The Pavilion Care Centre Limited

Kings Lodge Care Centre

Inspection report

The Pavilions
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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

About the service
Kings Lodge Care Centre is a care home with nursing for up to 44 older people, including people with physical disabilities, sensory impairments and dementia. There were 40 people living at the home at the time of our inspection.

People's experience of using this service and what we found
People had not always received safe care in the period prior to our inspection. For example, one person was given a meal which did not comply with guidelines about their food and another person had experienced unexplained bruising. One person had been put at risk of harm by faulty equipment. Medicines were not always managed safely.

Many people's care plans and assessments were overdue for review and, as a result, did not provide accurate, up to date information for staff. This meant people may not have received the care they needed.

Prior to our inspection, the provider had identified that some areas of the service needed improvement and had developed an action plan, which was reviewed regularly. The provider had also put additional management support in place and begun monthly monitoring visits.

There were enough staff on each shift to provide people's care. However, people's experience of care was affected by the home's reliance on agency staff. The provider had made efforts to recruit permanent staff and had introduced measures which aimed to improve recruitment and retention. The provider had also block-booked agency staff in an attempt to improve the consistency of care people received.

Staff understood their responsibilities in terms of protecting people from abuse and knew how to report any concerns they had. Safeguarding incidents had been reported to the local authority and the provider had contributed to safeguarding enquiries when requested to do so.

People were involved in decisions that affected them and they and their relatives had opportunities to give their views at regular meetings. Staff feedback was also encouraged, and staff told us their views and suggestions were listened to. The home had established links with the local community, which had benefited the people living and working at the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The registered provider for the service had changed since the last inspection. The last rating for the service under the previous provider was Good (published 6 May 2017).

Why we inspected

We received information of concern about some aspects of the care people received and the management of medicines. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

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 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.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full 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 Kings Lodge Care Centre on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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.

Kings Lodge Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by an inspector, a medicines inspector and a specialist nursing advisor.

Service and service type
Kings Lodge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We received feedback from nine relatives, three staff and three professionals as part of our monitoring activity of the service. We reviewed information we had received about the service since the last inspection, including notifications and safeguarding records. The provider sent us documentation including audits, training records, reports of quality monitoring visits and the minutes of residents' meetings.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with ten staff, including the registered manager, the provider's regional manager, two nurses, four care staff, a housekeeper and the chef.

We observed the support people received and the engagement they had with staff. We reviewed records including risk assessments and support plans for four people and four staff files in relation to recruitment and supervision. We checked accident and incident records and the arrangements for managing medicines.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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.

Assessing risk, safety monitoring and management

- In the period leading up to our inspection, there were some instances in which people had not received safe care and treatment. For example, in July 2021 a person who required texture-modified food had been given a meal which did not comply with the guidelines recommended by a speech and language therapist. Also in July 2021 a person left the home unnoticed by staff and attempted to leave the premises, only failing to achieve this when they were unable to scale the home's boundary fence.
- In August 2021 a person sustained bruising on their arm and face but the provider was unable to establish how the bruising had been caused. Also in August 2021 the provider notified us of an incident in which a person's bed had collapsed, putting them at risk of harm.
- On the day of our inspection, one person's pressure mattress was set for a weight of 70kg although the person weighed 51kg. This put the person at risk of sustaining pressure damage.

The failure to ensure people received safe care and treatment was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always managed safely. Controlled drugs administered during our inspection were not recorded in line with current guidance issued by the National Institute for Heath and Care Excellence (NICE).
- Some of the equipment in the home's first aid kits was out of date.
- One person at the home was using oxygen. There was an oxygen concentrator in the person's room and portable oxygen cylinders in a storage room on the first floor. Oxygen stored at high pressure, such as in a cylinder, can present a risk of fire but there was insufficient signage indicating these were areas where oxygen was stored.
- Medicines care plans were generic and, in some cases, were not in place where they should have been. For example, there were no medicines care plans in place for people prescribed anticoagulants or time-sensitive medicines. Some people who were at risk of seizures did not have an epilepsy care plan in place.
- The provider's current medicines policy was reviewed in 2018. However, the medicines policy available to staff in the first-floor medicines room was a 2015 version. This meant staff may not have access to the most up to date policy guidance for the management of medicines.
- Internal medicines audits were not sufficiently robust. For example, they had not identified the issue regarding signage for areas where oxygen was stored.

The failure to manage medicines safely was a further breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We identified no concerns regarding the ordering or disposal of medicines. We saw that appropriate procedures had been followed for people receiving their medicines covertly (without their knowledge or consent). The provider had identified that work was required to ensure protocols were in place for medicines prescribed 'as required' (PRN) and had carried out this work. There were appropriate procedures in place for reporting medicines incidents and for responding to medicines alerts.

Staffing and recruitment

● There were enough staff on each shift to provide people's care. People told us staff were available when they needed them and our observations during the inspection confirmed this. Staff said they had enough time to provide the care people needed without rushing them.

● Although there were sufficient staff on duty to support people, people's experience of care was adversely affected by the high usage of agency staff. The provider estimated that, at the time of our inspection, approximately 70% of staffing hours were filled by agency staff.

● Relatives told us the home's permanent staff knew their family members well but the reliance on agency staff had affected the consistency of care their family members received. One relative said, "The permanent staff are very good, they are always professional and easy to communicate with, but in recent times there have been a lot of agency staff working, which has affected the consistency of care." Another relative told us, "Most of the staff are lovely and they treat [family member] very well but there are far more agency workers now, which is a shame as relationships cannot be formed so easily."

● The provider was aware of the importance of providing consistent care and had made sustained efforts to recruit permanent nursing and care staff. The difficulties the provider had experienced in recruiting permanent staff were caused by a number of external factors and were shared by providers across the health and social care sector. In an attempt to overcome these difficulties, the provider had given consideration to how staff recruitment and retention could be improved and had recently developed a staff recognition and reward scheme. The provider had also block-booked agency staff where possible to improve the consistency of care people received.

● The provider's recruitment procedures helped ensure only suitable staff were employed. Prospective staff had to submit an application form and to attend a face-to-face interview. The provider obtained proof of identity and address, references and a Disclosure and Barring Service (DBS) check in respect of staff. DBS checks help employers make safer recruitment decisions and include a criminal record check.

Systems and processes to safeguard people from the risk of abuse

● Staff were confident in their knowledge of safeguarding and the process for reporting any concerns they had. They were able to describe the signs of potential abuse and the action they would take if they observed these.

● All staff attended safeguarding training in their induction and had access to regular refresher courses. Staff told us they would feel confident to speak up if they had concerns about people's safety or wellbeing. They said they had been given information about whistleblowing, including how to escalate concerns outside the home if necessary.

● Potential safeguarding events had been reported to the local authority where necessary, including unobserved falls, pressure damage and skin tears. When requested to do so by the local authority, the provider had contributed information to safeguarding enquiries

Learning lessons when things go wrong

● Where accidents and incidents had occurred, we saw that these had been recorded and reviewed to identify any actions that could be taken to reduce the risk of a similar incident happening again.

● We saw evidence that feedback from professionals had been acted upon when improvements were required. For example, in July 2021 a healthcare professional had advised that people were not being

supported to maintain adequate hydration, especially in hot weather. At this inspection we observed that staff frequently encouraged people to drink to ensure their fluid levels were maintained. Fluid charts had been put in place for people at risk of dehydration and these were completed daily by staff to ensure people were adequately hydrated.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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 using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People's care records did not provide accurate, up to date information for staff about how people's care should be provided. This was particularly concerning given the high use of agency staff who may not have known people's needs well.
- For example, one person's diabetes care plan instructed staff to, 'Look for signs and symptoms' of hyperglycaemia (which occurs when blood sugar levels are too high) and hypoglycaemia (which occurs when blood sugar levels are too high) but did not record what these signs and symptoms were or how they may present in the person.
- The care plan also instructed staff to monitor the person's blood glucose levels but did not record what level would constitute a concern. The care plan advised staff they could treat unsafe blood glucose levels with rapid acting insulin but did not clarify at what point this intervention should be used.
- Many people's care plans and risk assessments were overdue for review and reassessment, which meant guidance about the care they needed may no longer have been accurate. The electronic care planning system showed that 23 of the 40 people living at the home had at least one element of their care plans overdue for review and reassessment.
- In some cases, people had significant needs in the areas in which reviews and reassessments were overdue. For example, one person's nutrition care plan was due for review by 2 August 2021. The person's risk plan stated they were at risk of losing weight as they did not always eat well and declined support to eat.

- Another person's mobility care plan was due for review by 8 July 2021. The person's risk plan recorded, 'Is not able to mobilise independently. Requires the use of slide sheets. To change position 3-4 hourly with the assistance of two staff. Care plan to be reviewed and updated monthly / when required.'

The failure to maintain complete and accurate records about people's care and treatment was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; 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 provider responded positively to the feedback we provided following our inspection, confirming that this would be used to make improvements where these had been identified as necessary.
- The provider had identified prior to our inspection that some aspects of the service required improvement

and had put additional management support in place, including from the regional manager and the quality and compliance manager.

● The senior management team had developed a service improvement plan, which was reviewed and updated regularly to ensure actions were being completed. The quality and compliance manager had implemented monthly monitoring visits, which assessed quality and safety across the service. The reports of these quality assessments fed into the service improvement plan.

● When people had not received the quality of care they were entitled to expect, the provider had demonstrated a transparent and open approach to investigation and information-sharing. The registered manager understood their responsibilities as a registered person, including the duty of candour, and had notified CQC and the local authority about incidents where necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People who lived at the home and their relatives had opportunities to give their views at regular meetings. Prior to the pandemic these had taken place face-to-face and had continued via video call during COVID-19 restrictions.

● The provider aimed to involve people in decisions that affected them. For example, the chef had organised 'taste testers' when planning the menu to enable people to give their views about different meals. The chef also spoke to people after meals to hear their feedback about the food provided.

● Relatives told us they were kept up to date about their family members' wellbeing and informed of any changes or concerns. One relative said, "As next of kin I receive a telephone call if there are any changes or developments to [family member's] health."

● Staff were able to contribute their feedback at regular team meetings. Staff told us they were encouraged to speak up if they had suggestions or concerns and said their views were listened to. One member of staff told us, "They will listen if we have something to say." Another member of staff said, "We have a very good manager here; very supportive. She will walk around and comment if something is not quite right."

● The home's wellbeing coordinator had established strong links with the local community, which had benefited the people living and working at the home. This included links with local schools, scout groups and churches, which provided opportunities for people to engage with others and to celebrate their faith. A local business had donated money for improvements to the home's garden and local supermarkets and food outlets had provided meals for staff during Carers' Week.

Working in partnership with others

● Care records demonstrated that external healthcare professionals were involved in people's care where necessary, including dietitians, speech and language therapists, specialist nurses and mental health professionals.

● Feedback from healthcare professionals indicated that staff worked cooperatively with them and were receptive to their advice. One healthcare professional told us, "The staff I worked with were engaging and wanted input and help from me. I was able to supply some background information and provide some tips to help them engage better with my patient."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure people received safe care and treatment and that medicines were managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to maintain complete and accurate records about people's care and treatment.