Pharos Care Limited

The Lodge

Inspection report

Beebee Road
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West Midlands
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04 September 2020
07 September 2020

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22 January 2021

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
The Lodge is a residential care home providing personal care for seven younger adults with learning disabilities and/or autism spectrum disorder. The service can support up to eight people.

The service has been designed taking into account best practice guidance and the principles and values underpinning Registering the Right Support (RRS) in respect of the environment. The building design fitted into the residential area as it was domestic in style in keeping with other homes in the street. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found

People's behaviour was not always safely managed, and restraint was not always implemented for the shortest possible time.

There were not always enough staff to safely support people and meet their identified needs.

Staff were not always following current government guidance in relation to COVID19 and the use of personal protective equipment.

People received their medicines when needed and staff where trained to administer people's medicines safely.

A lack of oversight meant potential risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were not always effective and had not identified the areas for improvement found at this inspection.

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 Good. (Published 30 January 2020).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, use of restraint and the care being provided. Additional concerns were shared with us by the Clinical Commissioning team and Sandwell Local Authority. A decision was made for us to inspect and examine those risks.

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 changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID19 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 person centred care, safeguarding, recruitment practices and 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.

Follow up
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.

The 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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by two inspectors. Two inspectors visited the home on the 04 September 2020, one inspector undertook telephone calls to staff and relatives on 07 September 2020.

Service and service type
The 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 did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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 saw all seven people that lived in the service, however people living in the service were unable to effectively communicate with us on their safety or the effectiveness of leadership in the home. We spoke with three relatives about their experience of the care provided to their family members. We spoke with four members of staff, the manager, and two heads of operations. We also spoke with one healthcare professional.

We reviewed a range of records. This included three people's care records, restraint records and medication records. We looked at one staff file in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider did not ensure restraint was implemented safely. Staff supported some people that displayed behaviours that may challenge others. We found where restraint was used as a way of managing this behaviour, the records did not always detail the actual duration of the restraint. In one record it stated a hold was implemented for, 'over an hour'. It was not clear and transparent if the restraint used was the least restrictive technique for the shortest possible time in line with best practice guidance.
- People's support plans we reviewed identified safety checks to ensure people's airways, breathing and circulation were maintained during restraint were to be completed. We found these had not been recorded in any of the incident records we reviewed.
- We saw people's support plans identified a debrief to discuss the cause of the incident, actions during the incident and how the incident could have been prevented was to take place following all incidents. We saw in the incident reports we reviewed a debrief did not always take place therefore learning and development was impeded.
- Systems and processes were not operated effectively to prevent potential abuse of people living at the home. A professional told us, "My only concern is how they manage behaviour as they use [restraint] and it's too much for [person]."
- Sufficient numbers of skilled staff were not always deployed appropriately to safely meet people's needs. We observed people were left unsupported which led to them becoming agitated. We also saw incident records which showed people had been left unsupported which resulted in harm to others and the need for the use of restraint. One family member told us, "Staff at the moment don't have the confidence." Another told us, "They do not have control of the situation and don't feel they meet [person's] needs."

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.

- Risk assessments were in place and detailed the risks to people that staff needed to be aware of. Staff we spoke with were able to tell us about the risks they needed to be aware of when supporting people. One member of staff was able to tell us the different triggers to one person becoming anxious and how they would deal with this.
- Staff understood their safeguarding responsibilities, the signs to be aware of and knew how to report concerns. One staff member told us, "Safeguarding is in place to protect the rights and well-being of people, to keep them free from abuse."

Preventing and controlling infection;
● We found staff were not wearing Personal Protective Equipment (PPE) in line with current guidance.
● The manager informed us the provider does not require staff to wear PPE at all times and told us, "It's because we deal with learning disabilities and facial features changing can affect people."
● After we directed the manager to the current government guidance, we observed staff wearing masks for the remainder of our inspection.
● The provider failed to ensure the adequate procedures to support people to social distance and support people who may need to isolate in line with current government guidance.
● We found there was no risk assessment in place for people who may need to isolate, there was no cohorting of staff or zoning of the environment to mitigate the risk of spreading infection to people, staff or visitors.
● People required to isolate were not being supported to isolate and were accessing the community. We observed people required to isolate mixing with other people and staff in the home which put people at risk of COVID-19 infection.

This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw people's temperatures were recorded each day and the temperatures of all staff and visitors were recorded when they arrived and left the home.
● Staff told us they had completed additional infection control and PPE training provided by Sandwell local authority and the NHS which included the donning and doffing of PPE. One staff member told us, "We did infection control training recently online."

Using medicines safely
● We reviewed the medicine administration records which confirmed people received their daily medicines as prescribed and medicines where stored appropriately.
● We saw staff who administered medicines had received training and had their practice observed to ensure they were competent in this area.

Staffing and recruitment
● We reviewed rota records and found there were not always a sufficient number of staff to meet the needs of people in the home. A staff member told us, "Yeah we are short staffed though the last 3 weeks has been better, before this we have had major staffing issues."
● The provider continued to recruit staff safely through the requirement of references and application to the Disclosure and Barring Service (DBS). A DBS check enables a potential employer to assess a staff member's criminal history to ensure they were suitable for employment.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service lacked consistent direction and leadership as a result of management changes which meant systems and processes were not used effectively to review and maintain oversight of the service being provided.
- Systems failed to identify the absence of individual risk assessments and implementation of procedures to safely support people required to isolate. This meant people in the home were at greater risk of infection.
- In July 2020 systems and processes identified a shortage of staff. We saw in records after you had identified this concern there remained a shortage of staff caused by poor staff deployment across the week, specifically in the evening. A staff member told us, "We didn't have enough staff recently we were running on fewer numbers and staff were tired and not picking up the overtime."
- Systems and processes failed to identify the times service users were not sufficiently supported by staff. During the inspection we observed a staff member had gone to prepare lunch for the person which left the person unsupported and caused them to become agitated.
- We reviewed people's behaviour management booklets which identified the monitoring and recording that must be completed when the use of restraint has been required. We found monitoring and recording during incidents was not consistent and the provider did not always follow their own procedures.
- The providers systems failed to ensure care records were up to date and accurate to include the updated instructions of professionals involved in peoples care.
- We saw the providers systems and processes had not been followed to ensure people's safety equipment was checked to confirm it worked as it should to alert staff of concerns. We found equipment that had not been checked in July 2020 and August 2020 to ensure it worked correctly.
- The provider had process of fire safety checks in place however this had not always been consistently completed, therefore the provider did not have sufficient oversight of the safety of the home.
- We saw risk assessments had been completed for each person in the service regarding the use of face masks though these were all identical and did not reflect the individual needs of people in relation to the use of face masks by staff in the home.

The lack of governance systems and oversight meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had three different managers since January 2020. A new manager has been recruited and working in the home for one week at the time of inspection. They acknowledged the shortfalls we found in the service and advised they were working towards addressing them.
● The provider had met their legal responsibilities ensuring their inspection rating was displayed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Family members we spoke with told us the home did not involve them and communication with them was poor. One family member told us, "Management have not communicated that well with me at all." Another told us, "Communication has been very poor indeed."
● Staff told us they received supervision there were regular staff meetings where they could feedback and share their views of the service with the manager.

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 manager and provider understood their responsibilities in relation to the duty of candour regulation. However, the provider had not notified CQC of all events which had occurred within the service as they are legally required to do.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

● Both the manager and the provider were receptive to our feedback and advised us of their commitment to making the required improvements.

Working in partnership with others;
● A professional we spoke with told us they had raised concerns around the use of restraint with each of the managers the home has had since January 2020 and said, "Nothing seems to get done."
● The manager and provider had been engaging on a regular basis with the local authority during the COVID19 pandemic.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure restraint was implemented safely

The enforcement action we took:

Impose positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure consistent management of the service and oversight including IPC, incidents with the use of restraint and sufficient deployment of staff.

The enforcement action we took:

impose positive condition