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Epsom 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
Epsom Lodge is a care home providing accommodation and personal care for up to 13 older people, some of whom may also be living with dementia. There were 12 people living at Epsom Lodge on the first day of our inspection and 11 people on the second day. Accommodation is arranged over three floors of an adapted building with shared bathroom facilities on each floor.

People's experience of using this service and what we found
There was a lack of management oversight of the service. The provider had failed to implement effective quality assurance and audit systems to ensure people received safe, effective and responsive care. The concerns found during our inspection had not been identified by the provider. People who had moved into Epsom Lodge in the past six months did not have care plans in place and their health care needs were not recorded.

The provider had not ensured robust procedures were in place to keep people safe from the COVID-19 virus. On the first day of our inspection we found staff were unaware of the guidance they should follow. Although improvements were found during our second day of inspection, continued areas of concerns were identified.

Risks to people's safety were not always identified and acted upon. There was a lack of detailed risk assessments and guidance for staff to follow in relation to people's individual risks and support needs. Accidents and incidents were not always reviewed to minimise risks and were not always shared with the local authority and CQC as required. We have made a recommendation in relation to the prompt reporting of safeguarding concerns.

Medicines were not always managed safely and staff competence in this area was not consistently assessed. There were not sufficient staff deployed to ensure people's needs could be met in a responsive manner.

People and relatives told us they felt safe living at Epsom Lodge and that staff were kind and caring in their approach.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 29 May 2019) and a continued breach of regulation in relation to the governance of the service was identified. We completed a further targeted inspection on 14 January 2021 (published 17 February 2021) in relation to infection prevention and control procedures and identified a further breach of regulation. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.
The provider completed an action plan following both of these inspections to show what they would do and

by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The first day of our inspection was prompted in part due to information received from the provider and local authority regarding an outbreak of COVID-19 at the service. Concerns were shared regarding the difficulties in sourcing staff and in relation to people's safety.

During the first day of our inspection we found there were concerns in relation to how risks to people's safety and medicines were managed so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks to people's safety and well-being, safe medicines processes, infection prevention and control procedures and staff deployment. We identified a lack of management oversight and robust quality assurance systems.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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.

Epsom 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 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 team consisted of one inspector on the first day of our inspection and two inspectors on the second day.

Service and service type
Epsom 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 service did not have a manager registered with the Care Quality Commission. A manager was in post who had submitted an application to register. A registered manager 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
Both days of this inspection were unannounced.

What we did before the inspection
We reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required

to send us by law. We sought feedback from the local authority in relation to information they held about the service. 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
As part of our inspection we spoke with four people who lived at the service. We observed the care and support provided to people. We also spoke with four staff members, the manager and the two providers. We reviewed a range of documents about people's care and how the home was managed. We looked at care records for five people, medication administration records, risk assessments, safeguarding records and policies and procedures.

After the inspection
Following both days of the inspection we requested urgent assurances from the provider in relation to infection prevention and control procedures and fire safety procedures. In addition, we informed the fire safety officer of our concerns. We requested a range of information to be forwarded including copies of audits, staffing rotas and policies. We spoke with three relatives regarding their experience of the service provided at Epsom Lodge.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last inspection in January 2021 the provider had failed to ensure robust infection prevention and control measures were followed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of this inspection the service was experiencing an outbreak of COVID-19. We identified concerns regarding infection control processes and how people were protected against the spread of the virus. We wrote to the provider requesting urgent assurances about people's safety. The provider forwarded an action plan informing us of the steps they had taken and would continue to implement to keep people safe. On the second day of inspection we found improvements had been made to infection control practices although further action was required. The provider was still in breach of regulation 12.

- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. We found they had failed to embed safe infection control and prevention processes in line with government guidance. Although improvements were observed during our second day of inspection, the provider had not addressed all the concerns identified.
- We were not assured that the provider's infection prevention and control policy was up to date. Guidance for safe infection control practices had been implemented by the previous registered manager. However, this had not been updated since January 2021. During the first day of our inspection we asked staff where they would find the infection control and prevention (IPC) policy and guidance. They were not aware of where the guidance was kept and were not aware of the requirements of the guidance. On the second day of our inspection we found the guidance had not been updated although some staff had received training in relation to the processes they needed to follow.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules had not been fully completed in line with guidance. There were no cleaning staff employed at weekends and cleaning checklists had not been completed for these days. For the months of August and September 2021 records showed the cleaning of high touch points such as door handles had only been completed on five days each month. On the first day of our inspection we found there were no system in place to ensure laundry and dirty crockery were handled separately for those testing positive for COVID. This increased the risk of cross contamination between people. On the second day of our inspection we saw systems had been implemented to manage these processes safely. However, due to additional concerns being raised we checked some people's mattresses. Two of the three mattresses checked were stained and had a bad odour. This presented an infection control risk and also impacted on people's dignity.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. On the first day of our inspection we found that social distancing guidance was not being adhered to. One person who had tested positive for COVID was sat in the lounge and in close contact with people who had tested negative for the virus. Staff did not intervene to prevent contact between people. During our second day of inspection we found the provider had made improvements. People were sat at a reasonable distance in communal areas and those testing positive for COVID were cared for in their rooms.
● We were somewhat assured that the provider was using PPE effectively and safely. On the first day of our inspection we observed staff were sitting in close contact to people whilst not wearing a face mask covering their nose and mouth. Staff did not remove their PPE when coming out of one person's room who was in isolation. They walked through the house and into the kitchen area before changing their apron and gloves. This increased the risk of spreading the virus within the home. On the second day of our inspection we found staff followed guidance on the safe use of PPE. However, we found safe hand hygiene practice was not followed. The provider, manager and a staff member were observed to have long fingernails and be wearing nail varnish and jewellery. All were involved in providing people's care.
● 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.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach including updated government guidance, CCG training support and the local authority quality assurance team. .

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Relatives told us they felt risks to their loved one's safety were managed well. One relative told us, "They know how to support (family member) with their anxiety and they keep in touch."
● Despite these comments we found risks to people's safety and well-being were not comprehensively assessed and monitored. Each person had a risk screening plan in place which reviewed potential risks. However, where risks were identified, guidance had not always been implemented as to how these risks should be mitigated.
● The impact of the lack of risk assessments was reduced to an extent due to the small staff team supporting people knowing people's needs. However, during the COVID pandemic when agency staff were supporting the service there was no guidance in place for them to follow. This meant people were placed at risk of not receiving the support they required to stay safe.
● Where people displayed behaviours which impacted on others, there was no guidance in relation to the support staff should provide, triggers to potential anxiety or actions to take to support the person in remaining calm. Decisions regarding changes in people's support were not always risk assessed despite there being potential for harm to the person and others. During the COVID outbreak incidents occurred between two people which put them at risk of injury. The manager told us staff should have been present to observe and intervene in incidents. No guidance was in place to make this clear to staff and no additional staffing was provided to ensure this could happen.
● Where people had been assessed as being at risk of falls, consideration had not been given to the environment. One person's records stated they were at high risk of falls and could be disorientated when waking at night. No risk assessment had been completed in relation to the persons room being near to an open staircase.
● Records in relation to people's healthcare needs were not always comprehensively maintained. One person told us of their on-going healthcare needs. We found no record of these within their care file. The manager assured us referrals had been made to relevant healthcare professionals. However, there was no

guidance for staff to follow on how to support the person with their healthcare. The person described an incident where they had experienced pain when being supported with personal care. There was no guidance for staff to ensure this was not repeated. Whilst permanent staff were aware of the support the person required, any agency staff would not have this knowledge.

● Guidance in relation to people being supported to eat safely was not always followed. We observed one person being supported to eat their lunch. The person was reclined back in a position which would make swallowing safely difficult. We spoke to the manager who addressed this concern.

● Accidents and incidents were not consistently reviewed. Where one person had left the service unaccompanied, a comprehensive risk assessment had not been implemented to ensure they remained safe going forward. No review of accidents and incidents had taken place in order to identify any themes or trends.

● Fire safety systems were not robust. Personal emergency evacuation plans (PEEPS) lacked detail and were not completed for all those living at Epsom Lodge. This meant emergency services would not have access to information regarding the support people required in the event of an emergency. There was no evidence of any fire drills having taken place in 2021. The annual fire risk assessment had last been completed in February 2021 which meant this was seven months out of date.

● The upstairs room leading to the fire escape was cluttered, with furniture blocking safe exit. Discarded furniture was also found at the top of the fire escape. The provider told us the fire escape was no longer in use as it was unsafe. However, staff risk assessments stated the fire escape should be used as a means of exit. One staff member told us they had been trained to use the fire escape to support people to leave the building in the case of an emergency.

● We shared our concerns with the fire safety officer and asked the provider for urgent assurances regarding fire safety precautions. The provider sent information regarding the action they had taken to update records and implement safe systems.

Using medicines safely

● Safe medicines practices were not consistently followed. On the first day of our inspection we observed the medicines cabinet had been left open and unattended. One person's medicines were left on top of the cabinet. The cabinet was stored in the office area which people regularly accessed. This presented a risk of people taking medicines which they were not prescribed for them.

● Each person had a medicines administration record (MAR) in place which recorded what medicines people were prescribed and when they had been administered. Two of the four MAR charts we checked did not balance with the medicines in stock. Forms to record that prescribed topical creams had been administered contained gaps in recording. This meant the provider could not assure themselves people had received their medicines in line with their prescriptions.

● Protocols were not in place to guide staff on how 'as and when required' (PRN) medicines should be administered. One person's MAR contained a handwritten entry for a PRN medicine which was difficult to read. Records showed that on one occasion an additional dose of the medicine had been administered. No explanation had been recorded on the MAR as to why the person had required this medicine.

● The provider had not ensured staff competency to administer medicines had been assessed. We asked to see competency checks for two staff members we had witnessed administering medicines. The manager told us these had not been completed.

The provider had failed to ensure robust infection control processes were embedded into practice, that risks to people's safety were assessed and managed and that safe medicines systems were in place. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People we spoke with told us there were not always enough staff to meet people's needs. One person said, "I'm not going to lie; they are very short (of staff). Especially at night, more things happen and there are fewer people around. People here need a lot of care, and sometimes ambulances are called when someone falls and the staff have to manage all that, and sometimes it takes the two staff to do this, and look after everyone else."

● Staff told us there were not always enough staff deployed. One staff member said, "It's impossible with two staff to do everything for 12 residents. Some of them need two of us in their room and where does that leave everyone else." A second staff member said, "We could certainly do with an extra member of staff in the morning. there was a lot of pressure on us. Three or four days a week we have to do all the personal care; medicines; prepare breakfast, clear up after that and then start to prepare lunch. It's quite a lot."

● Staff rota's showed two staff members from the care team were scheduled to work on each shift. In addition, a part-time cook was employed to cover three to four days and a domestic staff member covered Monday to Friday. This meant on certain days the two care staff were also responsible for preparing meals, cleaning tasks and laundry.

● We asked the manager if they had a dependency tool to assess how many staff were required to meet people's needs safely. They told us they had not completed this exercise and that staffing levels had not been reviewed despite the number of people living at Epsom Lodge increasing from six to twelve.

● Additional support was available from the providers and manager on the second day of our inspection. Despite this, we observed staff went from one task to another and did not have time to spend with people socially.

The provider had failed to ensure sufficient staff were deployed to meet people's needs in a safe and person-centred way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they felt safe living at Epsom Lodge. One person told us, "I have no concerns about staff hurting me, I do feel safe." One relative told us, "If anything happens, they'll ring me straight away. It's homely and caring. I have no concerns."

● Safeguarding concerns were not consistently reported to the local authority as required. Following the COVID outbreak at the service, multiple medicines errors were identified. These concerns had not been reported to the local authority as required. The manager told us that due to the errors being made by agency staff they did not believe it was their responsibility to report this. The manager assured us they would inform the local authority of the errors. We checked this had been completed.

● In other instances, we found concerns had been reported appropriately. Safeguarding incidents had been shared and discussions had taken place regarding actions required to keep people safe.

● Staff had completed safeguarding training and were aware of reporting procedures. One staff member told us, "Safeguarding can be a variety of things; from someone hitting someone to financial abuse. It is our job as staff to make sure residents are safe and to report it to the manager."

We recommend systems are implemented to monitor incidents to ensure they are reported in a timely manner.

Inadequate

Is the service well-led?

Our findings

Our findings - Is the service well-led? = Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated 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.

At our last comprehensive inspection in January 2021 we found the provider had failed to ensure robust oversight of the service. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they had not been involved in their care planning. One person told us, "(The manager) has said they will talk to me about it, but this hasn't happened yet. I'd like to do it; I'm looking forward to it."
- Comprehensive records of people's care needs were not maintained. The providers website stated, 'Together with family members and their own GP, we create a bespoke care plan – tailormade to suit all personal and specific care requirements and support levels'. We found this was not the case during our inspection. Of the five people's care files we reviewed, four people did not have a care plan in place in relation to their care at Epsom Lodge. The fifth persons care plan had not been updated following an incident which meant staff needed to vigilant regarding the persons whereabouts. No audit of care records had been completed to monitor the guidance and information in relation to people's care and safety were available to staff.
- Where audits were completed these had not been effective in ensuring concerns were identified and addressed. Medicines audits had not led to robust oversight of people's medicines systems. Audits concentrated on individual records did not look at the processes involved such as ensuring staff competence had been assessed. Infection control audits had not identified the lack of controls in place and had not ensured that safe systems had been embedded into practice in order to keep people safe.
- Safety audits were not comprehensively completed. Fire systems were not regularly reviewed to ensure they remained current. Issues found during our inspection in relation to the lack PEEPS, contradicting information in relation to the fire escape and the fire risk assessment had not been identified or actioned by the provider. Mattress audits had not been completed to ensure all mattresses remained safe and suitable for use. We asked the manager to complete a mattress audit which found two mattresses needed to be replaced and three mattresses required cleaning.
- There were no systems in place to ensure shortfalls in the service were addressed. The manager told us they were aware there was a lot of work required to update records and get the service running smoothly.

They said they regularly discussed this with the provider who they believed listened to their concerns. However, no action plan had been completed to identify how the shortfalls identified would be addressed.
● The manager and provider lacked understanding of when to report concerns to external agencies. They told us they did not believe they needed to report a number of medicines errors made during the COVID outbreak as these errors had been made by agency staff. This demonstrated a lack of understanding regarding their responsibility for all aspects the service and what needed to be reported to the local authority.
● The provider had failed to learn from previous concerns and had not ensured robust governance of the service. Breaches of regulations had been identified at the past five inspections completed since 2017. Previous inspections highlighted the lack of management oversight of the service and the providers failure to implement effective and robust quality assurance systems. The improvements found during our last comprehensive inspection in April 2019, had not been sustained following the registered manager leaving the service.
● People and staff were not routinely involved in the running of the service. There was no evidence of how people's views of the service were captured, and evidence of staff meetings was not available.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Working in partnership with others
● Relatives told us they felt the management team were caring and there was a nice atmosphere in the service. One relative told us, "With an open heart I can't fault anything they have done for my Dad. They are all caring, and I know he's looked after there."
● People told us the management team were available when they needed them. One person told us, "I usually get along with management and they will help me if I need it."
● We received mixed responses from staff regarding the management of the service. One staff member told us, "They're very supportive and caring; they help us a lot when we are busy if they have the time." A second staff member told us they did not always feel supported in their role, "They're not always nice and they don't always do things that are needed to be done. They don't always listen."
● Despite positive comments from people and their relatives we found the service provided to people was not always person-centred. There was no system in place to assess people's experience of the service they received. Two people we spoke with told us they were sometimes bored. Records showed that people spent the majority of their day watching television. We observed this was the case during our inspection. The manager told us they planned to look at activities specific to people's interests as people preferred to do things on a one to one basis. They said they had not had the opportunity to do this to date. The manager and provider told us people had not been going out of the service, unless with a family member, but again stated they hoped to look at this in the future.
● Staff did not always interact with people in a caring and understanding manner. We observed a person stand up several times and begin to walk across the lounge. Staff appeared exasperated with the person and directed them back to their chair by pointing rather than speaking to the person. On another occasion we observed a staff member speaking with an inappropriate manner regarding another person living at Epsom Lodge. We observed on other occasions staff spoke to people in a caring manner. However, we did not observe staff have the opportunity to sit with people on a social basis.
● The provider did not always follow the policies and procedures in place. The provider had a duty of candour policy in place which highlighted the action they would take in the event of a significant incident occurring. Relatives told us they were informed of incidents by phone or when they visited the service. The policy stated a follow-up letter would be sent to the persons representative explaining the details of the incident, investigation summary and an apology. The manager told us no letters had been forwarded in line

with the providers policy.

● The manager attended meetings arranged by the CCG and the local authority quality assurance team. However, the guidance discussed in the meetings such as safe infection prevention and control measures had not been implemented in the service in order to protect people from the risk of harm.

● Following the inspection, the provider forwarded an action plan in response to the concerns discussed. However, as identified in previous inspections, the provider had failed to identify the shortfalls found at the inspection in order to ensure people were receiving safe and effective care.

The lack of effective management oversight and good governance was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure the CQC were notified of significant events within the service in line with their statutory responsibilities. This included incidents between people living at Epsom Lodge and an incident where a person was supported to returned to the service by the police. This meant we were unable to effectively monitor risk and the actions taken. Following the inspection, the provider submitted the notifications retrospectively.

Failing to submit statutory notifications was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.