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Russley Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Russley Lodge is a residential care home. The service provides support with personal care and accommodation for up to 17 people. At the time of our inspection, 17 people used the service.

The service was providing support to people with a wide range of needs, including younger and older adults, people living with dementia and people living with mental health support needs.

People's experience of using this service and what we found
Medicines were not managed safely. We found serious concerns which placed people at risk of harm. This included concerns around the ordering, storage, administration and disposal of medicines. Risks associated with choking were poorly managed. Standards for preventing and controlling infection had deteriorated. Staff were not always deployed safely and effectively at key times during the day. Staffing levels were reduced in the afternoon which meant there was a risk of people's needs not being met.

People were not always supported to have maximum choice and control of their lives. We were not assured that care and support was being provided in the least restrictive way possible. Robust pre-admission assessments were not always completed which meant the registered manager could not always be sure of people's individual needs before they moved into the home.

There was an inconsistent approach to involvement. This included missed opportunities for the involvement of external advocacy services to support people with more complex decision making. There was a lack of a joined-up person-centred approach that took full account of cultural differences, beliefs, and individual identities. This was a missed opportunity to truly celebrate and promote difference within the service. We have made a recommendation about this in the full report.

In response to Covid-19 restrictions on visiting in care homes, a wooden structure had been built in the grounds. The structure was poorly designed, exposed people to the elements and due to its location adjacent to neighbouring houses, did not enable private and dignified visits between people and their family members and friends. Gaps, omissions and errors in records were present throughout people's care plans. This meant we could not be assured people's needs and preferences were consistently met.

Systems for audit, quality assurance and questioning of practice were inadequate. There was an absence of meaningful overarching analysis of the governance systems that were in place. There was a failure to identify themes, trends and newly emerging risks, which placed people at an increased risk of harm. Russley Lodge has consistently been rated as requires improvement with continued breaches of regulations since March 2018. This shows the provider has failed to respond adequately to serious concerns raised by the Care Quality Commission (CQC) and has failed to implement a culture of continuous learning.

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 requires improvement (published 14 January 2020). At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified new and continued breaches of regulations in relation to: safe care and treatment; staffing; dignity and respect; meeting nutritional and hydrational needs; premises and equipment; and good governance.

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.

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.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Russley 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 two inspectors and an Expert by Experience. 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
Russley 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 CQC. 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
We gave the service 24 hours' notice of the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke nine members of staff including the registered manager, senior carers, care assistants, and the activities coordinator. We also spoke with a representative of the provider partnership.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included care plans and associated documentation and multiple medication records. A variety of records relating to the management of the service were also reviewed.

After the inspection
In respect of the most serious concerns highlighted in this report, we raised individual safeguarding alerts with the local authority. In addition to this, the CQC, local authority and NHS partners took urgent steps to ensure the health, safety and wellbeing of everyone who used this service.

Inadequate

Is the service safe?

Our findings

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

In January 2020 this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At the last inspection we identified risks were not always assessed and 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.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- Risks associated with choking were poorly managed. Assessments for the management of swallowing difficulties were not robust and lacked detail. They did not adequately describe the actions staff needed to take to keep people safe at mealtimes.
- Referrals to speech and language therapy (SaLT) were not always completed in a timely way. One person had waited in excess of 17 days to be referred to SaLT. This meant they were at continued risk of choking.
- We observed one person experience a significant choking episode at lunchtime that caused them significant distress. Staff had not followed SaLT guidance contained in the person's care plan which exposed them to a risk of harm.

Aside from the choking episode described above, we found no evidence people had been harmed. However, risks were poorly managed which placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely. We found serious concerns which placed people at risk of harm.
- Staff did not follow safe medicines management practices when supporting people to take medicines. For example, stock levels of boxed medicines were not always reflective of the amount received from the pharmacy and the amount administered. This included medicines for the treatment and management of epilepsy. Unlabelled and unidentifiable medicines were administered by staff from a person's own dosette box.
- Medicines were stored inappropriately in a room and cupboard that was too warm. The medicines cupboard was also crammed with plastic bags full of medicines waiting to be returned or disposed of.
- The medicines fridge was used inappropriately by staff to store drinks and snacks for personal use.
- Vitamin D supplements supplied by the Government in response to Covid-19 restrictions within care homes had never been administered and remained unused.
- Thickener for use in drinks and prescribed to people with swallowing difficulties was not always given as prescribed. People's care plans did not contain adequate information to support staff to use thickener in a

safe way.

We found no evidence that people had been harmed however, systems for the management of medicines were not operated effectively. 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.

Preventing and controlling infection

● Systems for effective infection prevention and control were not consistently safe. At the main entrance, the space dedicated to donning and doffing of personal protective equipment (PPE) lacked an appropriate waste disposal bin and PPE items such as disposable gloves and aprons were stored on the floor.

● High touch areas were not always sanitised in-between usage. This included the communal dining area where tabletops had not been cleaned after lunch and before an activity took place.

● Good ventilation was not always promoted through the opening of windows. We also observed a member of staff walking freely around the home without a facemask.

We found no evidence that people had been harmed however, systems for preventing and controlling infection were not consistent. 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.

Staffing and recruitment

● Staff were not always deployed safely and effectively. People were frequently left unattended in the lounge area for extended periods of time, including at mealtimes. This meant people did not always receive help and support in a timely manner. This included one person who fell asleep shortly after being served their lunch and then waited 11 minutes to be helped by staff.

● After 1400hrs each day staffing levels were reduced from three care staff down to two care staff. However, the dependency tool used to help calculate staffing levels had not been completed in its entirety. This meant we could not be assured it was reflective of people's needs.

●The provider expected the member of staff responsible for administering medicines to also supervise people in and around the lounge. This was both unsafe and impractical.

There were not enough staff deployed to consistently meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong; systems and processes to safeguard people from the risk of abuse

● The approach taken by the registered manager and provider was not one that supported a culture of learning lessons when things go wrong. There was a lack of awareness of how to access credible sources of information related to known and emerging risks within social care settings, and how to apply that learning within Russley Lodge.

● The serious concerns identified at this inspection visit demonstrated systems and processes for protecting people from a risk of harm or abuse were inadequate and not operated effectively

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

In May 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes and was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- Food preferences based on cultural beliefs were not always respected. This caused one person great distress during lunchtime.
- People did not always get the right amount of help and support at mealtimes. Due to difficulties in using a knife and fork, one person resorted to eating their cooked meal with their hands. No consideration had been given to the use of either adapted cutlery or a plate guard. Such items promote independence and dignity at mealtimes.

Reasonable requirements based on cultural beliefs were not always met and necessary support was not always provided. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Food was home cooked and of good quality and choice was offered. Comments from people included, "The food is good. I enjoy spicy food and wish there was more." and "I enjoy the food; you are given a choice of two options at lunchtime. The staff ask you the day before what you want. There's always enough to eat."

Adapting service, design, decoration to meet people's needs

- The drain running out the back of the building was blocked and gave off a foul odour. The drain ran directly underneath a person's bedroom window and ran parallel to an outside seating area where people using the service (and staff) who smoked would sit.
- In respect of the 'smoking area' this was located directly outside the doors which led down into the communal garden. Cigarette butts were strewn across the floor and the environment was distasteful in appearance.

The premises were not always properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Inside the home was traditional in presentation but homely. One person took great delight in being able to regularly settle comfortably into a big armchair in the lounge area. Wayfinding signage was appropriate to meet the needs of people who lived with memory loss.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 particular 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The principles of the MCA were not always followed. Systems and processes used to ensure consent was obtained, capacity assessed, and best interest decisions made were not operated effectively and were not embedded into everyday practice.
● One-to-one close supervision had been put in place at night for one person. However, no behavioural charts had been put in place so there was no evidence around the effectiveness of the one-to-one close supervision and whether this was the least restrictive intervention. No clear rationale had been recorded and there was no evidence of best interest decisions and how this supported least restrictive practices.

There was failure to record the care provided to people and decisions taken in relation to that care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Robust pre-admission assessments were not always completed to ensure the home could meet people's needs before they moved into the service.
● The registered manager was not familiar with the latest government guidance around commencing visits in and out of the home. Ad-hock conversations had taken place with some relatives, but a systematic approach had not been adopted.

Staff support: induction, training, skills and experience
● Staff did not have the right skills, knowledge and experience to safely and effectively deliver care and support to people living with complex physical health needs, and those living with mental health support needs.

Staff working with other agencies to provide consistent, effective, timely care
● Access to primary medical services such as GP and district nursing services had been maintained during Covid-19 restrictions. The vast majority of GP consultations were done remotely, with district nurses regularly attending in-person. Referrals were also made to other community-based health and social care services as-and-when required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

In May 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- It was unclear to what extent people had been provided with meaningful opportunities to contribute to their own care plan. This included a lack of involvement about goals, aspirations and future plans.
- There had been missed opportunities for the involvement of external advocacy services to support people with more complex decision making.

Ensuring people are well treated and supported; respecting equality and diversity
- Russley Lodge benefited from a richness of diversity and was reflective of the community it served, both in terms of people using the service and the staff employed within it. However, there was a lack of a person-centred approach that truly took full account of cultural differences, beliefs, and individual identities.

We recommend the provider considers current guidance on diversity and inclusion and take action to update their practice accordingly.

Respecting and promoting people's privacy, dignity and independence
- We observed a number of positive interactions in which people were treated in a dignified and respectful way. Staff sought to promote independence through encouragement. Comments included, "Appearance is important to me, I like to look smart; my clothes are washed for me and I can choose what I want to wear." and "The staff are very kind and pleasant towards me. I feel well looked after and couldn't be looked after any better".
- Staff had clearly developed positive relationships with people over time. Communication was often informal in tone and delivery, but everyone appeared to be relaxed with this and communication was always respectful. Comments included, "I know the staff don't change much, I can talk to them quite openly if I didn't like something I would tell them."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

In May 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- It was not clear to what extend people had been supported and encouraged to maintain relationships and avoid social isolation throughout Covid-19 restrictions.
- In response to restrictions on visiting within care homes, the provider had erected a wooden structure in the grounds to facilitate visits from family and friends. However, the structure was poorly designed, exposed people to the elements, and due to its location adjacent to neighbouring houses, did not enable private and dignified visits. Records evidenced that on at least eight separate occasions the facility was out of use because it was deemed 'too cold.'

The provider had not ensured privacy and dignity was always respected and promoted. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Activities were provided each morning in the main lounge area. Whilst these were delivered as 'communal activities' such as bingo, arts and crafts, quizzes and card games, we saw people seemed to enjoy participating.
- However, activities were only provided in the mornings at a set time. We asked the registered manager how they would cater for people who expressed an interest in doing activities at other times, and we were told it would be difficult for staff to facilitate this.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Gaps, omissions and errors in recording were present throughout people's care plans. This meant we could not be assured needs and preferences were consistently met.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans were structed in such a way that captured people's individual communication needs. However, we saw no tangible examples of these assessed needs being put into practice. For example, where applicable, care plans and associated information was not provided in large print or in an easy-to-read format.

End of life care and support

● Staff had completed training for end of life care. People's preferences and choices in relation to end of life care were recorded in their care plans.

Improving care quality in response to complaints or concerns

● Records indicated no complaints had been recorded since our last inspection. However, one relative had raised some issues via a questionnaire that had been circulated by the registered manager. However, the registered manager told us this had been dealt with 'informally.'

● The complaints procedure was displayed for reference and people told us they knew how to make a complaint or raise a concern. Comments included, "I know who the manager is and I would them if I had any problems." and "I can talk to any of the staff if I have an issue."

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.

In January 2020 this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. 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.

At the last inspection we identified continued issues around governance and oversight. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the service remains in breach of Regulation 17.

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

- Russley Lodge has consistently been rated as requires improvement with continued breaches of regulations since March 2018. This is evidence of a history of failing to respond adequately to serious concerns raised by CQC and a failure to implement a culture of continuous learning.
- Systems for audit, quality assurance and questioning of practice were inadequate. There was an absence of meaningful overarching analysis of the governance systems that were in place. There was a failure to identify themes, trends and newly emerging risks, which placed people at an increased risk of harm.
- Care plans and associated records contained gaps and omissions which meant records were not reflective of people's needs. Where an external professional had visited or telephoned in relation people's ongoing care needs, records of such contacts had not always been maintained.
- Where issues around poor and inaccurate recording in daily notes had been identified, no meaningful checks had been put in place to ensure such errors were not repeated.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Since the last inspection there had been no recorded notifiable safety incidents which would trigger duty of candour requirements. However, the serious issues identified at this inspection fall within the duty of candour framework.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

- It was not clear what systems and process had been established to ensure people using the service, their relatives or lawful representatives continued to be engaged and involved throughout the pandemic. No meaningful analysis had been completed of responses received to a survey that had been sent out to relatives by the registered manager.

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

- The issues highlighted throughout this report demonstrates the culture and ethos within the service was not person-centred and did not always achieve good outcomes for people.
- The provider and registered manager had lost sight of the fundamental standards of quality of safety.