B & M Investments Limited

The Lodge Care Home

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

About the service
The Lodge Care Home is a residential home registered to provide accommodation and personal care for up to 45 older people, some who may be living with dementia. At the time of our inspection there were 34 people using the service.

The home is built over four floors, with a number of communal and dining areas on the ground floor.

People's experience of using this service and what we found
Staff used risk assessment tools to assess if people were at risk of pressure ulcers, falls, malnutrition and skin integrity. Care plans were developed to ensure measures were in place to mitigate these risks. Risk assessment tools were not always completed correctly, therefore there was a risk that measures in place were not always as effective as they could have been.

Governance systems, audits and analysis of accidents and incidents had not led to improvements. The information recorded by staff was not always consistent, in enough detail and not always submitted to the registered manager. As a result, some safeguarding incidents were not reported to the local safeguarding authority for investigation.

Medicine administration and management was not always done safely or following best practice guidance. People were not always receiving their medicines as intended by the prescriber.

When things went wrong, lessons were not always learnt and staff practices were not changed to improve the quality and safety of the care provided.

Staff told us they were aware of people's needs, however there was not enough staff to meet people's needs safely and effectively. We observed people left waiting for staff, sitting in wheelchairs without pressure relieving cushions in place, although care plans detailed they had to sit on those. This increased the risk of people's skin breaking down.

People felt safe in the home and told us they liked living there. Relatives were complimentary about staff and management and told us they felt the staff team provided care and support to people in a safe way.

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 good (published 14 December 2018).

Why we inspected
We received concerns in relation to the management of medicines, people's personal hygiene needs not

being met and lack of accurate records kept about people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 safe care and treatment, safeguarding and governance systems at this inspection.

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 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.

The Lodge Care Home

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 two inspectors.

Service and service type
The Lodge Care Home 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. We carried out this inspection on 17 February 2021. Between 22 and 24 February 2021 we received feedback from relatives and staff about the care people received. We gave feedback to the registered manager about the inspection on 24 February 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with 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.

During the inspection
We spoke with two people who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff check lists in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who are regularly in touch with 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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- We found that staff had not always reported to the registered manager safeguarding incidents and concerns. These were then not reviewed which meant protection plans were not developed for people to help keep them safe. For example, staff recorded an incident between two people. One person pushed another which resulted in a fall. This had not been investigated or reported to the local safeguarding authority.
- There were other incidents where a person had displayed behaviours that challenged others on a number of occasions and this had not been reported, investigated or a care plan developed for staff to know how to prevent these from happening or manage them effectively. This meant that the person themselves and others were at risk of harm.
- There were three safeguarding concerns raised with the local safeguarding authority for people by the registered manager and/or people's family members recently. Following the investigation, carried out by the local safeguarding authority and the registered manager, there were further actions and improvements needed to ensure staff practices were improved in regard to medicine management, record keeping and meeting people's personal hygiene needs.
- We found in this inspection that lessons were not learnt, and staff practices had not improved. This meant that the systems and processes in place did not protect people from the risk of abuse.

The lack of response to safeguarding incidents and failing to develop protection plans and learn from incidents was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe living in the home. One person said, I do feel safe. Staff help me when I need it." Relatives told us they were happy with the care and support people received in the home.
- Although we found that not all safeguarding concerns were reported, care staff told us they had safeguarding training and they knew how to report their concerns. Staff we spoke with told us they reported concerns to their seniors.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of not receiving their medicines as intended by the prescriber. We checked individual medicine administration records (MAR) against the tablets remaining in the blister packs and found that the MAR had been signed to indicate the medicines had been given, when it remained in the blister. This meant some people had not received their medicine as prescribed.
- Medicines were not always stored safely. We found stocks of medicines stored in the medicine cabinet for

the previous three months. Most of these were not labelled, therefore we could not establish who they belonged to or what medicines these were. Daily temperature checks of the medicines room had not been consistently completed for the previous two months. Controlled medicines were removed from the controlled drugs cabinet and stored in the medicines trolley whilst staff administered other people's medicine.

● The morning medicines round took until after 12 o'clock to be completed and the lunchtime medicines round began at 1pm. Staff did not record on the MAR the time when medicines were administered meaning people may have not received their medicines at the required spacing between doses.

● People were at risk of developing pressure ulcers because not all the staff we spoke with were knowledgeable about people's needs. For example, two staff members told us they were not supporting one person with repositioning as they were not aware this was required. The person had a pressure ulcer and their care plan instructed staff to turn them every two to three hours. Often this person laid in the same position for up to five hours.

● People's personal hygiene needs were not met safely. People did not receive bath or showers and staff had no guidance to follow in how and whom they had to report if people consistently refused.

● We found that from 21 January 2021 to 17 February 2021, five people had no bath or showers, nine people had one bath/shower recorded and the remaining had two or more. Staff told us they were not enough staff during the day or night to offer people daily bath or showers. One staff member said, "I wish we could offer people a bath/shower every day, but we just don't have enough staff to do this." Staff told us people received a wash every day, however there was a risk for people to develop skin integrity issues due to poor personal hygiene.

● Staff told us they shared hoist slings between people as there were insufficient slings in the home. This was not in line with infection prevention and control guidance and put people at risk of harm

The provider failed to ensure the care and support people received was safe and fully met their needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● All staff we spoke with told us there was insufficient staff to ensure people received care and support safely and in a personalised way. One staff member told us, staffing was 'woefully inadequate' and some staff have worked nine days in succession without a day off.

● One staff member told us that on the unit where people lived with dementia there were two care staff allocated for 10 people. Five of those people needed assistance of two staff for their personal care and mobility. This meant that communal areas had no staff member to support people whilst the two staff were assisting people in their bedrooms / bathrooms. People were not receiving baths or showers and they had to wait for both staff to be free to transfer them from their wheelchair to a comfortable chair. This put people at risk of developing pressure ulcers and skin conditions.

● We reviewed the providers dependency tool for the week commencing 15 February 2021. We found that some people in the low dependency category had regular falls and some people in the medium dependency category required support in all aspects of their life including repositioning every 2-3 hours and support with eating. This meant that there was a risk that the dependency assessments may not have been accurate in identifying how many staff were required to support people.

The provider failed to ensure they had enough staff effectively deployed to meet people's need safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checklists were in place to ensure staff went through robust pre-employment checks before they started working at the home. These included references, criminal record check and record of employment history.

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 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.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- Systems and processes in place were not used effectively to ensure quality and safety of the care and support people needed. Audits carried out by the registered manager and the provider had not independently identified the concerns we found in this inspection. This included staffing, safeguarding and medication administration
- The provider had failed monitor staffing levels to ensure people's needs could be met and therefore missed opportunities to improve the quality of the care. For example, a person had lost 10% of their body weight and had treatment for pressure areas where their skin had deteriorated. However their skin integrity risk assessment detailed they had not lost weight and their skin was healthy.
- Staff told us they had not had regular supervisions; they did not feel supported by management and in some instances had not received training relevant to their roles. They told us they have not received COVID-19 training and they could not describe donning and doffing of personal protective equipment (PPE) correctly. They told us they were issued with FFP2 masks (A face mask with code FFP2 protects against solid and liquid irritating aerosols. Minimum filter efficiency of 92%.) and were advised to change these every six hours. They knew how to ensure the masks fit correctly, however one staff member told us the registered manager had advised them that if the masks were in 'pristine' condition they could re-use them. This was not in line with current best practice guidance.
- The registered manager and the provider failed to ensure staff were knowledgeable and followed best practice guidance when administering people's medicines and government guidance on infection control and PPE.
- The registered manager had previously assured the safeguarding authority and the inspector in a recent safeguarding meeting that actions were taken, and lessons were learnt. However, in this inspection we found concerns about medicine management and people's personal hygiene needs were not being met. This meant that the actions taken by the registered manager and the provider were not effective to ensure staff practices improved.

The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people in line with current national and best practice guidance. They failed to ensure lessons were learnt and improvement to the service were sustained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● The provider had failed to notify CQC of reportable incidents. There were two safeguarding alerts raised by family members with the local safeguarding authority. The provider failed to notify the Commission about these when they were made aware.

This is a breach of regulation 18 (1) of The Care Quality Commission (Registration) Regulations 2009.

● The service worked in partnership with health and social care professionals who were involved in people's care, however due to current visiting restrictions, communication mainly happened over the phone or video calls.

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

● People told us they were happy with how the home was managed. We observed the registered manager and staff talking to people and this gave people an opportunity to feedback about their care.

● Residents meetings were a regular occurrence in the home and minutes of these meetings with actions resulting displayed for everyone to read.

● Relatives told us, staff and the registered manager were approachable and they felt confident in raising concerns or giving feedback about the service.

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 The provider failed to notify CQC of reportable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the care and support people received was safe and fully met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to take appropriate action following safeguarding incidents and failed to develop protection plans and learn from incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough staff effectively deployed to meet people's needs safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that safe governance systems developed by B & M Investments Limited were followed effectively and this resulted in breaches of regulations and exposed service users to the risk of harm.

The enforcement action we took:

Issue warning notice