Pharos Care Limited

The Lodge

Inspection report

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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

This service was inspected on 07 December 2018 and the inspection was unannounced. At our last inspection in January 2018, the service was rated as 'Good' in all questions asked.

We undertook an unannounced focused inspection of The Lodge on 07 December 2018. We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well led? This was because information of concern had been bought to our attention regarding the service.

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 Lodge accommodates eight people with a learning disability in one adapted building. At the time of the inspection there were eight people living at the service. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager, but they were not present during the inspection and had recently submitted their application to de-register as the registered manager of 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.

People appeared comfortable in the company of the staff who supported them and regularly approached them for reassurance and support. Staff now felt confident that they would be listened to if they raised concerns and that management would act on those concerns appropriately.

People were supported by sufficient numbers of safely recruited staff. Staff were aware of the risks to people and how to support them safely but audits in place had failed to identify where information had not been updated in some care records.

People received their medicines as prescribed but 'as required' protocols in place for some people were incorrect and did not provide staff with the information they required in order to administer the medication safely and effectively.

Concerns regarding the reporting and recording of accidents and incidents were being looked into and analysis was taking place to ensure lessons were learnt when things went wrong.

Management acknowledged they had failed to respond appropriately and provide the relevant support to staff when six staff had been dismissed.

A number of whistle-blowing concerns had prompted management to act swiftly and meet with all staff. Plans were in place to address the concerns raised by whistle-blowers and additional support was being provided to all staff.

Staff felt supported and listened to and were confident that management would act on issues raised.

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 consistently safe.

Risk assessments in place were not consistently up to date. Protocols for 'as required' medication were ineffective. People were supported by sufficient numbers of safely recruited staff. Systems were now in place to ensure lessons were learnt from incidents and accidents.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Management had failed to plan adequately to ensure people received safe and effective care following the dismissal of six staff. Audits in place had failed to identify inconsistencies in care records and medication care plans. Management had responded to whistle-blowing concerns and staff felt confident that action would be taken and they would be listened to.

The Lodge

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.

The inspection was prompted in part by a number of whistleblowing concerns that were bought to our attention regarding the safety and the running of the service. These included concerns regarding staffs' confidence in management's ability to recognise and act on concerns raised, inconsistent recording and reporting, concerns regarding the effectiveness of existing care plans and risk assessments.

This inspection took place on 07 December 2018 and was unannounced. The inspection was carried out by one inspector.

As well as the information of concern we received, we reviewed other information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths. We also asked the local authority for their views about the service provided. We used the information we had gathered to plan what areas we were going to focus on during our inspection. We spoke with one person who lived at the service and observed the interactions of staff and people living at the service. We also spoke with the operations manager and seven members of care staff.

We reviewed a range of documents and records including the care records of four people using the service, three medication administration records, two staff files, accidents and incidents, minutes of meetings, surveys and quality audits.

Requires Improvement

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection of this service on 29 and 31 January 2018 at this inspection we rated the service as 'Good' in the key question, Is the service safe? At this inspection we found the rating had changed to 'Requires Improvement' in this key question.

Prior to the inspection, a number of whistle-blowers had contacted both the Local Authority and the Care Quality Commission regarding the safety of people living at the service and management's response to accidents and incidents of a safeguarding nature. Six staff had recently been dismissed from the service and this had had an impact on service delivery. Concerns had been raised regarding the number of agency staff bought in to fill the vacancies and whether they were qualified to support people with behaviour that may challenge. This had a direct impact on existing staff and one told us, "I was worried every time I came on shift", and another said, "Losing six staff had a massive impact on the remaining staff and service users as well". Staff described how the introduction of new staff into the home had an unsettling effect on some people living there which resulted in an increase in their behaviours that may challenge, as the new staff were unfamiliar with how to support people in line with their care needs.

At this inspection, we saw that in response to the whistle-blowing concerns, the provider had met with staff and provided assurances and additional support. The home was supported by permanently employed staff who were confident that if they raised any concerns, they would be listened to. One member of staff told us, "I didn't feel listened to [before], but feel I would be now. I feel there's been a change". Staff spoke with were fully aware of their responsibilities to raise concerns if they felt people may be at risk of harm. Staff told us that since raising their concerns with the provider, actions had quickly been taken and they felt confident that if they did raise a concern then their voice would be heard and action would be taken.

Prior to the inspection, we were made aware that one person's care file had highlighted that in March 2015 they had been identified by healthcare professionals as being at risk of choking, but this had not been updated on their care plan and staff had continued to provide meals which may increase that risk. At this inspection, staff spoken with told us they had recently been made aware of the potential risks to the person and had been provided with information regarding the consistency and types of food they should be offered. We noted this information was also on display. However, a member of staff told us they had had to point this out to another staff member that morning, as they had not taken note of the changes. We raised this immediately with the operations manager who provided assurances that they would ensure this information was passed onto each member of staff when they came onto shift.

We observed staff supporting people safely and in line with their care plans and people appeared comfortable in the company of the staff who supported them. We observed one person had come out of their room and was agitated and staff spoke successfully to the person to reassure them and try to calm them and keep them and other people safe from harm. However, at the same time, we observed a workman appear in the vicinity and start drilling. There was no recognition that this could have been a potentially unsafe environment for people at that moment. We raised this with the operations manager who agreed that this was an accident waiting to happen and would speak to staff to ensure thorough risk assessments

were in place, which staff adhered to, prior to maintenance work being carried out at the service.

New staff who had recently been recruited to the service confirmed that prior to them commencing in post they had been requested to provide two references and a DBS [Disclosure and Baring Service] checks. The DBS check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed.

We saw that for medication that was to be administered 'as required', the protocols in place did not provide staff with the information required to ensure the medicines were administered in the correct circumstances. For example, for three people, the protocol for each of them stated their medicines should be given for, "behaviours which challenge lasting longer than an hour with no period of calm". There was no description of what the behaviours were or what action to take to alleviate them [if possible], before administering the medicine. We spoke to staff regarding the circumstances in which they would administer these medicines. Staff provided detailed responses to these questions which demonstrated that they were aware of the specific circumstances in which the medicines should be administered. A member of staff told us, "The protocol doesn't describe [person] at all. It needs updating". We saw for another person, the 'as required' protocol was incorrect as it stated it should be administered for 'behaviours which challenge lasting longer than an hour' but staff told us this medication was to be administered after a person had experienced a seizure. This meant there was a risk that people could be administered a medication in the wrong circumstances by staff who were not familiar with them. We raised these points immediately with the operations manager who assured us the protocols would be updated immediately.

We noted daily audits of medication took place which would allow the manager to take action following any errors, in order to reduce the likelihood of re-occurrence. We carried out a stock check of the medicines of three people and found that what had been administered and signed for, tallied with what was in stock.

Prior to the inspection, concerns were raised that some incidents were not reported as safeguarding concerns and that lessons were not being learnt from accidents or incidents. We saw evidence that accidents and incidents were being reported, but the forms that were being used were inconsistently completed. For example, information was missing or analysis of the incident had not taken place. We discussed this with the operations manager who confirmed that work was underway to review the reporting and recording of accidents and incidents and all reports sent through from September 2018 were being looked at again to ensure they were completed appropriately. They confirmed that the system that had been in place to analyse this information had not been completed for a few months and it was a priority to get this work reintroduced. We saw that members of the behaviour management team had commenced analysis of accidents and incidents and this information was in the process of being analysed.

We did see for one person that lessons had been learnt following analysis of information that had been collected regarding a number of behaviours they had displayed. In response to this a number of changes had been made to the person's routine and consistently applied.
A member of staff said, "We try and given [person] structure to their day and not overload them with information".

People were protected by the prevention and control of infection. We observed the home to be clean and regular audits of the environment in place.

Requires Improvement

Is the service well-led?

Our findings

We carried out an unannounced comprehensive inspection of this service on 29 and 31 January 2018 at this inspection we rated the service as 'Good' in the key question, Is the service well led? At this inspection we found the rating had changed to 'Requires Improvement' in this key question.

Prior to inspection we received a number of whistle-blowing concerns regarding the service including the failure of management to respond to the concerns raised by staff. A member of staff told us, "I felt things were not being addressed properly and that some things should have been raised as a safeguarding and they weren't". Leading up to the whistle-blowing concerns, six staff had been dismissed from the service. The project manager, who was responsible for the day to day running of the service, was placed onto shift which meant that day to day management duties were not followed up and acted upon. This had an immediate impact on the service and this was something which the provider had failed to plan adequately for, resulting in existing staff feeling demoralised and stressed and placing people living at the service at risk of harm.

People were being supported by agency staff or staff from the provider's other homes, who were not familiar to them. Arrangements were not in place to ensure staff were in possession of the skills and knowledge to meet people's needs. Existing staff did not always feel safe as there was confusion as to whether new staff were trained to support people with behaviour that may challenge. This meant people and staff were put at risk of harm. The operation manager acknowledged, "We [management] have definitely taken a backward step. We should have identified the problems sooner".

We saw that a number of audits in place were not effective. For example, audits had not picked up the risks associated with eating for one individual were not being actioned by staff. Medication audits had not identified that 'as required' protocols in place for some people were not fit for purpose to ensure they had their medicines as when needed.

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

The operation manager was in the process of reviewing the audits and told us they were introducing the 'live reporting' of incidents which had been in use at the previous inspection. This would provide the management team with up to date information regarding any accidents and incidents taking place in the service.

In response to the concerns raised, the provider had met with all staff, initially in a group meeting and had then arranged to meet staff on a one to one basis. All staff spoken with talked positively about the impact this meeting had on them. They told us they now felt listened to and were confident that their concerns were being acted upon. We received the following positive comments from staff, "[Provider's name] came in and had a meeting. They met with every member of staff and gave us their phone number; any concerns and you can get hold of them", "We have actually got a full staff now and it's amazing. I come into work and I'm

actually happy", "I am very positive things are going to be ok", "Since [operation manager's name] has come in it's improving", "I've been interviewed and I've told staff you have to be honest, unless you tell the truth, things won't change", "I feel people are safe. I feel happy and I would phone [operation manager's name] if I had a problem, I wish I had before. It feels more positive and more at ease".

The provider had also instructed two independent members of their own management team to interview all staff, discuss their concerns and carry out investigations into the issues raised. At the time of the inspection, these investigations were ongoing. The registered manager and the project manager were not present on the day of the inspection and were being supported to take up new roles within the organisation. The operation manager acknowledged that the registered manager who had been bought in was 'over stretched covering three services' and was spread 'too thin' between them. It was clear the operation manager and the provider fully supported both the registered manager and the project manager and wanted them to remain within the organisation.

We saw the provider had bought in the operation manager, who was familiar with the service, to oversee the changes taking place. Representatives from the provider's behaviour management team were present on site and worked with staff to support people living at the service. All staff spoke positively about the impact the team had on their work and how they supported people. One person said, "I observe how the behaviour management team respond to [person's] behaviour and they give advice as well. The person's behaviour is managed successfully and their behaviour reduces quickly". Other staff described new strategies that had been suggested and had had a positive impact on how they supported the person. The operation manager told us, "The behaviour management team had been bought in to give staff more confidence that they are doing the right things".

A number of staff were currently taking on board additional duties and management had recognised this, the operation manager told us, "[Staff name]; I'm confident in their ability to keep the service safe, I've never had any question about their abilities". We saw the provider had purchased a number of gift vouchers to be given to staff to thank them for raising concerns and working with them.

The operation manager told us they had been tasked with ensuring all care files were fully audited to ensure they held the most up to date information regarding people's needs. We saw that for those staff who had recently been employed by the service, a new induction was being put in place to ensure they were being provided with the opportunity to develop their skills in order to meet people's needs. Offers of additional training for staff with regard to the reporting of safeguarding concerns, by the local authority, had been taken up and arrangements were in place for this training to take place the following week.

Families had not been made aware of very recent management changes at the service but we saw a letter had been drafted and was being put together to send out within the next week.

All organisations registered with CQC are required to display the rating awarded to the service. The registered manager had ensured this was clearly on display.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems were in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity.