Colourscape Investments Limited

The Lodge

Inspection report

The Lodge Residential Care Home
Heslington
York
North Yorkshire
YO10 5DX

Tel: 01904430781

Date of inspection visit:
27 March 2019
04 April 2019

Date of publication:
07 June 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: The Lodge is a care home for up to 30 older people and people with a dementia related condition. At the time of the inspection there were 28 people using the service.

People's experience of using this service: People were not receiving a service that provided them with safe, effective, compassionate and high-quality care.

Care and support were not tailored to meet people's specific needs. Care plans and risk assessments were not personalised. Information generated from an electronic system did not contain personal information about people.

Infection control measures were ineffective. Areas of the service were unclean and had unpleasant odours. Some equipment was either broken or not fit for purpose.

Staff morale was low; staff felt unsupported and frustrated with the running of the service. Staff did not always complete their training in line with policy and relatives told us they didn't feel staff had the understanding to support the needs of people. Supervisions and induction were completed. However, staff felt unsupported.

Some staff were kind and caring. However, other staff prioritised their own needs over the needs of the people at the service.

People were not supported to take part in activities. They sat for extended periods in the communal area without any engagement from staff.

The service was not well led. Ineffective quality assurance systems failed to identify the improvements required within the service.

Rating at last inspection: The service was last rated Requires improvement. (published 4 April 2018). This service has been rated Requires Improvement for the last three consecutive inspections. Following the last inspection, the service received a warning notice in relation to good governance. We also met with the provider to discuss improvements needed within the service.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Follow up: At this inspection improvements were still needed and the provider continues to be in breach of regulations. 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 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.

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. We have received some initial assurances from the provider about action they plan to take and we will continue to seek updates about the progress being made.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

The Lodge

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check 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.

Inspection team: The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The Lodge is a residential 'care home'. People in care homes receive accommodation and nursing or personal care. 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. The registered manager was registered shortly after our inspection of the service and had been at the service for six months.

Notice of inspection: This inspection was unannounced.

What we did: 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 reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority and spoke with other professionals who work with the service. We used all this information to plan our inspection.

During the inspection we spoke with six people who used the service and two relatives. In addition, we spoke with six members of staff including the registered manager, operations manager, deputy manager,

senior care workers and care workers. We reviewed a range of records. This included four people's care records and medication records. We also looked at three staff files and records relating to the management and safety of the service.

Requires Improvement

Is the service safe?

Our findings

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

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.

At the last inspection this domain was rated requires improvement and we identified a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we have identified a continued breach of Regulation 12.

Preventing and controlling infection
• At the last inspection we saw areas of the home which were not clean. At this inspection bedrooms and communal areas were unclean and presented an unpleasant smell.
• A recent infection control audit had not identified concerns with the cleanliness of the home.
• Staff had not completed training in infection control and we saw cleaning products left within communal areas unattended and accessible to people.
• Improvement plans for the service did not identify the concerns we identified within the environment. The registered manager told us this would be amended to address the issues.

Assessing risk, safety monitoring and management.
• People were at risk of harm due to poor information recorded in care plans. A new electronic system was in place to support care planning and risk assessing for people. This did not always identify risks in relation to people's specific health conditions or behaviours.
• Health and safety audits were completed by the registered manager but these audits failed to identify that various equipment within the service was damaged and not fit for purpose.
• Hospital passports to provide health professionals with information regarding the level of support people may need, should they need to go into hospital, were not in place.

The failure to protect people from the risk of infections spreading, and the failure to adequately assess, monitor and mitigate risks to the people's health and safety were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely.
• Information about medicines people were prescribed for use 'when required' was not clear. We found information was not always recorded in line with good practice and national guidance.
• Staff administering medicines completed training and had their knowledge and competence checked.

Learning lessons when things go wrong.
• Systems to monitor accidents and incidents did not always identify actions taken to prevent the risk of recurrence. Accidents and incidents were not effectively monitored to use as learning opportunities.

Staffing and recruitment.
• On the day of inspection there were sufficient staff available to meet people's needs. However, feedback from staff and relatives indicated this was not consistently the case. Comments from staff included, "There is not enough staff on a regular basis" and "Staff are always ringing in sick which leaves us short and stressed."
• Rotas confirmed staffing levels were inconsistent. The provider advised us that cover was sought, where possible, when staff called in sick at short notice.
• Safe recruitment procedures were in place. This helped to ensure people were supported by staff that were of a suitable character.

Systems and processes to safeguard people from the risk of abuse.
• The service had a safeguarding policy in place. The registered manager followed internal and external processes to keep people safe.
• People told us they felt safe living at the service. One person told us, "I feel safe here because of the way the rooms are set out and they are signposted.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• People's needs were assessed before they moved to the home. Care plans and risk assessments did not always reflect the personalised information that staff required to meet people's diverse needs.
• Care plans and risk assessments for specific health conditions were not in place. Staff did not have the information or guidance on how to support people or recognise a change in their condition.
• People's needs in relation to equality and diversity were considered during the assessment and care planning process. For instance, age, disability and religion.
• Daily records and monitoring charts were not consistently completed by staff.

Staff support: induction, training, skills and experience.
• Some relatives did not feel staff understood people's specific needs. Comments included, "I feel that the staff who write case notes don't understand [relatives name]" and "I don't think the staff understand my relative or are trained to care for people with dementia."
• Systems were in place to monitor staff induction and training needs. Some staff were overdue completing their refresher training in particular topics. The registered manager was aware and taking steps to address this.
• Records showed staff supervision meetings had taken place on a regular basis. However, not all staff felt supported or listened to.
• The registered manager told us they operated an open-door policy and were always available to staff.

Supporting people to eat and drink enough to maintain a balanced diet.
• Potential risks to people with complex needs in relation to their eating and drinking were not well managed. For example, their actual intake was not recorded or reviewed.
• Snacks such as individually wrapped biscuits, chocolate and crisps were available in the main lounge area. We saw people helping themselves to these throughout the day.
• People's nutritional needs were assessed and their weight was monitored. Advice was sought from relevant healthcare professionals, when required.

Staff working with other agencies to provide consistent, effective, timely care: ; Supporting people to live healthier lives, access healthcare services and support.
• People had access to health care professionals when needed.
• Staff sought support when required and assisted people to access other healthcare services.
• Staff acted quickly to support people's changing needs and sought medical attention straight away.

Adapting service, design, decoration to meet people's needs
• The environment was not purpose built and the corridor downstairs followed a loop. Whilst this enabled people to walk around freely there were spaces on corridors where people were out of sight of staff.
• People's bedrooms had stained flooring and contained broken equipment.
• There was some signage to help people with dementia to navigate their way around the service.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• We found DoLS applications had been made for people who lacked capacity to consent to their care.
• Mental capacity assessments and records to evidence decisions made in people's best interests were not always in place. Improvement was required to ensure there was a clear record of how any best interests decisions had been made and who had been involved.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity.
• People's needs were not met by the staff. Staff prioritised their own tasks instead of the needs of people.
• Not all staff spoke to people in a respectful way or showed genuine care and compassion.
• People were not always given the time to understand what staff were saying to them; staff were not always clear when communicating with people about what they were asking.
• People's basic care needs were not always met. Staff told us that the level of care provided depended on which staff were on shift that day.

Respecting and promoting people's privacy, dignity and independence.
• People were not always treated with dignity and respect. People remained in clothes that they had spilt food down and were not supported to change.
• People's personal information was not treated in a confidential manner. People's personal files were left on a desk and we saw other people trying to access these.
• Staff did not recognise when people needed support with their independence.

Supporting people to express their views and be involved in making decisions about their care.
• People and their relatives were not always involved in making decisions about their care. One person told us, "I do what I am told to do." And a relative said, "They never answer the phone so it's difficult to find out how my relative is."

People did not always receive person centred care which was appropriate, met their needs and reflected their personal preferences. This is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Regular meetings were held to engage people and their relatives to make choices relating to the running of the home .
• People were given choices, such as what they wanted to eat or drink.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Care plans were in place and reviewed on regular basis. An electronic system was used to support their development. Information created from this system was generic and not personalised to the individual.
• People's life histories were recorded in their care plans. However, this information was not used to provide person centred care, stimulation, or meaningful activities for people.
• People were not supported to take part in activities that were socially relevant and appropriate to them. People repeatedly walked around the building. Others sat for extended periods in communal areas with no engagement from staff
• Documentation showed people had not participated in any kind of activities within the home since 10 March 2019. The registered manager was actively recruiting for activities staff.

End of life care and support.
• Where appropriate people's end of life wishes were discussed and recorded.

Meeting people's communication needs.
From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carer's.
• The service provided information in a way that people could understand.

Improving care quality in response to complaints or concerns.
• People and their relatives knew how to raise a concern and were confident they would be responded to appropriately.
• Where complaints had been made, they were responded to in line with company policy.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection this domain was rated requires improvement and we issued a warning notice in relation to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we have identified a continued breach of this regulation.

At our previous inspection we had identified breaches of regulation and at this inspection we found that these breaches remained.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
• The visions and values of the service were not promoted and the management team had failed to provide an open and transparent service for people.
• There were elements of care which needed significant improvement. The lack of oversight required from the provider and management team resulted in people not having their basic care needs met.
• Relatives found it difficult to speak with the registered manager. Comments included, "You can never speak with them, they are never available", "I have asked to speak to the registered manager on occasions, but they never get back to me" and "They have been here a while now and I still haven't seen them."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• Systems for identifying and monitoring risk were ineffective and did not identify improvement required at the service.
• Numerous concerns were identified with records. These included incomplete, inaccurate and conflicting care plans, monitoring charts and quality assurance audits.
• The lack of robust recording created a significant risk of people receiving unsafe care.
• The service had failed to notify us about any applications/outcomes made to deprive a person of their liberty under the Mental Capacity Act 2005.

The failure to ensure that the Care Quality Commission had been notified without delay of outcomes made to deprive people of their liberty is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

• The registered manager said they felt well supported by a regional manager and deputy manager.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others.
•There was no engagement within the local community and feedback received from relatives was not always responded to.
• Staff felt isolated and were not supported or listened to. The registered manager said she operated an open-door policy and always made time for the staff.

Continuous learning and improving care.
• The provider and management team lacked understanding of good quality assurance systems.
• The provider's own quality assurance was ineffective and had failed to identify shortfalls. For example, with the premises. Other audits had not identified common trends; there were no plans in place to reduce the risks to people's wellbeing.
• Audits to monitor people's daily progress and needs were not in place.
• There was a lack of systems in place to ensure continuous learning and improve the care people received.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This is a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider spoke about the need to make improvements following our inspection and was keen to take action as soon as they could to make the service better for people.

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 18 Registration Regulations 2009 Notifications of other incidents CQC statutory notifications had not always been submitted in a timely manner as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support that was appropriate to their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers failed to ensure the premises and equipment was safe and maintain people's health, safety and welfare. Infection control measures were ineffective and areas of the service were unclean and had unpleasant odours. Some equipment was seen to be broken or not fit for purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of monitoring information for peoples care and support needs. Quality assurance systems were ineffective and failed to identify concerns within the service.