. People benefitted because staffing levels had increased. At the time of this inspection the staffing ratio was one staff member to two people during the day and one staff member to three and half people during the night. Staff confirmed the use of agency staff had increased the levels of staffing. One staff reported "It is much nicer now." Rotas showed where there were gaps in the required number of staff attending the home, agency or bank staff were brought in. There was only one nurse employed at the home, the provider relied on agency nurses to provide nursing cover. Two relatives told us they had noticed the increased numbers of staff in the home.

During our previous inspection we had concerns about the number of falls people experienced that were unobserved by staff. During this inspection the peripatetic manager told us the number of falls in the home had reduced dramatically. They believed this was directly linked to improved staffing level and staff awareness and the purchase of falls prevention technology. We observed people were supported by staff with their mobility. The peripatetic manager told us the provider had purchased footwear and we observed everyone was wearing appropriate slippers or shoes.

People received a prompt response when alarms were activated. We entered one person's room that triggered an alarm sensor in the mat. Staff appeared very quickly within a minute to check the person's welfare. We observed the same response time on both floors.

Inadequate

Is the service effective?

Our findings

During our previous inspection in March 2015, we found that the service was not effective in delivering specialised care and support to people living with dementia. Since that inspection the provider has supplied training for 24 staff in person centred care. This training concentrated on the well-being of people, communication skills and how to engage with people who lived with dementia.

During this inspection we did not always see evidence the training staff had received had been put into practice. For example, We observed one person lying in bed. The bed had a low height, but the person's legs were hanging out of the bed and their head was on the pillow. We drew this to the attention of a member of staff who repositioned the person in bed. Later in the morning we found the person in the same position again with their legs hanging out of the bed nearly touching the floor. We brought this to the attention of a different staff member. They informed us there was no point helping the person back into bed as they would keep moving out of the bed. We brought this to the attention of the peripatetic manager. Immediate action was taken to improve the comfort and safety of the person.

One person's dentures had fallen out of their mouth whilst in bed. The nurse took them and placed them in a container with a sterilising tablet. When we examined the dentures we found black debris in the ridges of the gum fixtures. We were later told by a different member of staff they had noticed the debris in the morning, but could not remove it. They said they had therefore placed the dentures in the person's mouth because they were going to have their breakfast. One relative told us they were concerned as they had found their relative's dentures were not being cleaned. This placed the people at risk of infections.

Staff we spoke with were unclear whose responsibility it was to assist people with cleaning their dentures. Records were not available to demonstrate when people's dentures had been cleaned.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the care and treatment of people was not appropriate and did not meet people's needs.

We observed one person was in bed all day during the first day of the inspection. On the second day they were dressed and seated in the lounge. We asked staff why they had been in bed the previous day, and we were told it was because the person had developed a pressure sore. We examined the person's care plan, which had recorded a "superficial wound" along with photographs We noted the person had been seated on a chair in the lounge for over four hours, without the protection of a pressure relieving cushion. We brought this to the attention of the nurse, who organised for the person to be taken to bed, to relieve the pressure on the sore area. We were told by the agency nurse the wound was a grade two pressure sore, this was disputed by the peripatetic manager following the inspection and described it as "superficial scratches". This meant we were given inaccurate and conflicting information. This did not ensure information about people's health was understood by the staff caring for them and left people at risk of receiving inappropriate care and support.

During the previous inspection we had concerns that people's nutritional needs were not always met. Although overall we saw improvements to the food, and the encouragement people received, there were still further improvements required. For example, on the first day of this inspection we observed a person eating a cooked meal with their fingers. They dropped food on the floor which they picked up and ate. They added cooked vegetables to their drink and attempted to eat it with a knife. We noted that most of the staff on duty who were working on that floor at the time walked past the person but did not offer any assistance. We informed the peripatetic manager of this at the end of the first day of the inspection. On the second day we noticed the same thing happened again. The person was left unsupervised, and ate with their fingers. One staff member picked up the person's cutlery when it fell on the floor, and replaced it with clean cutlery, but no other assistance was offered to support them to eat. On both days they wiped their fingers on their clothes which resulted in them being dirty. A relative told us of a similar occurrence a couple of weeks prior to the inspection. On that occasion the same person had dropped their jelly on the floor and staff walked by without offering assistance.

The person's care plan did not identify the support the person needed from staff. When we spoke with staff one staff member told us the person could eat independently,

they only required encouragement when they did not want to eat. Another staff member told us the person usually eats independently of staff but they sometimes asked the person if they wanted help. They told us occasionally this was refused. From our observation the person clearly enjoyed their food, and they were offered additional food when they had finished their meal.

One person used a special plate with a raised side and lip and a special spoon to eat with. On the first day of the inspection the lip of the dish was placed to the left side throughout their meal. They did not appear to have much problem with eating with the plate positioned in this way. On the second day the lip of the dish was placed directly in front of them. A passing staff member moved the plate around so the lip was on the left side. Another staff member rotated the plate so the lip of the plate was away from the person. The care plan did not reflect how the plate should be positioned, and staff told us they did not know which way the lip should face. It was clear that when the plate was not positioned correctly, the person struggled to manoeuvre the food onto their spoon. This resulted in food spilling onto the table and their apron. The local authority safeguarding team made us aware of a concern raised by a relative who had visited the home late one morning. The person was still in bed and their breakfast and drink were cold. The person was not in the correct position to enable them to feed themselves; they did not have their dentures in and appeared hungry and thirsty. This concern was being investigated by the local authority safeguarding team.

This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 This was because people were not supported to ensure their nutritional needs were met.

Records related to food and fluid intake were confusing. These along with other care records were being reviewed by the provider who planned to keep all records in one file, with a clearer layout. At the time of the inspection records related to care were located in people's rooms, in the nursing office and those related to medicines and fluid thickeners were in the medication room. This meant there was a risk that different information would be recorded in different places. This could lead to people being given fluids that had not been thickened correctly. The local authority had raised concerns about this with the provider, several times since our last inspection.

The monitoring of fluid was made difficult due to the location of the care plans not being with the daily recording sheets or the medication administration records. For two people who had not met the desired target the total fluid intake had not been recorded. Due to illegible handwriting some amounts of fluid were not clear and this led to an inaccurate total being recorded. This did not support a robust and accurate system of monitoring.

During our last inspection in March 2015 we had concerns about the amount of time people had to wait for meals, due to the staff shortages. During this inspection we found this had improved and most people received their food in a timely manner.

When one person on the ground floor refused their meal at lunchtime, staff found alternative finger food which they accepted. Their food was provided to them in the corridor which is where they liked to be most of the time. Although care plans did not reflect how to support people who refused food or drink, staff on the ground floor knew alternative methods to encourage people to eat and drink by offering a choice of foods and by other staff intervening.

One person on the first floor did not eat any of their meal at lunchtime. They were not offered any alternative food at that time. The chef told us the person would be offered fortified food later in the day to compensate. Another person who did not eat their main meal was offered two desserts.

Documents showed snacks were available to people when the main kitchen was closed at the end of the day. Supplies such as chocolate bars, crisps, and desserts were available in a small kitchen. We observed cakes being offered to people in the afternoon.

On the second day one staff member set up a "pop up" café on the ground floor. We observed one person who spent a lot of time walking around the floor, stopped to have a drink and eat a snack.

Staff told us there were enough staff to support people with food and drink. We confirmed this and observed how people were encouraged to eat and drink throughout the day

Inadequate

Is the service effective?

People's preferences were not always respected. One person's records stated they did not like porridge, however, on their care plan it stated their usual breakfast was porridge. We checked the food intake records which showed they had been offered porridge for breakfast on some occasions. Another person was given toast, their relative told us they did could not eat toast as they had no teeth.

We spoke with the chef and the peripatetic manager. They informed us since the last inspection an additional chef had been brought in to offer guidance and advice to the home in relation to nutrition and food presentation. Staff understood how to fortify food to add calorific value. Food was presented in an attractive and appetising way. Pureed food resembled the food in its previous form, assisting people to know what they were eating, and food groups were kept separate on the plate. This assisted people to taste the different flavours and enjoy their meal.

During our last inspection in March 2015 we were concerned staff were not being supported by the provider. During this inspection staff told us they felt supported by the peripatetic manager but were concerned about the changes that were taking place within the home. The provider appreciated that the increased scrutiny and observations of staff along with people moving out of the home had raised their anxieties and increased their sense of insecurity. The provider told us they were offering support to staff through meetings, supervision and training.

We examined the supervision matrix. This showed all staff had received supervision or it was planned to happen before the end of June 2015. One staff who had received supervision told us they had received positive feedback during their supervision session which they had not experienced before. The peripatetic manager told us they had found supervision with staff beneficial as a way of getting to know staff and understanding their personal and professional needs.

The training matrix was sent to us following the inspection. This showed what training staff had received. We were told that recent training was not included in the matrix as this had not yet been entered onto the system. We could see from the information supplied that 82% of staff had completed safeguarding training, and 89 % had completed the moving and handling practical sessions. Other training areas such as nutrition and malnutrition in older people only 2 staff had completed.

Since the last inspection six staff had attended leadership training. A further six staff attended training on documentation. Person centred care training had been attended by 24 staff. Coaching had also been carried out. This involved senior staff observing and guiding staff in their practice, it included a reflective session where staff could explore how they could have improved on their practice or provided care differently.

Flash meetings had been introduced. This included a meeting with staff at 10.30am each day. It was a short meeting to update staff on the day's events including GP visits. It was also an opportunity for them to discuss any discrepancies they had found between the earlier handover and what was happening in the home on that particular day. On the second day of the inspection, one staff member told us they had attended a flash meeting, and had found it useful, especially as they had just returned from time off.

Each member of staff had been given a staff daily update reminder. This was printed on an A4 sheet of paper and included the essential details of care needed each day for each person in the home. Included in the information were details such as if the person had a do not attempt resuscitation in place, whether they required checking hourly, along with how much fluid they were supported to drink in a day. One staff member told us it was useful, especially as they were bank staff and did not work regular shifts.

Requires improvement

Is the service caring?

Our findings

During the previous inspection we found people's privacy and dignity was not always respected. People's privacy and dignity were still not being consistently protected. On the first day of the inspection, we knocked on two people's doors. On both occasions we were told to enter by someone in the room. On entering both rooms it was evident the person was receiving personal care, with one person in full view. We mentioned this to the peripatetic manager who thought it may be helpful to have a sign on the door to alert visitors and staff that privacy was required. On the second day we knocked on a person's door, on this occasion the staff member came to the door, but the person was not visible.

Whilst discussing the needs of people with a member of staff, they were unaware of a person's ethnic origin. Although they were able to describe some of the person's cultural needs they said these were not always met by the provider. For example, requiring female staff to support them with their care.

We were told by the peripatetic manager that people were encouraged to make choices about the food they ate. They recognised that people who lived with dementia may have difficulty in remembering choices or making decisions. To assist people with this, staff presented people with two meals that were available at mealtime. This enabled the person to choose which one they preferred. On the first day of the inspection we did not observe anyone being offered a choice in this way. On the second day of the inspection we observed one person being offered this choice on the ground floor. This meant people were not encouraged or supported to make choices and decisions in relation to their care such as what they had to eat at mealtimes.

Through observations and discussions with staff we found staff did not always understand about people's histories, likes and needs. For example, one staff member was able to tell us about the practical aspects of caring for people, but not about engaging with the person. Another told us they did not know the nutritional needs of the people they cared for. We observed how some staff found it difficult to engage with people and did not always speak to them in a meaningful way. For example we observed one staff member say to a person "I love you." The next day whilst the person was eating their lunch, the same staff member walked past their table and asked them "Do you love me?" The person looked confused on both occasions. We observed one person was having their nails filed. The staff member was working on the person's nails whilst appearing to watch television at the same time. There was very little interaction with the person.

This was a continued breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. Supporting staff. This corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because although staff had received training and support in how to care for people they were unable to demonstrate competency in the duties they were employed to perform,

During our last inspection in March 2015 we had concerns about people being cared for in bed all day with no stimulation. During this inspection we found most people were not in bed, however, one person was in bed with no radio, television or music playing. Their care plan stated they liked listening to music. The person was in bed for one and half days during the inspection there was no stimulation, apart from personal care and support with eating and drinking. We observed other people were in bed but did have engagement from staff whilst care was being carried out.

We found the same person's nails were long and dirty. We brought this to the attention of the peripatetic manager. A relative told us they occasionally found a person's nails long with brown matter underneath. This placed people at risk of infection and unintentional self-injury.

We observed some positive interactions between staff and people who lived in the home. We heard one staff member tell a person what they were eating whilst supporting them with their lunch. On another occasion staff were talking with a person about the activity they were participating in.

Staff told us they enjoyed working in the home and spoke positively about the people they cared for. One relative told us they had seen improvements in the home. They said the atmosphere appeared calmer, and "whatever I ask for is never too much trouble." They said the home met the person's needs and the care was good. In their opinion things had changed for the better. They said they were thinking of moving the person out of the home, but now they felt reassured by the improvements made to the staffing levels, and the general care, that they no longer wished to do this.

Is the service responsive?

Our findings

We did not look at this area during this inspection.

Is the service well-led?

Our findings

We did not look at this area during this inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services This corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of people was not appropriate and did not meet people's needs.

The enforcement action we took:
Because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown above we took enforcement action to cancel the registration of the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff This corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staff were unable to demonstrate competency in the duties they were employed to perform.

The enforcement action we took:
Because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown above we took enforcement action to cancel the registration of the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs This corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 People were not supported to ensure their nutritional needs were met.

The enforcement action we took:
Because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown above we took enforcement action to cancel the registration of the location.