Achieve Together Limited

Adrian 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

Adrian lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Support is provided over twenty-four hours with both day staff and a sleep-in staff at night who can be summoned in an emergency. The service can accommodate up to ten people who have a diagnosed mental health condition. It does not provide nursing care. At the time of our inspection there were ten people living permanently at the service.

People's experience of using this service and what we found
People were supported by staff who were familiar with their needs and were observed as being kind and responsive. People spoken with had some opportunity to go out and develop their independence with staff support.

Some people's needs had changed which meant they required additional support to stay safe. This was not reflected in the staff hours provided by the service. Three people had some one to one hours when staff supported them to go out or complete tasks within the service. Other people had shared support and staff had limited amount of time to spend with them.

Not all risks were appropriately assessed and monitored to ensure people were kept safe. People lived in a poorly maintained environment which made it more difficult for staff to keep clean. Facilities were poor.

Individual risks were not clearly identified and planned for. For example, staff did not keep fluid charts where people were prone to infection. Staff had not taken fully into account the recent hot weather and how this might impact on people's general health and wellbeing.

People were not fully supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; For example staff had sought consent to keep the main fridge in the kitchen locked but had not documented the clear rationale for this or considered if this was the least restrictive option.

Medicines were safely managed but people even those who took their own medicines were required to go to the medicines room which was not a very person-centred approach. We have made a recommendation about monitoring the use of medicines prescribed to be administered when required.

People discussed their care needs with staff regularly, but daily care notes and monthly reviews did not clearly focus on people 's wellbeing and mental health or identify new or unmet need.

Governance and provider oversight was poor which had led to a lack of investment and quality improvement. The last CQC inspection to this service was on 4 October 2018. Although rated good safe was rated as requires improvement and we found robust actions were not taken to address our concerns. During

a more recent inspection by the local authority in 2021 and a CQC review of the service in 2022 we found a continued lack of effective monitoring or action to address the issues found.
The registered manager was highly regarded by staff and people using the service and was engaging with health care professionals to get people's needs reassessed where changes were noted in their physical and mental health exacerbated by the COVID 19 pandemic.

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 good (published 14 December 2018.)

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

Why we inspected
This inspection was prompted by a review of the information we held about this service. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

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 COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

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 monitor the service and will take further action if needed.

We have identified breaches in relation to the environment, quality monitoring and assessing risk 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe.

Details are in our safe findings below.

Adrian 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 Health and Social Care Act 2008.

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
This inspection was carried out by one inspector over two days.

Service and service type
Adrian lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well

and improvements they plan to make.
We used information gathered as part of monitoring activity that took place on 7 April to help plan the inspection and inform our judgements. We also reviewed the information shared with us by the local authority who conducted their review of the service in September 2021.We used all this information to plan our inspection.

During the inspection
We spoke with three staff on duty. We spoke with a visiting engineer. We spoke with three people using the service. We observed people throughout the day in terms of their care and support and across mealtimes. We reviewed records including medication records. We reviewed arrangements for cleaning and maintaining the service
We visited the following day to review additional records and reviewed two care plans. We met the regional manager and had further discussions about the service and observe and spoke with people using the service.

After the inspection
We continued to seek clarification from the provider and spoke to staff to validate evidence we found. We spoke with two relatives about their experiences of the service.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires improvement. 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: Learning lessons when things go wrong

- Risks from uncovered radiators had not been assessed and although the provider has since given us a date to have these covered this issue was first identified in 2018. On the day of our inspection, it was 34 degrees outside, and the heating system had failed. Radiators were on and scalding to touch. People were potentially at risk from burns if they fell against a radiator and risks had not been mitigated.
- The provider failed to adequately assess the risks to the health and safety of people using the service. One person was unwell and although the staff called the GP without delay the person had suffered from recent and reoccurring infections. We were concerned that staff did not monitor people's weight, food and fluid intake where risks had been identified or ensure people were adequately hydrated. In addition, on the day of inspection access to food/drink was limited as the fridge was padlocked and so was the pantry. There was no fresh fruit or snacks and food prepared by staff at lunch time was left uncovered.
- Risks associated with constipation were not adequately documented and through our observations people were not encouraged to adopt a healthy lifestyle or had diets rich in nutrients. Lunch on both days of inspection had limited nutritional value i.e. high fat and salt content. People were able to choose what they ate but we saw limited opportunities for them to do so.
- Fire safety was a concern due to staffing levels at night and the proximity of the sleep-in room to the main fire exit. The sleep-in room was on the second floor and no waking night staff to assist with the safe evacuation of people at night. Several people using the service were older with reduced mobility and one person was having panic attacks which might impede their evacuation. Fire drills had taken place but not throughout the night and people had individual evacuation plans which did not reflect their changing needs and support required in the event of a fire.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were in place which included frequent cleaning of touch points. We found however the décor and repair of the building made it difficult to effectively clean the premises. We found stained and unflushed toilets, wallpaper and plaster coming off the walls, holes in the ceiling, unclean floors and dust around the home. We also noted multiple flies in the dining room. Jugs of juice and cooked food were left uncovered.
- Environmental risk assessments and a schedule of audits were in place and showed equipment was maintained and regularly serviced. We found however the premises had not been fully assessed in relation

to people's changing needs and age-related frailty. Staff reported that remedial actions were not carried out in a timely way and this was further evidenced by the lack of provider action following CQC and local authority inspections.

●Documented accidents and incidents were low in the service. However, we found the documentation could not be fully relied upon. One person's plan suggested they went upstairs to have a bath and, or shower, staff said this was no longer the case. They were unsteady on their feet and had no access to a bath or shower. The ground floor shower had been decommissioned for at least ten months. A safety incident for this person had not been reported to us.

The registered person had not ensured the premises were suitable for its intended purpose, secure or maintained to the expected standards of hygiene. This was a breach of Regulation 15 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●We were assured that staff received adequate guidance and training in infection control and prevention and staff were observed wearing personal protective clothing.

●There were robust procedures in place to prevent visitors from catching and spreading infections.

●Staff were accessing regular tests and risks in relation to COVID 19 were reduced as people and staff had been vaccinated. Risk assessments were in place considering people's vulnerability and what measures were in place to reduce the risk of infection.

Staffing and recruitment

●Staffing levels across the day and evening fluctuated and at times staff lone worked, including throughout the evening and sleep in staff were available to support people at night if required. The changing needs of people had not been adequately assessed and the risks associated with times of reduced staffing were poorly documented. For example, where a person was unwell or where there was a risk of them leaving at night when it was unsafe for them to do so.

We considered a breach of regulation but since our inspection the provider has increased its staffing and now has a waking night until such a time when people's needs are reviewed to ensure the placement remains suitable. We requested a fire officers visit who confirmed additional staffing is in place.

●Recruitment was ongoing and staffing levels at times were compromised. Staff reported being unable to support people in the way they would like due to other demands on their time. Administrative support was not available to assist the registered manager who was also covering care shifts and sleep ins.

● Staff written recruitment records were unlocked and therefore confidential information was not preserved. Gaps were identified in the paper records of one of the two records viewed. These records were also held electronically. A reference was missing and there was no evidence staff files had been recently audited.

Using medicines safely

●One medicines profile gave incorrect dosages of the persons medicines. Staff were administering from original boxes so the person was receiving the correct medicines. We asked the regional manager to ensure the information was updated to avoid potential confusion.

●The temperature of the medicines room exceeded the maximum temperature recommended for the storage of medicines on the day of our inspection. This could potentially reduce the effectiveness of the medicines. From temperature charts provided daily temperatures were within a normal range.

●Medicines were administered to people with their consent. Several people had been assessed as being able to manage their own medicines and their medicines were in blister packs and securely stored in the persons room.

●People had a medicines profile which included a description of when to administer certain medicines, as required like pain relief, medicines to relief constipation and additional medicines to help with people's anxiety.

● Daily medicine counts of tablets from the original packaging was undertaken to ensure medicines had been administered as required. Additional audits were undertaken, and medicines errors were rare.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

●We found the service was not fully working within the principles of the MCA. No one needed or had legal authorisations in place to deprive a person of their liberty. We found however some people's mental health and cognition was declining and at least one incident had occurred when a person had left the service when they were mentally unwell. The service had not considered people may have fluctuating capacity. We also identified consent for a locked fridge had been sought but the service had not considered whether this was the least restrictive option.

Systems and processes to safeguard people from the risk of abuse

●Staff received training to help them understand what constituted abuse and the reporting procedures to ensure people were safeguarded. The service recognised that some people would find it difficult to articulate their needs. Monthly key worker meetings were held, and some people had limited supported from family. Advice was in place to people about how to raise safeguarding concerns, but advocacy would greatly benefit people and help ensure their rights and needs were upheld.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. 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

- The provider's governance and oversight was not sufficiently robust and there was no evidence that the provider took timely action to improve the service and ensure people had access to adequate and safe housing.
- The staffing levels had not been kept under regular review to take into account people's changing needs and to ensure their needs could be met safety within the present environment.
- Risks associated with a poor environment had not been fully considered and people did not have access to enough bathing facilities.
- Reduction in people's independence had put a considerable strain on staff and had meant that people did not always get the support they required. For example, some people's physical health and mental health had declined particularly during the COVID 19 pandemic. Some people had no one to one hours and were reliant on staff supporting them when they had time to do this. Expectations and outcomes for people were low.
- The regional manager was newly in post and was not yet familiar with all the services they were responsible for but said they would be visiting their services monthly to support the manager. We asked how they were auditing services and they said there was no standardised template to do so .

The systems in place to monitor and improve the quality of the service were not always effective at identifying and sustaining areas for improvement. This was a breach of Regulation 17 of the Health & 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: Continuous learning and improving care

- Staff spoken with were positive about their work and their work colleagues. Staff told us they felt well supported by the registered manager and felt they were approachable and knowledgeable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Continuous learning and improving care: Working in partnership with others

- Surveys were used occasionally to gauge people's views of the service. Relatives were also asked for their feedback, but this information was not collated so we could not see what actions were identified to improve the service.
- Wider stakeholder engagement was not seen but the provider told us family forums were to be held

shortly. The provider told us they had a new governance approach which went live in May 2022. They said services would be reviewed four times a year and the last two audits were seen. The provider had not been proactive in identifying issues themselves but had been reliant on feedback from other agencies to highlight remedial actions. Staff confirmed this.

- Staff were well supported by the manager and had access to regular online training and formalised support. However, staff development and opportunity for professional growth was not clearly formalised and staff felt undervalued.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's environment and risks associated with people's individual needs were not adequately assessed and monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not suitably clean and did not provide safe accommodation which was appropriate to people's current needs.

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 17 HSCA RA Regulations 2014 Good governance The provider and governance oversight was not sufficiently robust and meant people were living in sub standard accommodation and the risks of doing so had not been assessed.

The enforcement action we took:

serve a warning notice on regulation 17