Huntercombe (Loyds) Limited

Pathfields Lodge

Inspection report

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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

About the service
Pathfields Lodge is a residential care home providing personal and nursing care for up to 48 people. At the time of the inspection 32 people were being supported.

The building is comprised of two wings, Pathfields and Greenfields, each of which have three floors.

People's experience of using this service and what we found
Improvements were required to assessing and mitigating risks to people. We found concerns regarding risks of scalding and risks to people's health and safety.

Improvements were required to the environment and the risks this posed. For example, we found several insecticide and rodenticide pods around the communal areas of the home.

Medicines management required improvement. Medicines were not always managed or stored safely.

Systems and processes in place to assess, monitor and improve the service were not effective. Audits completed had not identified the concerns we found during the inspection. When the provider identified issues detailed action plans had not been completed.

People's privacy had not always been maintained. We found personal information stored in an unlocked office.

Improvements were required with communication between the service and relatives. The provider sent out surveys to allow relatives to feedback on the service. However, not all relatives had received this or felt they had an opportunity to give feedback.

People were protected from Infection. Staff wore appropriate personal protective equipment and the home followed best practice regarding social distancing, shielding and accessing testing for staff and people.

Staff were recruited safely and trained appropriately. The provider completed a dependency tool and updated their rota to ensure enough staff were on duty. However, not all relatives thought there were enough staff on each shift to meet individual needs of people living at Pathfields Lodge.

The provider had systems and processes in place to protect people from abuse.

Relatives and staff knew how to complain. Complaints had been appropriately recorded and managed.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The service ensured that people can live as full a life as possible and achieve the best possible outcomes by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible to gain new skills and become more independent.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 16 July 2019) and there were breaches of three regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvements had been made, however the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to negative interactions between people who use the service, a lack of qualified nursing staff and delays in seeking relevant medical intervention. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pathfields Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, maintenance, medicines, controlling infection and management oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Pathfields Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and a specialist nurse advisor. An Expert by Experience contacted relatives of people who use the service via telephone following the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Pathfields Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced; however, we spoke to a member of staff on the phone before entering the service. This supported the home and us to manage any potential risks associated with Covid-19.

Inspection activity started on 8 December 2020 and ended on 9 December 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, such as notifications from the provider and information from the local authority and the public. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with ten relatives of people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, the regional manager, a nurse, two care staff, the maintenance officer, the chef and an administration assistant. We also spoke with a visiting speech and language therapist.

We reviewed a range of records. This included six people's care records and thirty-one people's medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, maintenance records and survey information.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely
At our last inspection the provider had failed to to ensure premises were safe to use or used in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● People were not protected from the risks of scalding. We saw exposed radiator pipes that were very hot to the touch. Whilst all radiators had covers on them, none of the pipework to and from radiators was lagged or boxed in. People who would not always recognise the risks presented by hot water had access to a boiling water dispenser in a kitchenette. The registered manager confirmed no individual risk assessments had been completed in relation to the boiling water dispenser. These issues put some people at risk of scalding.
● Several areas of the home that were accessible to people were cluttered and not well maintained. Two communal bathrooms were difficult to walk around as they were being used to store equipment. One contained a clinical waste bin that was rusty, stained and would not close properly. A full yellow clinical waste bag had been left on the floor. There was exposed rusty pipework and a damaged metal threshold strip had been left behind the door. There were several tripping hazards and general hazards to people's health and safety. The failure to maintain an appropriate environment put people at increased risk of harm.
● People had access to items that increased the risk of harm to them, including pest control traps. There were several insecticide and rodenticide pods around the communal areas of the home. Some people would not always be able to understand why they should not touch these. We saw these were placed in corridors, kitchenettes, the conservatory and lounge. The registered manager confirmed the service had a pest control problem and no individual risk assessments had been completed in relation to these pods. This put some people at risk of contact with and the potential ingestion of insecticide or rodenticide.
● People were able to access areas of the service that presented risks to them. There was a 'Quiet Room' which was unlocked and accessible to people. The carpet was very dirty, and the room was filled with damaged items and rubbish. The en-suite bathroom was very dirty, and the toilet had not been flushed for some time, containing dark green sludgy water. Two lightbulbs had been left on the sink and there was standing water in a mop bucket and in the drain to the shower. These environmental issues placed people at risk of significant harm.
● Medicines were not always managed safely. We found one person's specific medicines were out of date. These had been prescribed to be given in the event of a sudden deterioration in the person's health condition. The service had no effective system in place for the routine monitoring of the expiry dates of these medicines. This put people at risk of not receiving appropriate emergency healthcare.
● When people required feeding via a percutaneous endoscopic gastrostomy (PEG) feed, these were being

stored in wardrobes and staff were not completing room temperature checks. A PEG feed is a tube which goes through a person's skin and into their stomach to give them the nutrients and fluids they need. PEG feeds that are too cold put people at risk of gastro-intestinal intolerance problems such as vomiting or diarrhoea. PEG feeds that are too hot can put people at increased risk of infection. The improper storage of these feeds put people at increased risk of harm.
● Thickening powders were not stored appropriately. We saw thickening powders on worktops in two kitchenettes which were accessible to people and no staff were present. Thickening powders are added to foods and liquids to bring them to the right consistency so they can be safely swallowed. In 2015 the NHS released a patient safety alert following several incidents of harm caused by the accidental swallowing of thickening powder when it had not been properly stored out of reach. The failure to store thickening powders appropriately put people at risk of harm.

The provider had failed to ensure people were protected from the risk of harm. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements were required to wound management photography. Staff were not measuring wounds within photographs by placing a measuring device against the wound. This made it difficult to make clinical judgements based on the lack of perspective within photographs and there was an increased risk that written information about the size of wounds could be recorded incorrectly.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
At our last inspection the provider had failed to establish and operate an effective recruitment process. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider completed a dependency tool to ensure sufficient numbers of staff were on each shift. However, relatives consistently told us they did not feel there was enough staff to meet people's individual needs. One relative told us, "[Person] needed the toilet, but staff said [person] had to wait as they were too busy. [Person] then had an accident." Another relative said, "They never seen to have enough staff, [person's] speech is deteriorating as staff don't have time to sit and talk to [person]." Two other relatives told us that people needed to ring the call bells at least twice before staff answer.
● Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers

make safer recruitment decisions.
● Staff received appropriate training and induction to ensure they had the relevant skills to support people appropriately.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to protect people from abuse. Staff were trained in and understood how to recognise and report any abuse concerns.
● Staff were aware of the whistle blowing policy and who to contact should they feel it necessary.

Learning lessons when things go wrong
● Accidents and incidents were recorded including actions taken. This was reviewed by the registered manager to identify trends or patterns and to ensure lessons were learnt.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to effectively improve the quality of the services provided and assess and mitigate the risks relating to the health, safety and welfare of people using the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Quality assurance processes were not effective in identifying issues with the environment. We saw several health and safety audits stated "pipes to and from the radiators are covered by lagging or boxed in" and "all radiators and radiator covers are correctly secured to the wall". We also saw several infection control audits stated all bathrooms, showers and communal toilets were clean, tidy and in a good state of repair. These statements were not accurate. This failure to identify health and safety and infection prevention and control issues put people at risk of harm.
● When audits did identify issues, action plans were not always clear and on occasion there were no action plans developed as a result of issues found during audits. For example, the October 2020 health and safety audit identified eleven actions, but there was no information as to whose responsibility it was to complete these and by what date. The November 2020 health and safety audit did not contain an action plan. This failure to develop robust action plans as a result of audits put people at risk of harm.
● There was a lack of oversight of areas of risk to people. Risk assessments were not always completed in line with best practice guidance. We saw that the service had not recognised risks to people, such as access to pesticides, access to boiling water dispensers and access to thickeners. The service had not completed risk assessments in these areas. This failure to recognise risk and complete appropriate risk assessments put people at increased risk of harm.
● The provider did not always ensure documents were stored securely. We saw that archived residents' documentation was stored on open shelving in an office which was unattended and unlocked. This presented risks to people's information in terms of security, fire damage and water damage.

We found no evidence that people were harmed, however the failure to ensure good oversight of the service is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives told us that they did not feel they were always kept up to date with their loved ones needs or changes to needs. One relative told us, "I don't feel they are giving me enough input to [persons] care. The home knows I have concerns but on trying to speak to people I hit a brick wall." Another relative said, "I asked the manager whether they had conducted a risk assessment recently and she told me they have noted lots of risks which we don't know about."

● Records of daily care tasks were not constsitantly completed. For example, we found gaps in food and fluid charts and repostitioning charts for people who required additional support in these areas. The registered manager had recently increased the monitoring of these forms being completed.

● Mental capacity assessments and best interest decisions were in place to ensure when appropriate, people were able to have choice and control in decisions about them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Complaints were appropriately recorded and managed. The provider had a complaints procedure in place. People and relatives told us they knew how to complain. However, three relatives told us that their complaints had not been dealt with to their satisfaction.

● The manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had requested feedback from relatives via a survey tool. The responses received were positive, However, three relatives told us they had never been asked for feedback.

● People were asked to feedback on the service they received during monthly resident forums. We saw evidence of actions being taken after feedback was given.

Continuous learning and improving care. Working in partnership with others

● We saw evidence of referrals being made to external agencies including, doctors, dietitians and speech and language therapists. Staff had sought support when appropriate.

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
Treatment of disease, disorder or injury	The provider failed to ensure medicines were managed safely. The provider failed to ensure that assessment of risks and strategies to mitigate risks were in place to keep people safe.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to have sufficient systems in place to monitor and improve the quality and safety of care and maintain good oversight.

The enforcement action we took:

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