Paddock Lodge Care Home Limited

Paddock Lodge Care Home

Inspection report

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Paddock
Huddersfield
West Yorkshire
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Tel: 01484543759

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03 November 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Paddock Lodge is a care home providing personal care for up to 24 people, some of whom were living with dementia. When we visited 21 people were living in the home.

People's experience of using this service and what we found
Environmental risks had not been identified which meant people were at risk. We found the fire panel was flashing to indicate a fault in one zone. However, insufficient action had been taken to ensure the system would sound correctly in the event of a fire. This was resolved following the inspection. The provider informed us that on the morning of the inspection, they had already arranged for maintenance to be carried out on the fire alarm system.

Improvements were needed to ensure infection control was suitably managed. Relatives expressed concerns about restrictive practice around visiting rights. We found the provider was not following government guidance at the time of our inspection. We have made a recommendation about the management of people's visiting rights.

Staff rotas showed shifts were usually fully covered, although we saw several examples of staff working consecutive shifts, which meant there was a risk that staff could be tired and not alert. The provider told us they had experienced significant staffing pressures during this period. The provider had a dependency tool which they kept under review.

People said they felt safe, although safeguarding records did not include concerns we had shared with the provider before our inspection.

People received their medicines as prescribed and the administration process was seen to be caring. However, allergies people suffered from were not always recorded on people's medication front sheet. We could not be sure a time specific medicine had been given in accordance with the prescriber's instructions.

Timely action had not been taken after we identified concerns found at our last inspection. Quality assurance survey outcomes had not been accurately represented in the findings report produced by the provider. 'Resident' meeting minutes were repetitive in the way they were recorded and staff meetings lacked user voice.

Systems used to demonstrate oversight of the home were not effective. These did not show that robust checks had been carried out or highlight concerns and remedial action required.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 18

January 2020) when there was a single breach of regulation. The provider completed an action plan after the last inspection 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 regulation.

Why we inspected
The inspection was prompted in part due to concerns received about visiting rights, the culture and management within the home and concerns regarding people's safety. A decision was made for us to inspect and examine those risks.

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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led key questions of this full report.

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 the management of risks to people living in the home and the management team not having the necessary oversight.

Please see the action we have told the provider to take at the end of this report.

Follow up
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?

Requires Improvement

The service was not always 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.

Paddock 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
This inspection was carried out by two inspectors. An Expert by Experience also made phone calls to people's relatives to gather their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Paddock 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.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff, including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two people's care records and multiple medication records. 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, two recruitment files and quality assurance records. We spoke with a professional who had visited 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 requires improvement. At this inspection this key question has remained at 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.

Assessing risk, safety monitoring and management
• Risks to people's safety had not been assessed, monitored and reviewed.
• On the day of our inspection, the fire panel showed one of the zones was indicating a fault which a staff member estimated had been showing for two weeks. The staff member said they had reported to this to a contractor who said the system would work correctly, although the contractor had not been to the home to look at the fault. We could not be assured the fire panel would function in all areas of the home whilst the fault was showing. The provider informed us that on the morning of the inspection, they had arranged for the contractor to visit. Following inspection, we saw evidence of these works having been completed.
• A cupboard space used to store clean linen had items stored in bin liners which were stacked to the ceiling height. This was next to the light fitting for the room, but no one had identified this as a fire risk.
• A bolt was in place on the door which led to the cellar. This had not been recognised as a safety risk to people. Following our inspection, a lockable fitting was added to this door.
• A potential trip hazard in one person's bedroom due to raised sticker flex being on the floor had not been identified as a falls risk. This was resolved following our inspection.

This was a breach of regulation 12(2)(b)(d) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people had not been identified and action taken.

Staffing and recruitment
• Shifts were routinely staffed with enough staff, although risks were evident in some cases around staff working excessive hours.
• We looked at staff rotas which covered a three week period in October 2021. We saw seven occasions when care workers undertook double shifts which meant they worked continually for 14 or 15 hours. This was a risk to people's safety. Following our inspection, the nominated individual told us this was necessary due to workforce pressures due to COVID-19. The registered manager said these staff received regular breaks.
• The registered manager told us the home did not have vacancies for permanent staff, but they were recruiting temporary staff. Staff worked in different roles to ensure there was sufficient cover.
• One care worker, who had no prior experience of working in a care home, was supposed to 'shadow' another worker on 31 October 2021, but they were listed on the staff rota as part of the staff team that day.
• We looked at recruitment records for two members of staff and found appropriate checks had been carried out before these staff started working with vulnerable adults.

Preventing and controlling infection

• Improvements were needed to manage infection control.
• We observed that social distancing was not being maintained in the two ground floor lounges and in the dining room at lunchtime.
• We found some bedrooms where the basins had not been sufficiently cleaned.
• We looked in one bedroom and saw staff had stripped the bedding and wiped the mattress before putting fresh bedding on top of the mattress. The support manager said they would not expect this to happen.
• People and staff were part of a regular programme of testing for COVID-19. We have reported on visits to the home under the well-led key question.

Using medicines safely
• The management of medicines was not always safe.
• One person was prescribed a specific medicine which was time critical. There was nothing recorded on this person's medicine administration record to show they had received this as prescribed. We spoke with the support manager who told us night staff administered this person's medicines at 7am on the day of our inspection. Later, we saw this person received their medicines at 2pm. This meant the prescribed administration times had not been followed.
• Allergies were not listed on the front sheet of three people's medication records, despite them having allergies.
• The medication audit dated 1 October 2021 didn't show which people's medicines had been looked at. We found these checks were not effective as they had not identified the concerns we found.
• We looked at stocks of controlled drugs and found these matched the records we looked at. People routinely received their medicines as prescribed. We observed the administration of medicines and saw this was done in a caring and compassionate manner. Medication competency checks were found to have been completed and staff received medication training.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe. However, safeguarding records were not robust.
• People we spoke with said they felt safe living at Paddock Lodge and their relatives confirmed this. One relative commented, "In my opinion, my relative feels safe."
• The safeguarding log we requested following our inspection did not include safeguarding issues we had shared with the nominated individual during 2021.

Learning lessons when things go wrong
• The provider was unable to demonstrate a pro-active approach to lessons learned. Evidence we saw during and after our inspection failed to show how the provider looked to openly identify its own shortfalls and what action needed to be taken.

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.

At the last inspection this key question was rated as requires improvement. At this inspection the rating has changed 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 inspection in November 2019, we identified a breach of regulation 15 (Premises and equipment) of the Health and Safety Act 2008 (Regulated Activities) Regulations 2014 as bedrooms were in need of refurbishment and there had been an ongoing leak in the roof.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

Continuous learning and improving care
• We found a lack of examples where the provider was able to demonstrate prompt action was taken as a commitment to continuous improvement.
• We found new bedroom furniture for 15 people had been delivered and fitted two weeks before we visited. Following the inspection, the nominated individual said they had responded in a timely way, given restrictions around the ongoing pandemic.
• We looked in bedrooms and found one person did not have caps on their hot and cold water taps. The drawers on one person's cupboard did not have handles, a radiator cover was damaged in another room and a mirror on a bathroom cabinet was missing. A new leak was found in the roof which was resolved following our inspection.
• The support manager did not identify these concerns during their walkaround.
• Following our inspection, the nominated individual provided evidence and told us a programme of redecoration was near completion and 'new or nearly new furniture' was in all bedrooms. Since our last inspection, bedrooms had been fitted with a bedside light.

Action had not been taken to address concerns around the living environment. This was a breach of regulation 17(2)(a) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as these concerns had not been identified by the provider and timely action had not been taken based on our previous inspection findings.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The management team had not identified concerns around quality issues in the home.
• At our last inspection, we identified concerns around infection control as areas of the home required a deep clean. At this inspection, we still had concerns around the management of infection control.
• The infection control audit had not identified issues we found at this inspection.

• We identified one person who was at risk of choking and found they did not have a risk assessment in place for this. We raised this with the area manager who put this in place following our inspection.
• Records of meetings in the home lacked evidence to show where action was needed and what action had been taken to improve the service.
• The management meeting in September 2021 indicated extra support was being provided for the registered manager, but did not state why. The same record stated 'Audits and findings discussed' but did not provide any detail as to what was found and any subsequent actions needed.
• Records of accidents and incidents were kept. There was an absence of a review of these incidents to look for themes, including how they occurred and opportunities for lessons learned.
• We found training gaps and contacted the nominated individual after our inspection, who was unable to provide assurances about when this training would be provided.

This was a breach of regulation 17(2)(a)(b)(c) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to identify these risks were not effective and records were not sufficiently detailed.

• The registered manager carried out an unannounced night time spot check in October 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Prior to our inspection, we received information indicating the management of relatives visits to the home was not consistent with government guidance. We found restrictions were being enforced above those required by the government.
• Relatives told us they were required to undertake a COVID-19 lateral flow test 48 hours prior to their visit and again on the day of the visit. Government guidance did not specify the need to test two days before a visit.
• Relatives told us they were restricted to 30 minute visits and they were not able to visit people in their bedrooms. Instead, visits were conducted in communal areas which meant privacy was not maintained.
• Three relatives we spoke with said it was only possible to visit between Monday and Friday. Prior to our inspection, this concern had been raised by other relatives. The provider's face to face risk assessment we looked at stated 'Evening and Weekend visits are to be pre booked at the discretion of the manager'.
• We saw signage in people's bedrooms which was designed to indicate action staff needed to take. For example, 'This resident has creams that need to be applied twice daily' and 'Before you leave, check to make sure that you have completed the red folders for the residents'. This had not been identified by the management team as not dignified.

We recommend the provider reviews their COVID-19 visiting protocol and maintains people's visiting rights in line with government guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff meetings had been taking place in the months leading up to our inspection. These records were largely reminders for staff around their responsibilities.
• 'Resident' meetings were being regularly held throughout 2021. We looked at meeting minutes and found the September and October 2021 meetings were identical in how they were reported. The July and August 2021 meetings were also similarly worded.
• In August 2021, the 'resident' meeting minutes stated, 'They (people) want different meals on the menu. Informed them that we would have to stick to them but would see what we could do, also pitched the idea of having Chinese and Indian food as options' whilst the same record later stated, 'Meals – no concerns were

raised; residents were told if there was anything, they wanted on the menu to let staff know'.
• We saw information on display about religious beliefs and the LGBT community. The home accommodated people from different cultural backgrounds and was able to offer staff with relevant language skills to support these people. One person we spoke with and a relative spoke positively about the registered manager.

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
• A quality survey had been carried out and we saw responses dated July and October 2021. Feedback around activities was mixed, with some comments indicating this was good and others saying they wanted more to be done, others stating the provision had reduced during the pandemic. The 'You Said, We Did' summary of the feedback stated, 'We asked – How do you feel about the activities? You said – Very good'. This was not a candid summary of the feedback.

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 12 HSCA RA Regulations 2014 Safe care and treatment Action needed to reduce risks to people had not been identified and taken.

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 Steps to assess, monitor and improve the quality and safety of the service had not been taken. Systems of audit to identify risks were not effective and records were not sufficiently detailed. Meeting minutes and survey feedback was not fully reflective of feedback provided.

The enforcement action we took:

Warning notice served