Orion Healthcare Limited

Cedar Lodge

Inspection report

Culford
Bury St. Edmunds
IP28 6DX

Tel: 01284728744

Date of inspection visit:
15 March 2022
21 March 2022

Date of publication:
14 April 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cedar Lodge is a residential care home providing personal and accommodation. The service provides support for up to 25 people in one adapted building, across two floors. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found
The provider's governance systems in monitoring the quality and safety of the service were ineffective and did not identify the shortfalls we found at this inspection. Risks to people's safety associated with their care and treatment and operation of the premises had not always been identified.

People were at risk from a lack of staff to meet their needs, inadequate cleaning regimes and a poorly maintained environment. There was a lack of systems in place to identify the risks relating to; access to the stairs, scalding from hot water outlets and inadequate infection control monitoring.

The environment was not clean and well maintained to ensure people lived in a safe, homely environment. Areas of the service were in a state of disrepair and in need of cleaning. We asked for a schedule of works planned to bring the environment up to standard, but this had not been developed at the time of our inspection.

Action was not always taken to safeguard people from the risk of harm. The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns had not always been identified and reported to the local authority.

Not everyone had a care and risk management plan in place. Care plans were basic and lacked details of people's assessed needs including medical and mental health conditions. There was a lack of risk management plans in place for people at risk of self harm, choking, acquiring infections, diabetes, pressure wounds and their catheter care. This meant staff were not routinely given sufficient guidance to manage complex care needs in line with best practice guidance.

People were not assessed to check their capacity to make particular decisions when this was in doubt. Records were not maintained to show how decisions were made in people's best interests. People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible; however, the policies and systems in the service did not support this practice.
We recommend the registered manager put in place medicines profiles which describe the conditions medicines were prescribed to treat and how people chose to take their medicines.
Rating at last inspection
The last rating for this service was Good [published 28 June 2019].

Why we inspected
Prior to our inspection we received concerns in relation to the oversight and management of the service including a lack of infection control, maintenance of the building and staffing including the quality of staff training. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, safeguarding people from the risk of abuse, infection control and ineffective oversight of and management of the service. Immediately after the inspection we wrote to the provider and requested they provide us
with urgent information telling us what they were going to do regarding the management of risks, staffing, infection control and ineffective government arrangements.

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 work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Cedar Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cedar Lodge is a 'care home' without nursing care. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. 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 site visits were unannounced on both the 15 and 21 March 2022.

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 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 also spoke with stakeholders such as the local authority to gain their views.
We used all of this information to plan our inspection.

During the inspection-
We spoke with seven people who used the service and one relative about their experience of the care provided. We spoke with ten members of staff including the registered manager, company administrator, senior care staff, care staff, the cook, domestic staff, maintenance and agency staff.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files 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 staffing rotas and further records of care. We shared the findings from our inspection with the local authorities involved, including safeguarding teams.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were not always assessed or managed effectively to reduce the risks of harm. There was a lack of risk management plans in place for people at risk of self harm, choking, acquiring infections, diabetes, pressure wounds and their catheter care. This meant staff were not routinely given sufficient guidance to manage complex care needs in line with best practise guidance.
- One person admitted to the service seven weeks prior to our inspection did not have a care plan in place. The registered manager's response to our findings was, "I have not had the time." This meant staff had not been provided with the support and risk management guidance needed which would describe how care and treatment was to be delivered safely.
- Where people presented with distressed behaviours that posed a risk to themselves and others, and where they had expressed suicidal thoughts, these risks had not been assessed with risk management plans in place to guide staff.
- Where people had a diagnoses of epilepsy there was no management plan in place which would describe what type, how it presented and guide staff as to any potential triggers.
- Risks to people from falls and potential harm had not been assessed with actions to guide staff in reducing the risk of harm. During our inspection on the 15 March 2022 Inspectors observed one person, living with dementia walking with purpose up and down stairs and corridors unobserved by staff. Inspectors found this person to have clothing around their ankles placing them at risk of falling. Inspectors activated the call bell to seek assistance from staff.
- At our inspection on the 21 March 2022 staff told us all bedroom doors on the top floor of the service were kept locked to reduce risks to people. However, Inspectors found this was not accurate and a person living with dementia had access to an unlocked shower room and cupboard which contained a number of toiletries, including a razor, Denture cleaning tablets and a soiled urine bottle. This placed this person and others at risk of avoidable harm.
- People were exposed to the risk of scalding. We found hot water outlets such as baths and sinks where the temperature of water exceeded safe levels. There was a lack of health and safety management audits to ensure the safety of the environment was monitored and regular tests of water temperatures was carried out. We discussed our findings with the provider and signposted them to Health and Safety Executive guidance for the management of risks in care homes.
- We found wardrobes were not secured to walls. This meant people were at risk of injury from wardrobes and the items stored on top falling on them. In response to our formally notifying the registered manager of our concerns action was taken by day two of our inspection to secure wardrobes and fit thermostatic valves where needed to prevent the risk of scalding from hot water outlets.

Preventing and controlling infection

● The risks associated with COVID 19 were not sufficiently assessed, mitigated or reviewed. On arrival on 15 March 2022 CQC inspectors found two used staff lateral flow tests which had been left unattended on a dining room table where people ate their meals.
● During our inspection it became apparent the service was in an outbreak of COVID-19. Whilst we became aware of staff who had tested positive for COVID-19, the registered manager told us there were no people using the service infected. However, staff told us of one person using the service who had tested positive for COVID-19.
● The registered manager had failed to notify the local health authority of the COVID-19 outbreak until prompted by Inspectors to do so.
● Risks to people from COVID-19 Had not been assessed for all people who used the service. Where risk assessments had been carried out these were brief in detail and did not consider risks to individuals with complex health conditions with guidance provided for staff to keep people safe.
● There was a lack of PPE designated don and doff areas with full availability of PPE for staff to access, such as masks and easy access to clinical waste bins to dispose of used PPE.
● Staff including the management were observed throughout our visit accessing the kitchen without wearing protective clothing.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We found areas of the service unclean. Light pull cords throughout the service were found stained and in need of replacement.
● A number of commodes had not been emptied. Some that had been emptied had not been cleaned. We also found a number of commode chairs dirty with brown matter underneath and rusting legs which pose a risk of bacteria harbouring.
● Several rooms had flooring with brown stains, some perished and in need of replacement.
● The majority of taps in the service were covered in limescale and in need of de-scaling presenting a risk of bacteria harbouring. This activity did not form part of a regular cleaning regime and so presented a risk of cross contamination.
● staff did not have easy access to equipment to ensure effective hand washing and protective clothing to reduce the risk of cross infection. Not all bathrooms and en-suite rooms contained hand washing equipment, such as paper towels and pedal bins to dispose of clinical waste including PPE. PPE was not available in people's rooms where support was provided with personal care.
● The registered manager told us there was no system of regular infection control audits which would have identified the shortfalls we found at this inspection.

We have also signposted the provider to resources to develop their approach.

Systems were either not in place or robust enough to demonstrate the management of risk was effectively managed. This placed people at risk of harm. This demonstrated a breach of regulation 12 [Safe Care and Treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

● We were assured people had access to visitors. However, despite the registered manager informing us there were no restrictions on visiting, people told us their visitors were only allowed access to an outside log cabin and prevented from access to visit people in their personal rooms.

Staffing and recruitment
● There was insufficient staff available to meet people's needs and maintain effective cleanliness of the service.
● On arrival at the service on the 15 March 2022 CQC Inspectors found only the registered manager and one

senior carer available to support 24 people living at the service with their care needs. Staff told us at least three people required two staff to support them with mobilising and personal care. Therefore, there were periods of time when the majority (23 people) were left unsupervised. We observed periods of time where people in communal areas were not supervised. The low staffing levels had a significant impact on people's emotional and physical wellbeing.

● We observed an incident that could have been avoided if skilled staff were present. One person using the service was physically and verbally assaulted by another. Staff attended but did not know what had occurred so were unable to effectively deal with the situation. Staff confirmed similar incidents were a regular occurrence. This was a known risk and these people and others were placed at risk of harm due to lack of appropriate staffing.

● A review of rotas identified several occasions when there were only two members of staff providing support to 24 people, from 31 January to 10 April 2022. This meant low staffing levels observed on 15 March 2022 were not an isolated incident.

● Staff told us at least three people required two staff to support them with mobilising and personal care. The local authority also informed us of two people funded to receive two to one support. The deployment of staff was insufficient to provide the additional hours people had been funded by the local authority to receive, such as two to one support on a daily basis.

● There was a lack of regular activities provided for people. We observed people sat for long periods of time without social interaction or any meaningful activity provided.

● As well as providing personal care support, staff told us they were responsible for carrying out laundry and domestic tasks as well as social activities. Only one member of domestic staff was employed weekdays 9-2 but there was none employed at the weekends.

● Prior to our inspection we received information of concern that staff under the age of 18 were employed without sufficient training and guidance to equip them for the role they were employed to perform. For example, when apprenticeship staff were expected to work alone supporting people with personal care, mobilising safely and equipped with training to know the action they should take in response to safeguarding concerns.

The shortfalls we found in staffing levels demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 [Staffing]. This meant people were at risk of not having their needs met due to insufficient staff available to support them.

Systems and processes to safeguard people from the risk of abuse

● We raised a safeguarding referral following our inspection, where we identified incidents which had not been reported to safeguarding or the Care Quality Commission [CQC].

● Staff told us and records confirmed regular incidents of physical and verbal altercations which took place between people who used the service. Where incident reports had been completed the manager review section was often left blank. This meant necessary steps to ensure the abuse was not repeated had not always been taken. We also noted incidents had not always been referred to the local safeguarding authority as required for investigation.

● A recent incident whereby a person went missing from the service and was later found by a member of public and taken to the local police station. The registered manager did not refer this incident to the local safeguarding authority until prompted to do so.

● Where altercations occurred between people and staff physically intervened, people's mental capacity had not been assessed and action taken to ensure a best interests process had been instigated in accordance with the Mental Capacity Act 2005.

Systems were either not in place or robust enough to demonstrate people were protected from abuse. This

placed people at risk of harm. This demonstrated 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.

Using medicines safely

- An audit of medicine stocks against medication administration records [MAR] tallied.
- Staff had received training in medicines administration. However, we were not assured all staff had been regularly competency assessed.
- Care plans did not contain a list of all the medicines people had been prescribed.

We recommend the registered manager put in place medicines profiles which describe the conditions medicines were prescribed to treat and how people chose to take their medicines.

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 our last inspection we rated this key question Good. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Risks to people as referred to within the safe section of this report had not always been fully assessed or planned for. There was a failure to maintain accurate and fit for purpose care records.
- The registered manager did not have effective systems and processes in place to ensure they had a good oversight of the service. There was a lack of quality and safety assurance audits, including regular infection prevention control audits. There were no action plans to demonstrate how the provider planned to improve the environment with action plans to address the lack of cleanliness and areas of disrepair.
- The lack of quality and safety monitoring processes meant the registered manager did not identify the shortfalls we found during this inspection and the areas of development needed.
- The registered manager's response to our findings did not assure us they had an awareness of regulatory requirements associated with their registration and fundamental standards.
- Despite the evidence found during this inspection, people told us they were very happy with the care they received.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager demonstrated a lack of transparency and honesty when asked about the COVID-19 status of the service as they told us there was no one using the service currently infected. However, we found this not to be the case and the service was in a COVID-19 outbreak during our visit on the 21 March 2022.
- Risks to people's safety and welfare had not always been assessed with safeguarding incidents responded to with actions to prevent a reoccurrence.
- The registered manager had not always reported to CQC and the local authority all incidents as required by law. This included notifications of safeguarding incidents with investigation outcomes, as well as events that stop the service operating safely such as insufficient staff and power cuts. This meant there was reduced external oversight of risk.

The failure to understand assess,, monitor and mitigate risks, to maintain accurate and fit for purpose care records with ongoing plans to ensure improvement of the service demonstrated a breach of Regulation 17 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● In response to our inspection findings and following recent safeguarding incidents, the local authority told us the management team was working with them to make improvements needed.