Loxley Lodge Care Home Limited

Loxley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Loxley Lodge Care Home is a residential care home providing personal care to 37 people at the time of the inspection, including people living with dementia. The service can support up to 42 people. Loxley Lodge Care Home is purpose built and is split over two floors with communal areas on each floor. The provider has created a specific area, containing some of the bedrooms on the upper floor, which is used by people who need to be isolated from the rest of the care home for infection control purposes.

People's experience of using this service and what we found
People's care plans did not always accurately reflect their individual risk assessments, and some staff told us they were not always informed about people's dietary support needs. People didn't always receive the care they needed in respect of continence support, and they did not always receive safe support to use mobility equipment such as hoists.

People lived in an environment which was not always clean and hygienic; and were supported by staff who did not always follow best practice guidelines on wearing personal protective equipment in order to reduce the risk of spreading infections. People were not always supported by enough staff to meet their care needs, and the provider did not always ensure that recommended improvements in care were effectively and consistently implemented.

People were supported by staff who held mixed views on whether the service met people's needs. Similarly, feedback from people's relatives was varied; with some relatives telling us they were very happy with the care their loved one received, and other relatives telling us their loved one did not always receive the support they needed. The people we spoke to told us they liked the staff who supported them.

The provider did not have effective processes in place to monitor and improve the quality of the service provided to people. The provider's quality monitoring processes had not identified the issues we found on the inspection. Some staff told us they did not feel able to tell the provider about any concerns, and that the provider had told them not to contact CQC.

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 22 November 2019). This service has been rated Requires Improvement for the previous two consecutive inspections.

Why we inspected
We received concerns in relation to the management of the service, staffing levels, infection control arrangements, and the way people were supported by staff through moving and handling. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No new 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.

The overall rating for the service remains Requires Improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Loxley Lodge Care Home on our website at www.cqc.org.uk.

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 of people, staffing levels, hygiene and cleanliness, and the governance systems the provider has in place to ensure the quality of the service provided.
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 from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Inadequate

The service was not 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.

Loxley 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
Loxley 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.

At the time of the 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. Shortly after the inspection took place, the provider notified us that the registered manager had left the service and a new manager had been appointed. The provider told us the new manager would apply to CQC to be registered.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to understand the coronavirus infection control precautions the provider had in place, and to ensure the inspectors understood the current status of any potential infection risks.

What we did before the 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. We used all of this information to plan our inspection. 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. We spoke with nine members of staff including the, registered manager, deputy manager, senior carer, care staff, administrator, housekeeper, laundry worker, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a visiting healthcare professional. We observed the care home environment and how staff supported people. We reviewed medicine records and looked at the infection prevention and control measures which the provider had in place. We reviewed three staff files in relation to recruitment and staff supervision.

After the inspection
We reviewed, all or part of, 12 people's care plans and risk assessments. We received feedback, by email and/or telephone, from ten relatives of people receiving a service, and nine staff members. We also received feedback from a community healthcare professional and the Local Authority social services team. We reviewed a variety of records relating to the management of the service, including the provider's policies and procedures. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People's care plans did not always correspond to their individual risk assessments. For example, a person was assessed as needing a specialised diet, but accurate details were not included in the care plan. A staff member told us they were not always informed when a person's dietary needs changed, or about the dietary needs of new residents. This meant there was an increased risk of people being given food which was not safe for them.

● People received inconsistent support. For example, the provider's records showed a person was irregularly checked, and only had their incontinence pad changed twice in a 24-hour period, despite them needing full support from staff to manage their continence needs. This meant there was an increased risk of people developing skin lesions as a result of inconsistent continence support from care staff.

● Improvements in care were not always sustained. A health care professional told us, "After we go in and give advice, normally care improves. However, I'm not sure, once discharged from our care, whether that continues. Pressure sores and moisture lesions are often frequent, and we query whether residents were being checked appropriately. It is not always clear on asking, and evidence is not shown to our nurses." This meant people were at risk of receiving inconsistent care.

● People did not always receive support in a timely manner. The provider's Nurse Call system was barely audible in some parts of the care home. A Nurse Call is the system by which people can summon help from staff by pressing an alarm button. We tested the Nurse call system, by activating it in a toilet in the ground floor extension of the care home, and found staff working in nearby rooms could not hear the alarm. A staff member told us, "You cannot hear the buzzer in the extensions, staff will leave [two bedrooms in the extension] buzzing for sometimes 40 minutes before being answered."

● People were not always safely supported. For example, staff were observed supporting a person with a hoist in an unsafe manner. Additionally, people were sometimes hoisted using slings which were not assessed as being safe for them; which increased the risk of injury. A staff member told us, "Residents shared slings, until the inspection, when CQC questioned this." This was raised with the registered manager who told us people had their own individual hoist slings and action would be taken to ensure all staff used the correct ones.

Preventing and controlling infection; Learning lessons when things go wrong

● Staff did not always use personal protective equipment (PPE) effectively and safely. Reusable face shields, used in the coronavirus isolation area of the care home, were not always cleaned, disinfected, and stored safely prior to re-use. This increased the potential risk of the spread of health infections. We raised this with the registered manager; and additional guidance was provided by the inspector.

● Staff did not always have easy access to replacement PPE. On the day of our announced inspection we

saw the care home had recently received a supply of PPE. However, some staff told us they believed the provider limited access to facemasks. One told us, "[The registered manager] says we can only have one face mask per day, and told staff it's up to us whether we wear it or not. But only one mask for a 12-hour shift." Another staff member told us, "[The nominated individual] restricted access to the [PPE] cupboard because they say too many gloves are being used." This was raised with the nominated individual who told us they believed PPE had been taken from the building by some staff and so access was controlled, but that staff could obtain PPE when needed as the key to the cupboard was available.

● Staff did not always wear the PPE that they had been issued. Feedback was received from the Local Authority social care team, following their unannounced visit, that care staff were observed working without wearing face masks. This increased the risk of transmission of coronavirus infections to vulnerable people and staff at the care home. The care home had one confirmed case of coronavirus at the time of the inspection.

● People were not always supported to maintain effective hand hygiene. Some bedrooms were found to be without supplies of hand soap and disposable hand towels.

● Best practice guidance on new admissions was not always followed. A new person had moved into the care home and was not subject to the recommended 14-day isolation period. This was raised with the registered manager. They told us they had assessed the individual risks involved and decided the person could not be supported safely if they were subject to isolation arrangements. However, the risk assessment did not identify effective alternative measures which would reduce the potential risks of not isolating.

● The provider had an infection prevention and control policy in place which the nominated individual updated as and when Government guidance changed. However, we found the guidance was not always being followed.

The provider failed to ensure that safe care and treatment was adequately assessed and that they were doing all that is reasonably practicable to mitigate any risks to people using the service. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some areas of the care home were not clean. Sluice rooms and a linen storage room were not clean. The provider had identified higher risk areas such as sluice rooms, toilets and bathrooms, should be hygiene checked for cleanliness hourly. However, records indicated they were only being checked once a day.

● Some items of essential equipment were not clean. This meant there was an increased risk people would come into contact with equipment which was not hygienic.

● The management of incontinence waste was not always hygienic. We found the sluice room waste bin, in the coronavirus isolation area, to be overfull and the room malodourous. Feedback from a staff member indicated incontinence waste was not always well managed, and the Local Authority told us they had found similar malodours during their visit.

● Required improvements in hygiene had not been actioned. An audit was carried out on 4 March 2020, by the NHS infection prevention and control team, which identified continuing shortfalls in respect of standards of cleanliness in some areas. Our inspection found similar shortfalls. This meant the service had not taken effective action to address identified hygiene concerns.

The failure to take effective action to ensure the premises and equipment used by the service provider were clean, and to maintain standards of hygiene appropriate for the purposes for which they are being used, was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Visitors were prevented from catching and spreading infections. The provider had arrangements in place

to control visits to the care home, and to ensure any visitors wore appropriate PPE.
● People, and staff, were regularly tested for coronavirus infection. The provider had the necessary test arrangements in place.

Staffing and recruitment
● Staff absences were not always covered. During the 24 days prior to the inspection, there were six occasions when staff numbers fell below the minimum assessed, by the provider, as being safe. The registered manager told us they had worked those shifts themselves to cover shortfalls in staffing. However, care staff told us it was not the case. For example, one staff member told us, "[The deputy manager] helps out when they can, but [registered manager] is seldom on the floor, upstairs sees very little of them at all." There was no evidence to substantiate the registered manager worked those shifts. That meant staffing levels were unsafe on those six occasions.
● People's care was affected by insufficient staff sometimes being available. For example, a Local Authority safeguarding investigation substantiated a person had not had their continence pad regularly changed, by care staff, and had been left lying on a wet bed on at least two occasions. A staff member confirmed, "It's upstairs where being short hurts most because they have a lot of need for our time, more of them need us to help with the very basic human needs; feeding, using the toilet etc." Another staff member told us about the impact on people of being short staffed, "Some residents are left in bed as they take too long to get up (by some staff only) they are fed in bed and are in there all day."
● The provider's staffing contingency plans were not always effective. At the time of the inspection the registered manager told us the provider did not use agency care staff and staffing shortfalls needed to be covered by existing care staff. As detailed above, we found not all rota gaps were covered. Following the inspection, the new manager subsequently told us they now used regular agency care workers to cover staffing gaps and had commenced recruitment of additional staff.

The failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed, in order to meet people's assessed care needs, was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who were safely recruited. The provider had an effective recruitment policy and procedure in place and pre-employment checks helped ensure people were supported by suitable staff.

Using medicines safely
● Medicine stock checks were not always accurate. One person was found to have fewer items of prescribed nutritional supplements available to them than was indicated by the provider's stock records. Although we found no impact on the person, this was raised with the registered manager who told us it was due to an error and additional stocks would be immediately obtained from the local Pharmacy.
● People's prescribed medicine was stored safely, and the return of no longer needed medicines, to the local Pharmacy, was well managed by the provider.
● People's prescribed medicine was administered to them by senior care staff who had received the necessary training from the provider.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who had received safeguarding training and were aware of safeguarding procedures. Some staff told us they had been warned, by the provider, not to speak to CQC. However, CQC had previously received details of concerns which some staff had raised with us anonymously.
● Staff had access to safeguarding policies and procedures. Copies were available in the staff room and office areas for staff to refer to. Staff understood how to contact statutory agencies about issues if they felt

unable to raise their concerns with the provider.

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 Requires Improvement. At this inspection this key question has remained the same. 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

- The provider's governance processes did not ensure people always achieved good outcomes. Feedback from people's relatives was mixed. Some relatives told us they were happy with the care being provided. Other relatives told us the care was not person-centred and people's individual needs were not always met. For example, in respect of getting appropriate continence assessments and support to obtain, and use, hearing aids and glasses. That had a negative impact on the outcomes people achieved from the provider's service.
- The culture of the service was not always positive. Staff views differed on whether they would tell the provider about any concerns. One staff member told us, "The management are fantastic and very approachable." Other staff told us they did not feel confident to raise issues with the provider because of the negative consequences they believed they would suffer as a result. A staff member told us, "The treatment of staff who raise concerns, or health issues, with management is appalling, particularly during Covid."
- The leadership of the service was out of touch with what was happening at the care home. Prior to the inspection we received several anonymous concerns raised by current and former staff members. Those specific concerns had been investigated by the Local Authority safeguarding team and were found to be either fully, or partially, substantiated. That was discussed with the nominated individual who told us they had previously met with all the staff and none had raised any concerns with them.
- The provider's governance systems did not ensure all staff felt listened to, respected, valued or supported. Some staff told us there were cliques within the staff team, and that the leadership of the service favoured some staff members over others. A staff member told us, "[Registered manager] has their favourite staff at Loxley Lodge who can do as they like when they like, there is no confidentiality at all."

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

- The registered manager's quality monitoring was not effective. Quality audits were conducted regularly but had not identified the environmental and safety issues found on this inspection. For example, no improvement actions had been identified, by the registered manager, in the quality audits they carried out between April and August 2020. That meant opportunities to make necessary improvements had been missed.
- The provider's overall quality management process was not effective. Although the provider regularly reviewed the registered manager's quality audits, they had not identified the audits were failing to find

quality issues at the care home.
● Checks on the care provided were not always carried out. The registered manager had introduced daily checklists to monitor the important care people needed. Those checks were not always carried out, and the registered manager told us some senior care staff continued not to use them, despite being spoken to about it. That meant the registered manager was not assured that people received the care they required.
● Care records were not always completed accurately. Staff told us records of when people received support with continence aids, or to reposition when in bed, were completed at the end of their shift, rather than when the support was given. This was because personal care records were not kept in the person's room. The provider's governance systems had not identified that care records were not always accurate and did not support the provision of timely and appropriate care for people.

Continuous learning and improving care
● The service had been rated Requires Improvement for the previous two inspections and had further deteriorated since the last inspection. The provider had not taken necessary management action, and did not have effective governance systems in place, to improve the care provided since the previous inspection. There were repeated and significant shortfalls in governance and leadership across the service.

Working in partnership with others;
● Records of relative's involvement in decision making were not always accurate. For example, a Local Authority safeguarding enquiry substantiated that a person's relatives had not been consulted about the use of bedrails. A bedrail is a rail along the side of a bed connecting the headboard to the footboard. It is fitted to prevent people falling out of bed but can sometimes pose a hazard in itself. The person did not have the mental capacity to agree to the use of bedrails themselves. The provider's records indicated the matter had been discussed and agreed with the person's relatives. Relatives later confirmed the matter had not been discussed with them.
● Staff did not always work in partnership with people and their relatives. Some relatives told us they were not always informed about important issues relating to their family member. For example, in relation to a person moving bedrooms. Although they accepted coronavirus restrictions had made contact more difficult, they expected care staff to more regularly notify them about issues which affected the care their relative received.

The failure to have effective governance systems and processes in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity was a breach of Regulation 17 (Good governance) 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
● The provider had made the necessary statutory notifications to CQC, except for one. This was discussed with the registered manager, during the inspection, who told us a technical error had led to the oversight and that all other statutory notifications had been made to CQC in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The staff team were divided in their opinions about the care people received. For example, one staff member told us, "I have no concerns around any of the things mentioned and feel it is a safe place to work and for the residents to live." Other staff told us they would not want one of their own relatives to move into the care home because of how the service operated currently.

● The provider regularly wrote to relatives about the coronavirus situation, to ensure relatives understood the arrangements which were in place to support people. Relative feedback about the care home visiting arrangements was mixed. All relatives told us they supported the care home's decision in respect of limiting visits, but some relatives told us they found the visit booking system to be inflexible and difficult for those who did not have access to email.
● Feedback from the people we spoke with was positive. One person told us, "I get lots of help, and the carers are nice."

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 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to take effective action to ensure the premises and equipment used by the service provider were clean, and to maintain standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed, in order to meet people's assessed care needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to take reasonably practicable actions to mitigate the assessed risks to the health and safety of service users, and to ensure that the equipment used by the service provider was safe for such use and used in a safe way. The provider failed to take effective action to assess the risk of, prevent, and control the spread of infections, including those that are health related.

The enforcement action we took:

We issued a Warning Notice to the Provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective governance systems and processes in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity; including the quality of the experience of service users in receiving those services.

The enforcement action we took:

We issued a Warning Notice to the Provider