Gerald William Butcher

# Earlfield Lodge

## Inspection report

21-31 Trewartha Park
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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

About the service
Earlfield Lodge is a residential care home providing accommodation and personal care to older people, some of whom are living with dementia. The service can support up to 72 people. There were 52 people living at the service at the time of the inspection.

The service provides period accommodation in several adjoining premises. The service is over five floors. There are four areas to the service Bluebell, Lilly, Poppy and Buttercup. There is access to a garden and patio area.

At the time of the inspection the service had an additional seven beds registered in the adjacent property. There was no one living in this building and no service was operating from this site.

People's experience of using this service and what we found
People received unsafe care as the service had not made improvements or met legal requirements. In areas such as risk management, medicines, recruitment and staffing. Issues previously identified and highlighted had not always been addressed. The systems to monitor and oversee the safety and quality of the service were not effective. This put people at risk as improvements were not made in areas required.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 29 October 2019). There were five breaches of regulations identified and a recommendation made. Previous to this, the service had been rated requires improvement for the last four consecutive comprehensive inspections (published 12 August 2015, 17 November 2016, 12 January 2018, 15 September 2018).

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 5, 6 and 12 September 2019. Breaches of legal requirements were found in regulation 12, 13, 17, 18 and 19 and a recommendation was made in relation to end of life care planning.

We undertook this focused inspection to check their action plan had been followed, improvements were in progress and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led.

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this

occasion were used in calculating the overall rating at this inspection. The overall rating for the service remained the same and is inadequate. This is based on the findings at this inspection.

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

Enforcement
We have identified four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regulation 12; safe care and treatment, regulation 18; staffing, regulation 19; fit and proper persons employed and regulation 17; good governance.

At the last inspection a recommendation in the Responsive domain was made in end of life care planning. This domain was not reviewed during this focused inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

## 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.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-Led findings below.

# Earlfield 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by three inspectors and a member of the Care Quality Commission medicines team.

Service and service type:
Earlfield Lodge is a 'care home'. People in care homes receive accommodation and 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.

The service had a manager registered with the Care Quality Commission. This means 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.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We reviewed feedback from the local authority and professionals who work with the service. 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

During the inspection we spoke with four people using the service and two relatives. We spoke with 14 staff members which included senior staff, the registered manager and the former provider's personal representative.

We reviewed five people's care and support records and five staff recruitment files. We reviewed 18 Medicine Administration Records (MAR). We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, training records, policies, and quality monitoring systems.

After the inspection
We continued to seek clarification to validate evidence found. We looked at training, staffing and health and safety data.

Inadequate

# 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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the last inspection in September 2019 medicines were not managed safely. 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 not enough improvement had been made and the provider was still in breach of regulation 12

- As identified at the previous inspection the maximum fridge temperature was outside the recommended range. The records reviewed showed this had not improved. There was no evidence that this had been investigated to ensure medicines were stored at appropriate temperatures and were still safe to use.
- Topical administration records (TMAR) continued to have gaps in recording of topical preparations. This meant the provider could not be assured people received their creams as prescribed. We looked at seven peoples cream charts and four had not been fully completed to indicate people had received their creams as prescribed. For example, one person was prescribed a cream to be applied twice a day. The cream chart over eight consecutive days had not been completed on five occasions.
- Some medicines which were prescribed to be taken 'when required' did not have protocols available to explain the circumstances when these medicines should be given. For example, we found three protocols had not been completed for one person.
- Checks were being completed on the medication administration records (MAR) following the medicines round to identify any omissions. These were collated in a monthly audit. However, there was no evidence these omissions were being investigated to ensure people received their medicines as they were prescribed.
- There was a system to record, report and investigate medicines errors but this was not always followed. These systems are important to promote learning from errors and reduce the risk of reoccurrence.
- Medicines audits were completed. Whilst areas of shortfalls were identified, such as gaps in TMAR recording this did not lead to positive changes or sustained improvements.

The failure to ensure the safe management of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were stored securely.
- Medicines prescribed to be taken when required had the time it administered recorded to ensure adequate time was left between doses.
- One medicine was to be given at the same time daily. However, it was not documented the specific time

given. Staff could not confirm this medicine was given at the times it should have been.
● Dates of opening were recorded on medicines which had a reduced shelf life once opened to ensure they were discarded within an appropriate time frame.
● MARs reviewed showed management of medicine stocks was completed to ensure people's medicines were available.

Assessing risk, safety monitoring and management

At the last inspection in September 2019 the management of risks were not sufficient to keep people safe. 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 not enough improvement had been made and the provider was still in breach of regulation 12.

● After our last inspection we referred our findings to the fire service for further investigation. A site visit was conducted and found failings in fire safety management and systems.
● A fire risk assessment had been completed in November 2019. The actions from this were in progress and significant upgrades to fire systems were due to commence in January 2020 to meet legislative requirements.
● Personal evacuations plans were from October 2019. Two people had left the service since this time. Therefore, this was not an accurate record of people currently living at the service. These were updated during the inspection.
● Different versions of fire procedures were available to staff. Therefore, they may not access the most up to date copy. For example, one version gave clear instructions not to switch off the fire alarm as else it re locked doors in a particular area of the service. We highlighted, an emergency grab bag with equipment to support an evacuation was not available as mentioned in the fire procedure dated October 2019.
● Signage to orientate people and visitors to where they were in the service continued to be poor despite floor numbers now being displayed outside lifts.
● Risk assessments and management plans were completed for areas such as, falls, mobility, choking, malnutrition and dehydration and the environment. However, these and staff practices did not always ensure people were protected from the risk of potential harm. In addition, we found risks that the provider had not identified.
● One person had been given a portable radiator with a hot surface temperature in their bedroom. A risk assessment had not been completed, so the risk of the person burning themselves had not been mitigated.
● People who had been assessed as at risk of skin damage were provided with pressure relieving equipment. However, pressure relief mattresses were not always used correctly. For example, the pressure relief pump setting for a person who weighed 56.1kgs was set for a person who weighed 100kgs. This meant the person was not protected from the risk of further skin damage, because the equipment was not used properly. There was no guidance available for staff.
● A person's care plan stated they had been referred to the speech and language therapy (SALT) team, they needed to be assisted with eating and provided with a soft diet due to high risk of choking. We observed the person and whilst they were assisted with eating, they were provided with a meal that was not softened. Staff were not aware the person's care plan had been changed on 19 December 2019.
● A staircase leading from a communal area on the fifth floor had not been risk assessed and did not have handrails. This is not in accordance with published national health and safety guidance. We found two people on the fifth floor who were not clear where they were in the service and had access to two staircases.
● Window restrictors were fitted to reduce the risk of people falling from height. However, we saw two

windows that opened wider than published national health and safety guidance.
● A health and safety assessment in October 2019 highlighted a risk assessment and action plan, along with improvements to the systems and checks conducted to reduce the risk of Legionella were required. At the time of the inspection this had not been actioned. After the inspection the service initiated external support in this area.

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

● The business contingency plan had been reviewed and contained information and guidance on procedures to follow in the event of eventualities such as fire, damage to the building or IT failure.
● Gas safety was checked and recommendations from an electrical installation safety report in October 2019 were being actioned.
● Accidents and incidents were reported and recorded well. Systems were in place to analyse accidents and incidents and to review actions taken to prevent reoccurrence for people were effective.
● Some individual rooms had recently been refurbished.

Preventing and controlling infection
● The service was clean. However, infection control practices were not sufficient to protect people from the risks of infection.
● Systems were not in place to safely manage laundry, to reduce the spread of infections. Although there was an infection control policy, this did not provide guidance for staff about how to work safely in the laundry.
● The laundry room was in a building separate to the main care home. Open top laundry bags were placed on the floor in the care home, near the exit door that led to the laundry. Laundry staff emptied the contents of the laundry bags directly onto the floor just outside the laundry room, for sorting the items.
● Soiled items were not always placed in the water soluble bags provided. These are bags designed to be placed, unopened, into washing machines.
● The above practices were not in accordance with nationally published guidance for the prevention and control of infection.

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

Staffing and recruitment

At the last inspection in September 2019 recruitment processes had not operated in line with the provider's policy or legal requirements. This meant staff had been recruited without full checks being completed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 19.

● Since the last inspection in September 2019 recruitment procedures had not been reviewed to ensure they met legal requirements.
● There was no review or monitoring conducted of staff files to check recruitment processes had been completed fully and in line with the providers policy.

● The provider had not always followed their recruitment processes to ensure staff were recruited safely. We identified two staff members where full processes had not been followed.
● Job descriptions and specifications were not always provided for the post being recruited for as outlined in the providers policy. Gaps in employment were not always fully explored and proof of identity was not always evidenced.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous three inspections in November 2017, June 2018 and September 2019 staff had not received sufficient training to be skilled and competent in their roles and had not been adequately supervised. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18.

● Training for staff in areas of safety such as safeguarding and fire safety had progressed since the last inspection. However, the training overview held by the service demonstrated some training was still outstanding or required an assessment to determine the required need. For example, in safeguarding, first aid and health and safety.
● Staff were not regularly supervised in their role. This was confirmed by staff spoken with and by reviewing the supervision matrix. 41 out of 59 staff members had received their last supervision over seven months ago. This meant staff were not adequately supported and staff's performance was not reviewed and monitored.
● One staff member was not included on the training or supervision matrix, this had been highlighted at the previous inspection. Therefore, it was not clear what training or supervision they had received.
● There was a lack of assurance that staffing arrangements were always sufficient. There was no assessment of safe staffing levels based on people's needs.
● Staffing levels fluctuated. Review of staffing rotas demonstrated staffing numbers were not always kept to during the day but were at night. This was in comparison to the operating staffing numbers we were informed of. For example, between 8 to 21 December 2019 morning staffing levels were not kept at 12 staff members or above on ten occasions. One staff member said, "Staffing levels are still not sorted, but this is being worked on. There are still some days when there are too many staff, and not enough on others."
● Staffing levels at night had not been reviewed following the findings from external sources around fire safety to ensure people's needs could be met safely.
● Systems to plan and manage staffing levels were not always efficient. A staff member said, "Rotas are variable." Consultation was in progress with staff to develop a new staff rota. A staff member said, "I am aware a new rota has been completed."
● One person said, "Yes I'm safe enough, although I think they are short staffed because they do take quite a long time to answer my bell when I ring it." Another person said, "Staff come and check on me."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff absence still impacted on daily staffing levels. However, staff absence was formally monitored and managed.
● Agency staff were used at night. However, there was no induction documentation to support agency staff

who had not worked at the service before.

Systems and processes to safeguard people from the risk of abuse

At the last inspection in September 2019 safeguarding systems and processes had not been operated effectively. This had led to actions or procedures not being fully followed which placed people at potential risk. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 13.

● Since the last inspection most staff had received training in safeguarding adults.
● Staff were clear in their understanding of safeguarding and what they needed to report externally, to the local authority safeguarding team, and to the Care Quality Commission.

Learning lessons when things go wrong
● Systems for learning and reflection from when things had gone wrong were inconsistent and did not always lead to improvements. For example, accidents and incidents and the actions taken were reviewed to ensure the likelihood of a repeat event had been minimised. However, medicine omissions were reported but investigations did not occur to ensure reoccurrence was reduced. A staff member said in relation to medicine errors, "There is no organisational learning process."

Inadequate

# 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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Since 2015 and in all subsequent inspections the quality monitoring systems in place have been highlighted to the provider as being ineffective. As they have not identified or mitigated risks to people or driven improvements.
- At this inspection whilst the provider and registered manager were developing quality monitoring systems these were not yet in place. Therefore, the current systems continued to place people at risk of receiving unsafe and poor quality care as there was a lack of oversight and monitoring.
- An action plan was in place around areas identified at the last inspection which required improvement. However, the action plan had not prioritised actions, monitored progress or been kept up to date. Therefore, the action plan had not been effective in implementing improvements or ensuring legal requirements were met.
- The action plan completed after the last inspection in September 2019 in relation to the regulation 13 breach identified only addressed lack of staff training in safeguarding adults and not safeguarding systems and processes. Safeguarding systems had not been reviewed to ensure they operated effectively.
- Staff roles and responsibilities were not always clear. This had been raised at the previous three inspections. Senior positions did not always have job descriptions in place which detailed their roles and responsibilities. This meant accountability was unclear for key areas. This was particularly relevant for areas where there were repeated shortfalls, such as recruitment, medicines, staffing and safety.
- Since the last inspection some senior staff had been issued with a job description. One staff member said, "I think I am clear on my job role." Job descriptions were not always issued at the point of recruitment and one staff member had recently moved into a senior role with no written clarification of the additional responsibilities.
- At the two previous inspections the staff organisational structure had been highlighted. The chart did not make clear all of the staff roles conducted and the lines of accountability and responsibility. The organisational structure had not been reviewed since 2018.
- Staff development and performance continued to not be managed effectively.
- Staff attended meetings. However, an agenda was not planned and meetings were not structured. This meant discussions occurred but there was a lack of actions from the meetings to make changes and improvements. This had been raised at the previous three inspections. One staff member said, "At staff meetings, the same things are always said at each meeting."
- Systems did not support effective learning and improving of care standards. As areas identified and highlighted had not changed or resulted.

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

● Staff absence was now monitored and managed.
● Staff training had progressed since the last inspection. However, training was still required for some staff members. The audits in place did not detail outstanding or planned training.
● Notifications were submitted as required to the Care Quality Commission.
● The provider had displayed their assessment rating in different areas of the service. The provider did not have a website.
● Systems were in place to communicate information. A staff member said, "There is more communication, openness and honesty."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us that morale had improved. One staff member said, "We work well as a team and have all pulled together." Another staff member said, "Staff morale has improved."
● Feedback on a national website that reviews care homes was positive. One person said, "The staff are lovely."
● Feedback from staff about how the service was managed was varied. Comments from staff included, "I now feel more supported in my role and would go to [the provider and managers] with any problems," "I don't find [management] supportive," and "[Management] approach is variable."

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
● The provider understood their responsibilities on the duty of candour. A relative said, "They [staff] are good at phoning us with any concerns."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● A survey had been conducted with people, relatives and staff in June 2019. Action plans had been developed from the findings. However, actions devised were not always tangible and therefore they had not always been reviewed to ensure they were effective. Actions taken had not always been communicated to people and staff.