Heathbrock Limited

Chester Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focussed inspection of Chester Lodge on 17th of August 2016.
This visit took place in response to concerns that we had received. These concerns included concerns about the safety of people who used the service as well as the way in which the service was led.

During this visit, we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. We will publish the actions we have taken at a later date.

Chester Lodge is a nursing home that is owned by Heathbrock Limited. It is a modern three-storey building close to Chester city centre. There are car parking spaces next to the building. The service provides personal and nursing care for up to 40 people. At the time of the inspection there were 34 people using the service.

The service had a registered manager. 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 registered manager was not present during our visit.

A comprehensive inspection had taken place at the service in June 2016. At that inspection we found that the registered provider was required to make improvements in all the five key areas that we looked at. The inspection in June 2016 highlighted that there were breaches of regulations 11 and 17. Regulation 11 related to the need for consent to be gained from people in respect of their care. Regulation 17 related to the lack of a care planning in respect of medicines prescribed when needed and the need for person-centred and comprehensive care plans.

On this visit we found that the premises were not safely secured which meant that people who used the service could not have their safety guaranteed at all times. Visitors to the service were not monitored therefore staff had no way of knowing who was in the building, Fire doors were not always closed as required which meant that should a fire occur it could not be contained in one area. Cleaning products hazardous to people's health were left unsecured in a sluice room which in turn was not locked when not in use. An area designated for staff use only was not secured and contained hazards to people who used the service.

We observed people who used bedrails did not always have their safety and comfort taken into consideration despite this being identified as an issue during our last visit in June 2016.

Sections of care plans designed to take the safety of people in to account were out of date. No falls risk assessments were in place for people when there was evidence that they had experienced numerous falls in a short period of time.

Call alarms were responded to inconsistently. We timed the response to call alarms and found that the response times varied. For example some were responded to promptly and others exceeded 20 minutes. Some people stated that their calls were responded to quickly, however one person told us staff had taken some time to answer their calls or had not responded at all.

Staff demonstrated a limited understanding of the process for reporting any abuse allegations. Staff either had no understanding of whistleblowing or did not have the confidence to raise concerns whilst in employment at the service.

Medication was secure; however, a refrigerator used for the storage of some medications was not secure when not in use.

The registered manager had failed to notify us of many incidents that adversely affected the health of people who used the service. Audits undertaken in respect of falls and medication were not robust. Audits had not been undertaken in respect of many key areas such as care plans, bedrail risk and call alarms.

The registered provider was not able to produce a complaints procedure on request or a supporting record of complaints made. This was despite one comment made to us about a concern reported to staff about call alarms.

The registered provider was not able to produce an accident record of an incident that had resulted in a person attending hospital.

People told us that they felt safe and confident with the manner in which the staff supported them. They told us that they considered the service to be "well run".

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

The premises were not safe as parts were unsecured during our visit.

Staff had limited understanding of how to protect people from abuse.

People told us that they felt safe when being supported by the staff team. However, care practices did not protect people from the risk of harm.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager did not always notify us of incidents which adversely affected people who used the service.

Audits were limited in scope and those used were not robust.

Chester 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.

This focussed inspection took place on 17th August 2016 and was unannounced.

The inspection was carried out by a team of two inspectors. The team included an adult social care inspector and an adult social care Inspection Manager.

Prior to the visit, we looked at the information provided by the local authority, safeguarding team and commissioning team. We reviewed information we held about the service including the previous reports, notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required by law to send to us.

During the inspection we looked at the care records for five people and spoke with four people who used the service. We also spoke with four members of staff including the deputy manager and company director. We observed staff supporting people throughout the visit and toured the premises.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe. They told us that they felt safe with staff when they were being assisted with personal care needs. They felt that the staff team knew what they were doing. However, people raised concerns about responses to activating the call alarm. Comments included "I can't always get to my call bell", "They take a long time to respond sometimes" and "Once they did not even come". People told us they thought that there was enough staff on duty.

During our visit we found that people who lived at Chester Lodge did not receive safe care and treatment.

On arriving at the service, the front door was wide open. This meant that anyone could enter the building and potentially pose a threat to the safety of people. In turn vulnerable people who used the service could leave the building and be at risk from being outside on a busy street. The registered provider's statement of purpose stated that the front door was closed at all times and operated via use of a coded lock so that people who used the service could feel safe and secure. The front door was only closed later in the day. The statement of purpose also reassured people who used the service that staff would know who would be in the building at any time. We entered the building unchallenged despite members of staff seeing that we were there. We were only greeted once the front door bell had been rung.

During a tour of the building, the door to the sluice room was unlocked. Inside the room cleaning materials such as toilet cleaner, general cleaner and bleach were present and these had not been securely stored. This meant that people who used the service could have accessed these products and potentially come to harm. The room was secured later on in the day

We saw that a fire exit door had been left open. We exited the building through the fire door and could have accessed the busy road outside. We were informed that a member of staff had left it open to put items in a bin, however there was a period of time which any person could have entered or left the service unnoticed. An area of the ground floor was used by staff. The door from the lounge area to this area was wide open for most of the day. This area contained wheelchairs, a staff toilet and other store rooms. One store room had a fire door which was clearly marked lock when not in use. This was not locked. This whole area posed a potential risk to people who used the service yet was freely accessible with only a sign on the door indicating it was for staff only.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we saw that one person had a bedrail on their bed with a plastic protective bumper on. The person was leaning on the bedrail with a cushion providing head support between the wall and the bed and the person appeared to be very uncomfortable. Another bedrail was in situ but little protection was offered by this. A loose cover was placed over the bedrail which could have posed a risk to the individual accident records confirmed that this person had previously sustained bruising to their shoulder which was caused by

leaning on bedrails. No detail was in place as to how this could be prevented in the future. The Health and Safety Executive (HSE) define bedrails as medical devices whose use should be risk assessed to ensure that people are not at risk from their use. This person's care plan included details on whether bedrails were suitable for use but did not contain details on how they were to be used safely in line with HSE guidance. This issue was raised at our last visit to the service in June 2016.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Details on how people received safe care and treatment were looked at. Some care plans were out of date. For example one person's care plan was dated from 2014. Care plans did not accurately reflect the needs of people and evaluations did not provide a commentary of the care provided at each point. This meant that people were at risk of receiving support that did not reflect their current needs.

In another care plan we saw that although there was paperwork to complete a falls risk assessment in place this had not been completed for one person. This was confirmed by the nurse in charge at the time of our visit. This was despite the person having complex health issues and had experienced numerous falls within a short period of time. The care plan indicated that this person was able to walk independently but could be unsteady; however, a further assessment in August 2016 noted that the person required extensive support with their mobility .Despite needs identified in this person's assessment, no care plan was in place for daily activities such as breathing, sleeping or a particular health need that they had.

The lack of accurate information about people's needs meant they were at risk of unsafe care.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Call alarms were in operation during our visit. These at times were responded to promptly by staff and on other occasions were activated for more than twenty minutes. The Director of the service stated that 'we would like a new nurse call system and quotes have been obtained, however there are currently other financial priorities within the building'. One person had concerns that their call alarm cord could not always be reached. They also commented that call alarms were not responded to promptly in their experience and had on one occasion not been answered at all. Other people told us that staff responded promptly when they called for assistance.

Staff gave us accounts of how they would report abuse and their understanding of what constituted abuse. During their accounts of what constituted abuse staff initially covered areas such as falls which would not necessarily be regarded as abusive practice. Eventually staff accounts covered financial, physical and emotional abuse. Interviews noted that beyond the passing on of concerns, staff had limited understanding of other agencies' responsibilities in dealing with abuse.

All staff confirmed that they had received safeguarding training. This had been done by the Registered Manager although there was no evidence that she had been trained in turn to do deliver the training. Staff were either unaware of what whistleblowing was or told us in one case they would express concerns only if they left employment with the registered provider rather than report if they were still working there. Our

records indicated that we had received five safeguarding concerns relating to the service. One was being investigated at the time of this report.

A staff rota was available and this outlined the staffing numbers on shift at any one time. Chester Lodge provided care to people who had nursing needs and others with more social care needs. Initially the management team were not able to identify how many people had nursing needs and how many had social care needs. Care practice was such that nursing staff were responsible for everyone regardless of their needs. The registered provider was unable to provide any tool used to determine staffing levels in the service. This meant there was a risk that insufficient number of qualified nurses may be rostered to meet the needs of the people who required nursing care.

Medication stocks were stored in a medicines room which was locked at all times. Controlled drugs (CDs) had been prescribed to some people. These are prescription medicines which are controlled under the Misuse of Drugs Act 1971. These were separately stored with an accompanying register available countersigned by staff to confirm use and stocks of medication. The register tallied with controlled medicines in stock. Medication which required storing at lower temperatures was placed within a medication refrigerator, however it was not locked. All other medicines were securely stored. The temperature of the refrigerator was monitored although there were three occasions during the evening when this had not been done. This meant there was no guarantee that prescribed medicines were being stored at the correct temperatures to ensure their effectiveness.

Medication administration records were appropriately signed. Audits of signatures had been completed for the previous months and this had identified issues of non-signing of records. There was evidence that when received, each medicine was accounted for by signatures and amounts.

Inadequate

Is the service well-led?

Our findings

People told us that they considered the service to be "Well run" and said "They have done everything to help me settled in". People told us that they knew who the registered manager was and occasionally did see her within the building.

The service had a manager who had been registered with the Care Quality Commission since 2011. The registered manager was not present during our inspection visit. The deputy manager and a Director of the company which operated Chester Lodge were present.

We received evidence prior to the inspection visit which showed accidents which affected people who used the service had occurred. . However our records noted that we had not been notified about these in line with regulations. For example accident records viewed during our visit showed that a person was admitted to hospital following an accident which we had not been notified about. The registered manager and senior nurse could not locate this accident form during our visit. We asked that this be forwarded on following our inspection; however we have not received this to date.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits were not robust as actions identified had not been actioned. Audits were limited in scope.

Audits of falls had been undertaken however we found that these were not robust. For example one accident had not been considered in the audit and there was limited in detail of what action had been taken to identify trends or prevent re occurrence. The audit recorded the times of day that falls had occurred and the numbers yet there was no indication of how these could be prevented in future.

Audits of medication systems had been put into place, in particular medication records. Records for July 2016 had indicated that there were a number of occasions where medications had not been signed for. Actions from this audit had not been immediate for those omissions involving agency nursing staff. There was no evidence that supervisions had been arranged to discuss any omissions made by nursing staff employed by the registered provider. Whilst an audit had been done, limited actions had been identified and there was no investigation on whether people had received prescribed medication.

No audits of call alarms and response times were undertaken by the registered manager. This was despite comments being raised with us during the visit of people's concerns about the time taken to respond to call alarms which they had raised with the registered manager.

The deputy manager confirmed that no audits of care plans took place. Care plans showed that although monthly evaluations had taken place, care plans were still dated from 2014. In addition to this, care plans based on people's assessed needs had not been put in place. These included care planning on breathing, sleeping and managing behaviours that challenged. Daily records supplementing one care plan did not

include reference to falls that had been experienced by the person. In addition to this, a daily record indicated that one person was chesty and that this needed observing. There was no record that any observations had taken place.

Whilst care plans included reference to the dependency needs of people recorded on a monthly basis, there was no staffing tool used to determine the staffing levels needed to meet people's needs effectively. There was no evidence on how staffing levels had been determined by the registered manager on a day to day basis to ensure all people's needs were met.

Many people who used the service had been provided with pressure relieving mattresses to ensure that their skin integrity could be maintained. While the required settings were recorded, there was no evidence that these had been audited to ensure that correct settings were being used.

Whilst care plans reflected the need for people to have bedrails in situ and the suitability of their use, there was no evidence that the potential risks associated with these, such as entrapment and pressure injuries had been checked. This put people at risk of receiving inappropriate care.

A complaints procedure for the service could not be provided to us. In addition to this there was no record of any complaints, despite being made aware that a complaint had been made. The service's statement of purpose included the complaints procedure that could not be located and clearly assured people that the registered provider would record any concerns whether minor or more serious.

A statement of purpose had been devised by the registered provider. This, however, failed to clearly set out the age range of people the service could cater for.