Bliss Family Care Limited

The Lodge Residential Home

Inspection report

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25 September 2018

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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

This inspection took place on 19 and 25 September. The first day of our inspection visit was unannounced and the second day was announced. At our last inspection we found five breaches to the Regulations. We issued a warning notice to the provider because we were concerned about the leadership and management at the home; and three requirement notices because we were concerned about the safety and well-being of people who lived at The Lodge Residential Home.

Following the last inspection, we asked the provider to complete an action plan to tell us what they would do, and by when to improve the service. We gave the provider until 7 September to make improvements in the management of the service; and the provider told us they would have completed their actions in relation to the other breaches of the regulations by early September 2018.

Before we undertook our inspection visit we received information of concern from Leicestershire Local Authority about the management of the service and people's safety. The local authority had needed to safeguard people from harm; and the provider had not informed us of the safeguarding concerns which is their legal obligation to do so.

This inspection focused on two of the five key questions we ask of services. Is the service 'safe,' and is the service 'well-led.'

The Lodge Residential Home 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. The Lodge accommodates a maximum of 32 people in one building, with bedrooms on the ground floor and first floor. At the time of our inspection visit, 21 people lived at the home.

Since our last inspection, the registered manager had left the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the first day of our visit a new manager had started work at the service, but left two weeks after our inspection visit.

There were not enough staff who worked at the home who knew people's needs to provide safe care. Because of staff absences and vacancies, many staff who worked in the home were temporary agency staff. Some of the permanent staff did not have the skills and knowledge to support people safely with their care. This was the third inspection where staffing was raised as an issue and lack of improvements made to meet the regulation.

The Leicestershire County Council quality team had to support the provider in ensuring medicines were administered to people because staff considered trained in medicine management; did not know how to

order medicines and had not always administered and recorded their administration correctly. At the time of our visit, there had been some improvements, but we continued to find errors. This was the third inspection where medicines had not been managed safely.

Risk assessments and the associated care plans were not up to date (with some people's care needs having changed significantly since the last update). This did not provide staff with accurate information about how to support people's current care needs. This was the third inspection where risk assessments were not up to date.

People had not been safeguarded from harm because the lack of risk assessments and proper care planning contributed to staff not providing the right support to reduce the risk of people falling or skin being damaged from the lack of pressure area management.

The provider had a legal responsibility to inform the CQC of events which happen to people in the home. We had not received any notifications during a period where there were significant safeguarding issues being raised at the home.

Many of the actions detailed on the action plans submitted by the provider to the CQC to inform us of the improvements they were making to the service had not been acted on. The provider had not updated the CQC to inform us of this and the reasons why. Some of the concerns raised in our Warning Notice to the provider had not been addressed by the required due date of 7 September 2018.

The provider brought in a consultancy service to support them have management oversight of the home. The consultancy had identified many concerns at the service, but had not moved far in addressing them. There had been too much reliance in their action plans on IT software addressing the concerns raised, as opposed to making sure people with high dependency needs were protected by good auditing processes and systems.

During the second day of our inspection visit, we saw early signs of improvement; and the provider had further plans to improve the service. However, the changes were too recent to have had any meaningful impact on people who lived at the home; and the provider's plans had not yet been fully put in place.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to

varying the terms of their registration.

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?

Inadequate

The service was not safe.

Sufficient action had not been taken to improve safety.

People had not been safeguarded from harm. Risks to people's health and wellbeing had not been assessed and effective action taken to reduce them. Medicines had not been managed safely.

There were not enough staff who knew people's needs to provide safe support. The provider could not be sure people's care needs were met because the staff dependency tool relied on up to date information on people's care needs, and many people's needs had deteriorated but care plans not updated.

New staff had recently been recruited and were being inducted to the service.

The premises were safe and mostly clean. Staff understood the importance of using protective equipment to reduce the risk of transferring infection when carrying out personal care.

Is the service well-led?

Inadequate

The service was not well-led.

Sufficient action had not been taken to improve leadership.

Since our last inspection, the management team at the home no longer worked for the service.

Poor leadership in the home meant people had experienced poor care and been placed at risk.

The provider had brought in a consultancy team to support them with higher management oversight. They had identified what needed to be done to move the home forward, but this was still in its infancy.

The Lodge Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected this service to check whether the provider had addressed the concerns raised at our last inspection in May 2018, to determine whether the Regulations were now met. We also inspected because of concerns raised by the local authority and members of the public.

This inspection took place on 19 and 25 September and was unannounced on the first day of our inspection visit. One inspector undertook the inspection visit.

Before our visit we looked at the 'share your experience' information received via our website from the public; the notifications received by the home; and Leicestershire County Council information provided to us. We also spoke with one relative who expressed concerns about the care provided to their family member.

During this visit we looked at four people's care records, room (daily records), incident and accident records, medicine records, quality monitoring records, staff meeting records, staff training records, staff rotas, and relative meeting records. We spoke with four people who lived at The Lodge Residential Home, seven visitors, four staff, the new manager, members of the consultancy team, and the provider.

After our visit, we requested further information from the service; and received information by email.

Inadequate

Is the service safe?

Our findings

At our last two inspections in August 2017 and May 2018 we rated this key question as 'requires improvement'. On both occasions, Regulation 12; 'safe care and treatment' was not met, and requirement notices were issued. This was because risks related to people's health and safety had not been identified and acted on to keep people safe; and medicine management was not safe. The provider sent us an action plan detailing how and when they were going to ensure the Regulation was met. At this inspection visit the Regulation continued to not be met.

A visitor told us, 'This used to be a wonderful place, you'd walk in and say this is the place I'd bring my mum, but you couldn't do that now."

At our last two inspection visits we were concerned that risk assessments had not identified people's needs that had changed. This meant staff did not always know what risks related to people's care, and the actions they needed to take to reduce them. For example, people were at risk when they had become less steady on their feet and were now at risk of falling; or where people were no longer able to change positions when sitting or sleeping and were therefore more at risk of their skin breaking down. During this inspection, we found risk assessments continued to be out of date or lacked clear direction for staff to support keeping people safe, placing people at risk of harm from potential injury.

We received information of concern about a person who lived in the home. The person had fallen on numerous occasions (one which resulted in a hospital stay). We looked at this person's care records. We found that whilst some of the falls had been documented on the incident and accident record; this information had not been used to update the person's care record and risk assessment, or to inform staff of measures they needed to take to reduce the risk of the person falling in the future. The person had become confused. Their confusion had been identified but no attempts had been made to look at how the service could support the person to become less confused, and remain safe. Another person's needs had also significantly changed from them being a person who was relatively independent, to someone with high dependency needs including being at risk of skin breakdown. Their care record provided staff with no guidance about how best to support them now their needs had changed.

We looked at other contributing records to determine how people's care needs were being managed. This included daily 'room' records and records from professionals who supported people's health care needs. A district nurse had informed staff that a person's skin on their bottom was in such a bad condition that the person must not to be positioned lying on their back. This was because it would increase the damage and pain to the person. We looked at the 'repositioning' records for this person (they needed support from staff to move in bed); and we found that despite the district nurse reminding staff twice not to do this; staff had repositioned them on their back. This was because the information in the healthcare records had not been transferred to the risk assessment or care plan and meant staff would not necessarily be aware of this.

Relatives told us of situations where staffs lack of knowledge of people's care needs had put their family member at risk. For example, two sets of relatives gave us examples of witnessing staff trying to give their

family members, un-thickened drinks. Their family member should have had drinks which were thickened with a thickening agent to stop the person from being at risk of choking. They both said they had to stop staff before the person started to cough and potentially choke. The care plan of one of these people, had not been updated since 2017 to support staff in their understanding of the person's current needs. Another person's 'professional visit' record informed that the speech and language therapist had said the person now required foods to be 'pre-mashed'. This had also not been updated in their care plan which said they were on a 'normal' diet.

The provider's action plan made no reference to improving risks related to people's health and care needs. We also expressed our concerns about the lack of updated care plans and risk assessments in our warning notice to the provider, which had a compliance date set by the Commission of 7 September 2018. At this inspection we found that improvements had not been made.

At our last two inspections we had concerns about the management of medicines. At this inspection visit we continued to have concerns. The provider's action plan informed us that actions to improve the management of medicines would be complete by 31 August 2018. In September 2018 we received information from the local authority informing us of their concerns about the way medicines had been managed in the home. They told us that they had identified some people had not received their prescribed medicines for more than a week, because of poor ordering procedures at the service; and of medicines not being administered according to the prescription. Also, there were numerous errors on the medicine administration records. They identified staff working night shifts were not able to administer medicines because they had not received the required training to do so.

The local authority had been concerned about medicine management. They sent their own staff to the home daily to make sure medicines were ordered on time; and staff administered medicines safely to people. The consultancy firm the provider employed also brought in additional management support to specifically check each day that medicines were being administered correctly and ensure that medicines management was being appropriately managed to keep people safe.

During our visit we undertook a medicine check alongside the local authority. They told us they were now seeing improvements in medicine management, but this was very early days. Ordering of stock had improved, but staff were still not always administering medicines correctly. On the day of our visit we found MAR charts still contained errors.

The provider's consultancy company informed us all staff were going to be re-trained to ensure they understood how to manage medicines safely; and those who did not, would not be able to administer medicines. They told us they were improving the checks on staff ability and competency to administer medicines safely. However, this was still in its infancy.

The provider failed to ensure that care and treatment was provided in a safe way for people. This meant they continued to be in breach of Regulation 12(1), Safe care and treatment.

The lack of understanding of people's risks and the necessary action to protect people, coupled with staff lack of understanding of safe medicines management meant people had not safeguarded people from harm. At the time of contacting us; the local authority informed us they had opened 11 safeguarding investigations related to the care provided to people. These were around neglect and acts of omission. Many were linked to poor medicine management, but others were linked to poor physical care. For example, one safeguarding investigation which was substantiated by the local authority was that neglect and acts of omission had resulted in a person's skin breakdown becoming a grade 4 pressure sore.

The provider failed to safeguard people from abuse and improper treatment through the lack of a system and process to effectively prevent abuse. This meant they were in breach of Regulation 13. Safeguarding service users from abuse and improper treatment.

At our last two inspections we had raised concerns that there were not enough staff to meet people's needs. At our inspection in May 2018, the registered manager had informed us that five staff were ready to start work in the home and this would improve the staffing situation. This had not happened. Staff told us seven staff had left and they had not been replaced. They said there had been no new staff start with the service since May 2018. They told us there was a high level of agency and the pressures this caused them as permanent staff. One said, "Agency come in all the time. It's OK if they come all the time [regularly], but some don't know the home and you have to tell them how to do it as well as your own job." It also meant that people were not receiving consistent care from staff who knew them.

One relative told us that with the various 'comings and goings of staff' there was a lack of communication and this meant staff did not always know their relative's changing needs. For example, they said, "One agency staff was trying to feed my mother horizontally on the bed. I had to stop her because she would choke." At the time of our visit, approximately half the staff supporting people at The Lodge Residential Home were temporary agency workers.

The provider's action plan informed us they would implement an 'Indicator of relative need' staff dependency tool with immediate effect. This tool was developed and designed to support care managers understand how many staff they needed to give sufficient care to meet people's dependencies. To use this tool well, the person inputting the information had to have a good knowledge of people's needs. Because of the poor state of the care plans and risk assessments this could not be undertaken and was not being used.

The consultancy firm employed by the provider to support the home, had arranged for one of their consultants to manage the home on an interim basis from August 2018 until a new manager was recruited and commenced work. The consultancy informed us they had changed staff shift patterns to ensure the rota reflected people's needs.

They acknowledged there continued to be a high level of agency workers but said they had recruited new staff who were starting their induction training the following week. On the second day of our inspection we saw the new staff undertaking training. The consultancy was confident that this would improve the care provided in the home. They had also carried out an assessment of agency staff to ensure they only requested those who they felt worked to the appropriate standards of care, and who were familiar with the service.

Whilst there were beginning to be improvements in the staffing at the home. At the time of our inspection visit these were not yet sufficient to remove the breach of the Regulation.

The provider failed to ensure that there were appropriately trained and experienced staff working within the home. This was a continued breach of Regulation 18; Staffing.

During our inspection visit we saw that staff recognised the importance of using disposable gloves and aprons when providing personal care to people to reduce the risks of infection from being transmitted from one person to another. However, whilst sat in the living room during tea and biscuits being served to people; we saw a member of staff hand people biscuits instead of using tongs.

We looked at the laundry area and the ironing room. We were concerned there was not a clear dirty to clean

work flow for laundry; and this had the potential to compromise infection prevention procedures. The ironing board cover which clothes were ironed on, and plate which the iron rested on were also very dirty. The consultant for the Provider told us they would discuss the issue regarding the laundry room with the Provider and change the ironing board. The remainder of the home looked clean and tidy.

The provider had carried out some of the actions required since our last inspection visit. We had previously identified that medicines were stored in a room where the temperature routinely exceeded temperatures which ensured they remained effective. Since our last visit, these had been moved into a room which was cooler. They had also worked alongside the local authority team to improve medicine management in the home. Although improvements were very recent.

Inadequate

Is the service well-led?

Our findings

In August 2017 we rated this key question as 'inadequate' because there were eight breaches of the Regulations. There was some improvement when we went back in May 2018 and the home was rated 'requires improvement'. However, there continued to be five breaches of the Regulations. We issued the service a 'warning notice' in relation to Regulation 17; Good Governance, as this was a continued breach and we gave the provider a deadline of 7 September 2018 for improvements to have been made.

In July 2018, the provider contacted us to inform us the registered manager was leaving the service, and they would be recruiting a new manager. In early August 2018, we received action plans from the provider outlining how, and by when, they would improve the quality of care provided to people in the home. However, at this inspection we found that improvements had not been made.

The provider, had brought in external care consultants to support them oversee the service and make improvements. Their role changed as more concerns arose, identified both by themselves and by external authorities. One of the consultancy team based themselves in the home from the beginning of August 2018 to act as an interim manager until a new manager started work at the home. They told us it was 'absolute bedlam' when they arrived, and their focus was to ensure staff met the needs of people who lived at The Lodge Residential Home. They also acknowledged that medicines management had been a high-risk factor for the service, and staff had not had the appropriate training and checks on their ability to administer medicines safely. They acknowledged the home had a long way to go before they would be satisfied it was a 'good' home.

In September 2018, the local authority contacted us to inform us of their concerns about medicine management and concerns that staff were not adequately supporting people who had higher dependency needs. For example, people who were at risk of falling or skin damage. We had also received concerns from relatives of people who lived at the home outlining similar issues.

Some of the actions the provider told us they would undertake to improve the service had been carried out. These included changing the medicine room; and giving people, relatives and staff opportunities to discuss issues impacting on the care of people. A letter had gone out to relatives in August 2018 informing them the provider had met all the CQC actions. However, many of the actions had not been carried out. This was because a lot of the actions were linked to the introduction of IT software which the provider hoped would improve care planning, risk assessments and governance of the home. The provider decided not to use this computer based software, and instead used different software. This introduction was put on hold whilst the more pressing issues of staffing and medicine management were being addressed. They were hoping to introduce this system once the new staff had been inducted to the home.

The provider had failed to provide sufficient leadership at the home to improve the quality of care provided to people and to meet the Regulations. This meant they continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance.

Throughout July to September 2018 the provider had failed to send us notifications they had a legal requirement to send. The provider is required to notify us for example, of any deaths of people at the home, both expected and unexpected; any injuries where damage is likely to last more than 28 days; the development of pressure sores of grade 3 or above after admission to the home; and any safeguarding allegations. During our inspection we found there had been deaths, injuries, a development of a grade 4 pressure sore, and safeguarding allegations during this period and we received no notifications. This meant we were unaware of the issues impacting on the home until relatives and the local authority contacted us to tell us of these.

The provider failed to ensure the relevant notifications were sent to the CQC. This meant they were in breach of the Care Quality Commission (Registration) Regulations 2009; Regulation 16, Notification of death of a person who uses services; and Regulation 18, Notification of other incidents.

The consultancy had identified what changes were needed to improve the service but had not moved very far in addressing these. One of the consultancy team had been based at the service since the beginning of August 2018. They told us it had been a challenge to manage the service, deal with the investigations requested by the local authority, and move forward with the actions when there was no other management support available. They believed that now there was another consultant supporting the home on a temporary basis who was managing the medicines issues; and a new manager starting that they could really start to make improvements to the service that people received.

The new manager had only been working for the service two days when we arrived for our first inspection visit. They had been made aware prior to accepting the post that there were concerns about the service but told us they were not aware there were so many issues. They said they were up to the challenge of addressing these with the support of the consultancy team. On the second day of our inspection visit, the manager told us they had recruited a deputy manager and had made some decisions about staff and their roles and responsibilities. This was to ensure staff only took on responsibilities they were equipped to do so.

Relatives and staff informed us they felt more assured that the service would improve now that the consultancy and the new manager was in place. One relative told us they had been able to phone the consultancy if they had concerns and get a response, which they had not been able to with the previous management team. They also said about the new manager," [Manager] sits with the residents for lunch; she wants to get to know them. She says all the right things and I feel very confident." Another relative told us, "I'm quite impressed with [manager] and [consultant]." They said they had just had their first positive contact with management. Staff we spoke with told us they felt more listened to since the previous management left and were positive the new managers were beginning to make a difference.

On the second day of our visit, the provider met with us. They said they would be retaining the services of the consultancy firm. This was to support them maintain an oversight of the home to ensure the service met the regulations and support the manager. They had invested in a new IT software system which they expected to be introduced to staff within the next month which they hoped would improve record keeping; and ensure people's health and safety issues were addressed in a timely way. They hoped to start staff training on the system once new staff had been inducted to the service.

At our last inspection, we found the provider had not displayed the rating of the home on their website. This was after informing them of their legal responsibility to ensure their rating was displayed. Soon after our inspection visit the rating was displayed on their website. During this inspection visit we found the provider had yet again not displayed their rating in the home. This was corrected soon after our inspection visit. We checked the provider's website and found that whilst the rating was on the website, it was not positioned in

a conspicuous part of the website as detailed in our guidance to providers. We sent this guidance to the provider who informed us they would get this changed.

Two weeks after our inspection visit on 25 September 2018 we were informed by the consultancy that the new manager no longer worked for the service, and the provider was recruiting for another manager.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had not notified us of all the deaths of people who lived at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all the incidents that should have been notified to us.

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 had not used incidents to identify potential abuse and take preventative action, including escalation to the appropriate authorities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff deployment did not meet the needs of people with higher dependencies. Staff did not always have the knowledge, skills and experience to provide safe care to people.