Mr & Mrs J Dudhee

St Mary's Lodge Residential Care Home for the Elderly

Inspection report

81-83 Cheam Road
Sutton
Surrey
SM1 2BD

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22 March 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 7 October 2015 at which two breaches of legal requirements were was found in relation to safe care and treatment and safeguarding people from abuse. This was because the provider had not suitably assessed and managed some risks relating to the premises, equipment and specific risks to individuals. In addition the provider had not reported some possible allegations of abuse to the local authority safeguarding team for investigation. After the inspection, the provider wrote to us with a plan for how they would meet the legal requirements in relation to these breaches.

We undertook this focused inspection on 22 March 2016. We checked the provider had followed their plan and made the improvements they said they would to meet legal requirements. 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 St Mary's Lodge Residential Care Home for the Elderly on our website at www.cqc.org.uk.

St Mary's Lodge Residential Care Home for the Elderly provides accommodation for up to 40 older people some of whom were living with dementia. The care home is comprised of three converted properties and is run as one unit. During our inspection there were 35 people using the service.

There was a registered manager in post. 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.

At this inspection we found the provider was now meeting the regulation relating to safeguarding people. The registered manager had reported possible incidents of abuse to the local authority safeguarding team for investigation. They had also updated people's care plans and risk assessments in relation to guidance from safeguarding meetings for staff to follow in keeping people safe. However, the registered manager had not notified CQC of allegations of abuse as required by law.

We found a continuing breach in relation to safe care and treatment. This was because the provider was still not adequately assessing some risks relating to the premises, equipment and to individuals specifically and putting suitable management plans in place to reduce the risks. These risks included scalding due to hot water temperatures, environmental assessments and risks to individuals relating to mental health needs, stoma care, pressure ulcers and bed rails.

We identified the provider had improved some aspects of how risks relating to health and safety of the premises and equipment were managed. Frequent checks of the fire system and call bells were carried out and an electrical installation check had also been carried out. The provider had also improved their recording of accidents and incidents to ensure an audit trail. In addition aspects of medicines management

found lacking at the last inspection had also been improved, such as putting in place protocols to guide staff on administering 'as required' medicines and monitoring the temperature of the medicine storage area to check the temperature would not damage the medicines. The provider also had systems in place to monitor, respond to and reduce malodours in the home having replaced flooring and implementing a more robust cleaning schedule.

Although there was a range of systems in place to assess, monitor and improve the service these audits had not always been effective because they had not identified the issues we found during our inspection.

We found three breaches of regulations at this inspection. In relation to breaches regarding notifying CQC of allegations of abuse and good governance you can see what action we told the provider to take at the back of the full version of this report. We are taking further action against the provider in relation to safe care and treatment. We shall report on this when we complete our action.

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. The provider had not always suitably risk assessed and managed risks to keep people safe.

The service had made some improvements to some aspects of health and safety, medicines management and safeguarding people.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection of the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service had not ensured that notifications the provider is legally required to submit to CQC were submitted and promptly. In addition the provider's audits were insufficient in identifying and reducing some risks relating to the health and safety of the premises and equipment and specific risk to individuals.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection of the service.

St Mary's Lodge Residential Care Home for the Elderly

Detailed findings

Background to this inspection

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

This inspection took place on 22 March 2016 and was unannounced. It was undertaken by a single inspector. This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our focused inspection on 7 October 2015 had been made. We inspected the service against two of the five questions we ask about services: Is the service safe? Is the service well-led? This is because the service was not meeting legal requirements in relation to those questions at that inspection.

Before our inspection we reviewed information we held about the service and the provider and obtained feedback from a local authority commissioner. During the inspection we spoke with three people using the service, one relative and the registered manager, a senior care worker and a care worker. We looked at five people's care records, medicines records and records relating to the management of the service including health and safety and quality audits.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2015 we found that, although people, their relatives and friends told us they felt safe in the home we found evidence of two incidents of possible abuse between people using the service which had not been considered as safeguarding by the registered manager. The incidents involved possible physical abuse of a person using the service by another. While the provider had informed relatives of the incidents they had not reported these to the local authority safeguarding team as part of keeping people safe and according to their policy and procedures in relation to the management of abuse. There were also no clear action plans in place to protect people from the risks of these incidents happening again.

The provider wrote to us with their action plan setting out how they would meet the regulation regarding safeguarding people. They told us they would review procedures for reporting and record keeping for allegations of abuse and also retrain staff in how to keep people safe, meeting the regulation by the end of February 2016.

At this inspection we found that the provider was now meeting the regulation relating to safeguarding people. The registered manager had retrained staff in safeguarding procedures and had also reported the allegations of abuse we identified at our last inspection as well as other allegations of abuse to the local authority safeguarding team. The provider had also incorporated guidance from safeguarding meetings into people's care plans to guide staff on keeping them safe.

At our October 2015 inspection we also found a breach regarding safe care and treatment in relation to how risks relating to the premises and equipment and some health related risks to individuals were managed as well as accident and incident recording.

The provider wrote to us with their action plan setting out how they would improve to meet the regulation to become compliant by the end of December 2015. They explained how they would review their system of maintenance checks, review people's care plans and retrain staff in how to use the electronic care planning system in place so that recording of people's needs was improved.

At this inspection we found the provider was still not meeting the regulation relating to safe care and treatment. People were at risk of scalding from hot water because the service had not assessed and managed risks relating to people's health and safety satisfactorily. We tested hot water temperatures in two communal baths and found them both to be above 44°C. This is above the temperature recommended by the Health and Safety Executive "Managing the risks from hot water and surfaces in health and social care". If people are exposed to hot water above 44°C for either washing, showering or bathing, they are at increased risk of serious injury or fatality. The provider had also identified hot water people had access to was above 44°C at several hot water outlets across the home prior to our inspection. However, they were unclear about their responsibility to manage the risks of scalding in relation to this.

In addition we found some risk assessments relating to health and safety had not been reviewed for over a year, the timescale set by the organisation. These risk assessments included those for environmental health

and safety, lone working, general workplace and risks in people's bedrooms. Also risk assessments and management plans relating to specific risks to individual were also not always in place, including for some of the risks we identified at our last inspection. These risks included pressure ulcers, mental health needs, soma care and bed rails. These issues meant the provider could not be sure they had sufficiently identified risks to people using the service and staff and that risks were being managed safely.

These issues were a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our March 2016 inspection we identified the provider had improved the way they monitored some aspects of health and safety risks which were deficient at our last inspection. Weekly testing of call bells and the fire alarm system were in place and an electrical installation check had been carried out. The provider had improved their recording of accidents and incidents. We also identified that the provider had improved medicines management in areas we found lacking at our October 2015 inspection. They had sought and followed advice from a Pharmacist in relation to general medicines management. Protocols guiding staff in administering 'as required' or 'PRN' medicines were now in place as was monitoring of temperatures at which medicines were stored. Staff now recorded when they administered topical creams to people appropriately to ensure a clear audit trail of medicine administration.

At the last inspection we found the home was malodorous in some areas. At this inspection we found the provider had replaced flooring across the home and carried out regular cleaning of flooring to reduce odours. Although we smelt malodour on our arrival at the care home cleaning was in progress and this was promptly dealt with.

Requires Improvement

Is the service well-led?

Our findings

At our October 2015 inspection we rated the service 'Requires improvement' in relation to the key question 'is the service well-led?'. This was because of insufficient systems in place to assess, monitor and improve the service. These systems had not identified the issues we found in relation to the safety of the premises and equipment and some risk assessments and management plans not being in place for some people where specific risks had been identified.

At this inspection we were unable to improve the rating for the key question 'is the service well-led'. This was because the provider's audits were still insufficient in identifying, assessing and managing risks relating to the safety of the premises and equipment and also risks to individuals. In addition the provider's systems had not identified that statutory notifications in relation to allegations of abuse had not been made to the CQC.

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

At this inspection we identified the provider had failed to notify the CQC about three allegations of abuse in relation to people using the service which they are required to do by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission of three incidents with regards to abuse or allegations of abuse in relation to people using the service. Regulation 18(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems and processes to assess, monitor and improve the quality and safety of the services and to assess, monitor and mitigate risks relating to the health, safety and welfare of people. Regulation 17(1)(2)(a)(b)

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 Care and treatment was not always provided in a safe way for people through assessing the risks to the health and safety of people of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks and ensuring that the premises and equipment are safe and used safely. Regulation 12(1)(2)(a)(b)(d)(e)

The enforcement action we took:

We issued the provider a warning notice to be compliant with this regulation by 16/05/2016.