Foxley Lodge Care Ltd

Sonia Lodge

Inspection report

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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
Sonia Lodge is a residential care home providing accommodation and personal care to up to 28 people. At the time of the inspection 14 people were living at the service. The service provides support to older people, many of whom are living with dementia. People lived in one adapted building which had a garden at the rear and was set in a residential area.

People's experience of using this service and what we found
Some people living at the service told us they were not happy. Some relatives also expressed concern. One relative said, "Up until recently [my relative] was happy. In the past month they have been saying they don't want to stay there."

People were not being supported safely. Staff were not always following people's care plans. Where people expressed their emotions through behaviour this was not well managed and was allowed to escalate. Medicines were not well managed and medicine records were not well kept. Incidents continued not to be analysed for trends.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. There continued to not be enough staff to support people. Staff were busy and not able to provide reasonable standards of care. People were not provided with mental and physical stimulation during the day.

Cleanliness of the service had improved since the last inspection. However, the service did not smell clean and needed further improvement. Staff wore appropriate personal protective equipment (PPE). Staff knew how to raise concerns about abuse and whistleblow. However, systems had not been effective in reducing the risk of abuse by neglect.

The culture of the service needed to be better, to improve outcomes for people. Staff were not always happy in their role and did not always feel supported. People continued not to be treated with dignity and respect.

Following the last inspection, we received an action plan from the provider. This had not led to improvements and the standards of care had deteriorated. Auditing was not effective at ensuring quality was maintained. The provider told us relatives had been asked for feedback but was not able to evidence this. Relatives did not always feel well informed. Record keeping was poor and not always accurate.

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 28 October 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At

this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 22 September 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the safety and management of the service. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements. However, prior to the inspection we also received concerns about the standards of care at the service, infection control and the management of the service.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to Inadequate. This is based on the findings at this inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

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 Sonia Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment including the management of medicines, dignity and respect, good governance, staffing levels, and staff recruitment at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Sonia Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by two inspectors.

Service and service type
Sonia Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Sonia Lodge is a care home without nursing care. 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. The registered manager had left the service shortly before the inspection. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received 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 (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including housekeeping, care staff and the provider. We observed people and staff's interactions when people were in the communal areas of the service. We spoke with a visiting social care professional. 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 five people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke to visiting health and social care professionals. We raised concerns about one person's care with safeguarding. We sought further clarification from the provider about their plans to improve the service and provide effective management.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) 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 17.

● At the last inspection we found care plans and risk assessments contained contradictory information. At this inspection we found the same concerns. For example, one person's care plan stated they used the shower with grab bars and a shower chair. The person was being cared for in bed, this was not well reflected in the care plan for personal care. The person's care plan stated they had a pressure injury. We confirmed with a health professional this was a not a pressure injury but was due to an underlying health condition.
● At the last inspection we found some people displayed emotional based behaviours. There was guidance in place. However, this did not include triggers, how the behaviour may escalate and how staff should manage the behaviours. At this inspection we found the same concerns.

Systems continued to either not be in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks from emotional based behaviours were not well managed leading to the risk of incidents escalating. One person was triggered at certain times of the day, this had not been recognised in the care plan and was not proactively managed by staff. Some people living at the service did not get on well. Staff did not always intervene quickly to calm people. More than once during the day we saw the situation escalated to the point where people, in the lounge, were shouting and threatening to strike each other.
● Staff knew how to support people but were not always following the care set out in people's plans leading to risks to people not being well managed. For example, one person was at risk from diabetes. Staff were not monitoring the person's blood sugar in line with the care plan. When the person's blood sugar was too high or low staff recorded what action, they had taken. However, there was no evidence they had always tested the person later to ensure this action had brought the person's blood sugar back to safe levels. The machine staff used to monitor the person's blood sugar had not been calibrated to ensure it remained accurate.
● One person walked with purpose. They were observed walking around the home three times holding a bottle of hand sanitiser. If ingested this could cause the person to become very unwell. The person had

removed the lid and hand sanitiser was spread over several areas of the home causing a slipping risk for other people. One person's relative told us staff had not identified a change to their relative's known mental health needs and did not know how to distract the person's attention when this was needed to reduce behaviours which could be risky.

The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to deploy enough staff to meet people's needs. This was a breach of regulation 18 (Staffing) 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 18

● At the last inspection there were not enough staff to meet people's needs in that there were no laundry staff; care and housekeeping staff were expected to complete this role. There was one housekeeper, who worked each morning. People did not have sufficient meaningful activities and were not occupied. At this inspection we found the same concerns. Some staff told us there was not enough staff.
● There was a dependency tool in place. Since the registered manager had left this had not been reviewed by the provider. The tool had not been effective in recognising people's complexity of needs.
● Staff were busy and did not have time to provide people with the level of support they needed. There were three care staff on shift, one of whom spent most of the morning supporting people with their medicines. There was very little engagement between staff and people. People spent long periods of time in the lounge without stimulation. The staff member trying to administer medicines kept being interrupted as they were the only person in the lounge at times. This can increase the risk of medicine errors as staff are not supported to concentrate on the task. There continued to be no activities coordinator. Comments from relatives included, "There are not enough staff, they are always rushed off their feet." And, "It's a bit dull and dreary, I have never seen any activities or anyone chatting to [my relative]." One staff said, "We don't have time to sit and talk to people, there is no time. It's heart breaking."
● One person had not eaten their breakfast which was recorded as being served early that morning. This was left on the table next to them uneaten for some time. Staff had not offered the person an alternative later in line with the person's risk assessment for eating and drinking. During the late morning the person complained to the inspector they had not eaten all morning. We asked staff to get the person something to eat. The person was served a cup of tea but needed some support to drink it. Staff left the person to support other people, and the person struggled to drink their tea. Staff returned on two occasions to support the person but did not have the time to stay and support the person to have their drink whilst it was still hot.
● Prior to the inspection we received concerns that people were not being well supported with continence and were in wet pads when the afternoon shift commenced at 2pm. During the inspection we identified one person's continence pads had not been changed or checked for 8 hours. The lounge where people spent most of the day during the inspection smelt of urine.

The provider had continued to fail to deploy enough staff to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not recruited following safe recruitment processes. The provider had failed to ensure staff work history had been explored in full prior to new staff starting work. The provider informed us they did not realise this was a requirement.

The provider had failed to ensure safe recruitment procedures were established and operated effectively. This is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) 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 17.

● At our last inspection we identified there was no recording of action taken to mitigate risks when accidents and incidents occurred. We found this had not improved at this inspection. When incidents of emotional based behaviour occurred, staff documented these but no learning had been implemented to try to reduce the likelihood of the incident reoccurring.
● There continued to be no system in place to ensure accidents and incidents had been reviewed for patterns and trends. One person fell twice in a short space of time, and no action had been taken to reduce the risks of falls, such as a referral to healthcare professionals or review of the care plan in place.

Systems continued to either not be in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Peoples medicines were not managed safely, and we were not assured people received their medicines as prescribed.
● We were not assured staff competency to administer medicines had been undertaken effectively. Competency assessments were undertaken by staff but records did not include any information on what was discussed or observed.
● We were not assured people's pain was being well managed. There was no information on how people expressed pain. One person had been prescribed a new pain medicine. This arrived the day before the inspection but was put in a cupboard. When asked, staff did not know who had prescribed the medicine or taken action to ensure the person received it. We raised this with the provider and the issue was addressed during the inspection.
● Medicines counts and records did not always match including medicines which were subject to tighter controls such as some pain medicines. For example, one person had 3 pain patches in stock, however records stated there were none. The book used to record these medicines was not well completed. For example, the name and strength of the medicine was not recorded.
● Some pain patches need to be rotated to ensure they do not cause issues like irritation to the person's skin. There was not always a chart in place to ensure this was being done.
● Some people were supported with as and when medicines (PRN's) such as pain relief. There were some PRN protocols for some medicines but not others. There was information on how often some medicines could be given but not on what the medicine was expected to do or the minimum time between doses if the

first dose has not worked.

The provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had not consistently assessed the risk of controlling and preventing infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 12 for preventing and controlling infection

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● At the last inspection we were not were assured that the provider was using PPE effectively and safely as staff were observed not always wearing face masks. At this inspection practice had improved. However, PPE was not always disposed of correctly as some bins within the service did not have the correct bin liners and staff disposed of PPE in normal bins. We raised this with the provider who addressed this concern during the inspection.

● At the last inspection we were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was not always clean. Some communal areas were dirty including a shower room and stairs, some areas smelled of urine and some of the furniture was dirty. At this inspection cleanliness had improved. However, it took time for some areas of the service to be cleaned with limited cleaning staff. For example, one person had fluid spilt by their feet. Staff did not notice the spillage for hours until the person needed support to move. Areas of the service continued to smell. This is an area for improvement.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Inspectors were not asked to provide evidence they had been vaccinated when they visited the service. At the time of the inspection this was a requirement. However, since the inspection this regulation has been withdrawn.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● People isolated when they tested positive or were symptomatic.

● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

People were supported to receive visitors and go out with friends and family in line with current Government guidance.

Systems and processes to safeguard people from the risk of abuse

● Staff had the knowledge they needed to identify and raise concerns including alerting external agencies to poor practice by whistleblowing. In law, whistleblowers are people who raise their concerns in a certain way

and may receive protection in any employment dispute. Some staff had raised concerns with CQC prior to the inspection. However, the provider did not have effective systems in place to reduce the risk of abuse through neglect. For example, auditing had not recognised and addressed the concern that one person's blood sugar was not well monitored.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection staff did not always treat people with dignity and respect. This was a breach of regulation 10 (Dignity and respect) 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 10.

● At this inspection we found people continued to not always be treated in a dignified way. One person told us their clothes were missing since moving into the home. The provider was not able to evidence the clothing and belongings the person arrived with and was therefore not able to confirm if their clothes were or were not missing. Action had not been taken to contact the person's social worker to address issues rating to the person's finances to enable them to purchase more clothing.
● People were wearing clothes with stains on, and not supported to change. People's clothes were mis matched. One person had no shoes on. Staff had not noticed until they were being supported to walk towards a wheelchair. Staff did not notice the wheelchair only had one footrest and the persons feet dragged on the floor.
● Staff continued to be task orientated. We observed staff put food down in front of people and walk away without speaking to people. One person kept falling forward in their chair and as a result spent a considerable amount of time with their head resting on the table. Staff occasionally repositioned the person using a pillow which did not look clean to prop them up. This pillow was not sufficient to support them to remain sitting up in their chair and they quickly ended up with their head on the table again.

Staff did not always treat people with dignity and respect. This was a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the services provided This was a breach of regulation 17 (Good Governance) 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 17.

● At the last inspection audits had not identified the shortfalls found at this inspection, such as, the lack of guidance within risk assessments. At this inspection we found the same concerns. For example, audits had not identified some medicine records were not well completed or that personal protective equipment (PPE) was being disposed of incorrectly. Quality monitoring systems had not led to people receiving a safe service. For example, concerns had not been identified about the management of one person's diabetes or that the blood sugar testing machine had not been calibrated.
● Following the last inspection, we received an action plan setting out how the provider planned to improve the service and meet the breaches in the previous report. This plan had not been effective and had not led to sufficient improvement. The service had deteriorated since the last inspection.
● The culture at the service needed to improve. Some staff were unhappy and did not feel supported. Comments included, "The atmosphere isn't great.", "I don't feel [the provider] is approachable [they] can come across intimidating." And, "I don't feel respected anymore." Staff also told us they did not always feel listened to. We reviewed the minutes of the last staff meeting; the records did not evidence that discussion was two way or collaborative.
● The provider informed us that relatives had been asked for feedback since our last inspection. However, the provider was not able to provide evidence of this, and evidence any actions taken to address the feedback. There had been a lack of engagement with relatives and loved ones. Immediately prior to the inspection the registered manager left the service. The provider had recently taken over direct management of the service. The provider informed us they had spoken with some of the relatives since the registered manager left, but not all relatives. Relatives told us communication needed to be improved. Some relatives said communication had stopped recently others said that updates about how their relatives were getting on were basic and not very informative. One relative told us they had not been informed about significant changes to their relative's health.
● Record keeping was poor and not always accurate. For example, one person's record showed they had eaten all of their breakfast prior to the start of the inspection. The meal was still on the table uneaten when we arrived. One person told us they had not been to the toilet for four days and had pain in their stomach. Documentation was poor, and the provider was unable to evidence if the person had been to the toilet. The provider told us they were aware the person was in discomfort but did not contact the GP until the day of our inspection.

The provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the services provided. The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user. The provider failed to seek and act on feedback from relevant persons. This was a 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

At our last inspection the provider had not acted in an open and transparent way with relevant persons in relation to care and treatment provided to people. This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 20.

● We did not identify any incidents or accidents at the service which qualified as duty of candour incidents. A duty of candour incident is where an unintended or unexpected incident occurs which result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● The provider understood the need to be open and transparent if there was such an incident and understood their duty of candour responsibilities.

Working in partnership with others
● Staff had made some referrals to health care professionals when some people's needs had changed. However, other referrals were still needed. At the time of the inspection the provider was engaged with the local authority to look at how improvements could be made to the service. Relatives informed us they had been invited to or attended reviews of people's care needs. As a result, referrals were being made to other health and social care professionals where needed.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe recruitment procedures were established and operated effectively.

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 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always treat people with dignity and respect.

The enforcement action we took:

We took enforcement action against the provider and applied conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. The provider had failed to ensure medicines were managed safely.

The enforcement action we took:

We took enforcement action against the provider and applied conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems continued to either not be in place or robust enough to demonstrate safety was effectively managed. The provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the services provided. The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user. The provider failed to seek and act on feedback from relevant persons.

The enforcement action we took:

We took enforcement action against the provider and applied conditions on their registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had continued to fail to deploy enough staff to meet people's needs.

The enforcement action we took:

We took enforcement action against the provider and applied conditions on their registration.