Stride Lodge Ltd

Danes Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Danes Lodge is a care home. The service offers accommodation and personal care and support for up to 29 older people and people with a dementia related condition. At the time of the inspection there were 22 people using the service.

People's experience of using this service: People did not always receive a service that provided them with safe, effective, compassionate and high-quality care. Care and support was not tailored to meet people's specific needs.

Risk management was ineffective and placed people at risk of harm. Medication practice continued to be unsafe. Concerns were raised regarding the environment which posed a risk of spread of infection. There was inadequate staff on a night time to meet people's needs. Safe recruitment practices had not been followed.

People did always receive person centred care. People's human rights were not always upheld as the principles of the Mental Capacity Act 2005 were not adhered to.

The service was not well led and there was an ineffective quality assurance system in place. During this inspection we found multiple failings at the service and risks to people had not been mitigated. We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Four of these were repeated breaches which were found at the last inspection, and one of the breaches had been identified at the previous two inspections, which demonstrates learning and improvement had not taken place.

Staff did not always respond appropriately to people who were becoming distressed. People felt staff were caring but did not always have time to spend with them.
People did not receive personal care in a timely manner. Care plans were not reviewed consistently or updated when people's needs changed. Complaints had not always been responded to or investigated.

Rating at last inspection: This service was rated 'Requires Improvement' at the last inspection, with the well led domain being rated as 'Inadequate' (published 16 August 2018).

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

Enforcement: We have identified breaches in relation to safety, person centred care, staffing, governance, and failure to submit statutory notifications at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up: 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Danes 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two inspectors and an expert by experience conducted the first day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second and third day of inspection was conducted by two inspectors.

Service and service type: Danes Lodge is a 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.

It is a condition of the provider's registration that they have a manager registered with CQC. A registered manager is someone who, along with the provider, is legally responsible for how the service is run and for the quality and safety of the care provided. There was no registered manager at the time of our inspection. There had been no registered manager since August 2017. The provider had recently appointed a manager who was in the process of applying to become the registered manager. Within this report they will be referred to as the manager.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us plan our inspection.

During the inspection we spoke to five people who lived at the service, two relatives and one visiting health professional. We spoke with a variety of staff members including two care assistants, two senior care assistants, an agency care assistant, the general assistant, the cleaner and the chef. We also spoke with the

manager and the provider.

We observed how staff interacted with people who used the service throughout the day and at meal times. We used our 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 three people's care records in full, containing care planning documentation and daily records. We also reviewed specific areas of four people's care plans. We looked at records for eight staff members, relating to their recruitment, training, supervision and appraisal. We viewed records relating to the management of the service, including any audit checks, surveys and the provider's policies and procedures.

Following the inspection we wrote to the provider for assurances of what action they were going to take to address the concerns identified at this inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

This was the third consecutive inspection we have identified a breach of regulation 12.

Using medicines safely
At our last inspection in June 2018 we found unsafe medicines practice. At this inspection we continued to find unsafe medicines practice.
● We observed poor practice in relation to the administration of medicines. For example, we saw one staff member handling medication without gloves and placing this into a person's mouth.
● Protocols were still not always in place to guide staff on when to use medicines which were prescribed for use 'as and when required' with regards to pain relief. These were put in place during the inspection.
● Medication errors had not always been recorded internally. The new manager had taken action to address this and had implemented a new reporting form following a recent medication error.
● One person was prescribed emergency medication. We were told that this medication was no longer required. Records to reflect this had not been updated.

Assessing risk, safety monitoring and management;
● Risk assessments failed to mitigate the risk to people and put people at risk of harm as they did not contain adequate detail to meet people's needs.
● Some people's care records and risk assessments contained conflicting information. This meant staff did not have clear information on how to deliver safe care.
● Daily records did not reflect that care had been provided in line with people's care plans and risk assessments.
● Two radiator covers were in a bad state of disrepair. We raised this immediately at the inspection and the radiator covers were fixed that day.

Preventing and controlling infection
● Infection control procedures were not always followed, which meant the risk of infections spreading was not mitigated.
● Areas of the home and furnishings were dirty and smelled unpleasant.
● Staff responsible for cleaning on a night told us they were not aware of cleaning schedules and said they did not have time to do the cleaning tasks. Night cleaning records had not been competed since January 2019.

Learning lessons when things go wrong
● This was the third consecutive inspection where we have identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we continued to find poor practice with medicines management which demonstrated lessons had not been learnt and embedded into daily practice.
● We identified concerns with accident reporting. We were told by staff about a recent fall, however there was no accident report completed for this. There was no evidence of lessons learned from this incident or corrective action taken to minimise the risk of recurrence. During our inspection we saw this person was slipping out of their chair on three occasions, which showed that opportunities to learn from the previous incident had not maximised.
● Lessons had not been learnt from the monitoring of accident and incidents. We identified a high proportion of accidents were during the night and most falls that had occurred had been during the night, but no responsive action had been taken to address this pattern.

The issues relating to medicines practices, assessing and managing risk, preventing and controlling infection and failure to learn from incidents demonstrated a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Following the last inspection on 19 June 2018, where we raised concerns about staffing levels, we received an action plan which stated staffing levels would be increased to three staff on a night. At this inspection we found there were only two staff on duty during the night and there was no evidence to show how the provider had assessed the decision to reduce staff. There was no system to determine the number of staff required based on the needs of people using the service. We were told by the provider they had monitored call bell times and accident reports during the night and gained feedback from staff. However, records showed a high proportion of falls had been during the night yet staffing levels during this shift had been reduced.
● Our visit to the service during the night showed there were insufficient staff to meet people's needs leaving people at risk of neglect or harm. We observed people having to wait for care and support they required.
● People and their relatives told us there were not always enough staff. One person told us, "I keep seeing to this lady who keeps shouting I told her there is no point in ringing because there is nobody there. I just wish there were more of them." Some relatives also expressed concerns regarding staff numbers.

This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices had not always been followed as the appropriate checks had not been carried out prior to people starting work. We discussed this with the director who assured us this had been an oversight by a previous manager and assured us safer recruitment practice were now followed.

Systems and processes to safeguard people from the risk of abuse
● Staff confirmed they had received safeguarding training and were able to tell us when they would report abuse.
● People told us they felt safe.

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. Some regulations were not met.

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.

- There was no evidence to show how people who had capacity had consented to their care plans.
- The provider had continued to fail to act within the principles of the Mental Capacity Act. This meant that people's rights were not being protected under this Act.
- One person's DoLS authorisation had expired and no application had been submitted for renewal. We found applications had not been submitted for further people who may require a DoLS authorisation.

The failure to seek lawful authority to deprive people of their liberty was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At the last inspection we recommended that the provider seek guidance and advice from a reputable source about the implementation of effective inductions of new staff and providing ongoing staff support through supervisions and appraisals.

- At the last inspection the manager assured us induction records would be monitored. At this inspection the director assured us staff had received induction, but they were unable to locate the records.
- Staff had not always received training the provider classed as mandatory. For example, we saw seven staff did not have up to date first aid training. This meant they were not equipped with the skills required to fully carry out their roles.

This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection most staff had received supervision in the last 3 months.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed prior to admission into the home. However, assessments of people's needs were not always up to date or reviewed on a regular basis.

Supporting people to eat and drink enough to maintain a balanced diet
● People were offered a choice of food and drinks throughout the day. However, when we visited on the night time we observed people asking for food and drink and this was not given. We discussed this with the manager who assured us she would address this.
● We found improvements were required to the mealtime experience for people.
● People told us they enjoyed the food at the service. One person told us, "Food is lovely, both the chefs are very good."

Adapting service, design, decoration to meet people's needs
● People's bedrooms were not always suitable for their needs. For example, one person had a carpet which was not suitable for their needs due to its odour. The provider informed us they had previously replaced this carpet. This person was moved to another room during the inspection whilst the carpet was replaced.
● The provider had used colour contrast in some areas, such as bedroom doors and hand rails, to help people with dementia or sensory issues distinguish areas of the home and orientate themselves.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Records confirmed a range of healthcare professionals were involved in the care and treatment of people who used the service.
● 'Patient passports' were available for people when transitioning between services. Hospital passports are communication tools to inform other health services and professionals of people's health needs.

Requires Improvement

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 did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
- We saw negative interactions, with staff ignoring people when they requested items or support.
- Staff did not always respond appropriately to people who were becoming distressed.
- Some staff were caring in their approach when supporting people with tasks.
- People told us staff were caring but did not always have time to spend with them. One person told us, "They are busy people and have other things to do. I suppose if they could spend time with us they would." One relative told us, "Yes the staff are caring, very much so. It's the lack of them that's the problem."
- People's cultural and religious needs were considered when care plans were being developed. Information about people's life history and religious beliefs was included within the care plan.
- People told us their cultural and religious needs were met. One person told us, "Yes they have been this morning from the church. They come and bring me communion from the Catholic Church."
- Services were organised within the home to support people to attend religious ceremonies.
- People's friends and relatives were welcome to visit without restriction.

Respecting and promoting people's privacy, dignity and independence
- Staff did not always recognise when people required support to maintain their dignity.
- On a night shift, staff routines took priority over people's care and support needs.
- Procedures were in place to store information securely to respect people's confidentiality. However, on one occasion we saw a completed handover form had been left in the corridor.

Supporting people to express their views and be involved in making decisions about their care
- People were not always able to be involved in their care; when people were requesting support they did not always receive it.
- There was no evidence of how people had been involved in their care plans.
- We were told by the manager nobody required an advocate as people had family members or could self-advocate. Advocates provide independent support to help ensure that people's views and preferences are heard. The manager was aware of the process of applying for advocates if required.
- Resident and relative's meetings took place for people to express their views.

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

- People did not receive personal care in a timely manner. We observed one person requested to go to the toilet and was consistently told to wait. On the fourth occasion they asked they were supported to go to the toilet.
- People did not receive personalised care and did not have choice and control. We observed people asking for food and drinks and they were ignored. We observed one person who was repeating questions and becoming distressed. Staff failed to offer reassurance and kept answering the person with a question, causing more distress.

This person's care plan provided no guidance for staff on how they should respond when the person became distressed.

- Activities were available to people should they wish to participate.
- Care plans were not reviewed consistently or updated when people's needs changed.
- Staff recording in daily notes and on monitoring charts was not consistently completed and failed to accurately reflect how care was provided in line with the person's care plan.

This was a continued breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The service had received complaints on two separate occasions from a staff member. We were unable to see any response or investigation into this. We discussed this with the director who told us they were aware of the complaint, but they were unable to provide evidence of any investigation or response.
- The service had received one verbal concern since the last inspection. Records showed this had been addressed and responded to by the manager.
- People told us they had been made aware of how to complain.

End of life care and support

- People's wishes about end of life care had not always been explored. The manager told us they were aware of this and would be exploring people's wishes with them.
- We received positive feedback from one relative regarding the end of life care delivered. They told us, "I am more than happy with the care [Name] receives, the staff support me as well."

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.

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

- This was the third inspection in a row where the provider had failed to make enough improvement to meet all regulatory requirements and improve their rating to Good. At the last inspection in June 2018 we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified continued breaches of the above regulations. The provider had failed to develop the service.
- At this inspection, the provider assured us they had updated their quality audit and the new manager confirmed that she had started to carry out quality checks. However, this process had failed to address some of the issues found. This included concerns about recruitment, induction, training, record keeping, care planning, risk management, the environment, infection control and a lack of person centred care.
- The lack of robust recording about people's care needs and support provided meant there was a significant risk of a negative impact to people's health, safety and well-being.
- The service had failed to implement effective systems and processes to monitor and mitigate risks to people.
- Audits had failed to identify concerns found at inspection such as lack of compliance with the Mental Capacity Act, infection control procedures and unsafe recruitment practices.

- Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. The provider had failed to notify of Deprivation of Liberty Safeguards authorisations.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider accepted a fixed penalty and arrangements for payment have been agreed.

Continuous learning and improving care;

- The newly appointed manager had undertaken a full audit of the service. However, prior to this there a lack of auditing systems in place. This meant there had been a lack of oversight to identify areas of concern and drive forward improvements.
- Following the previous inspection, the provider had completed an action plan, however they had failed to meet the action plan and make the improvements required.
- Following the last inspection, the provider gave us assurances that staff were undergoing training and competency checks. However, at this inspection we found staff who were administering medicines had not been assessed as competent to do so.

● At this inspection we found continued breaches of four regulations and identified two further new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This demonstrated learning and improvement had not taken place.

A lack of good governance of the service and poor record keeping was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a continued breach.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● The provider was unable to evidence a response or investigation into a complaint submitted by staff about the care people were receiving.

● The provider had failed to identify that staff did not have time to deliver high quality person centred care.

● High quality person-centred care was not always promoted. People received poor care due to the staffing levels on a night.

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

● Staff, residents and relative meetings had taken place.

● Surveys had been sent out to people and relatives to gather feedback. The provider had developed a 'you said' and 'we did' approach.

● When feedback had been received, it was not always evident that this feedback had been fully explored or acted upon.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care in response to 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 had failed to seek lawful authority to deprive people of their liberty.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to notify the CQC regarding outcomes where applications had been submitted to the supervisory body to deprive people of their liberty including the outcomes of those applications. (DoLS).

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Unsafe medicines practices were in place that put people at risk. Accidents and incidents were not always reported so action could be taken. Risks to people were not mitigated.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and monitoring systems had failed to identify and address areas of concern found at inspection putting people at risk of harm.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staffing to meet people's needs at night.

The enforcement action we took: