Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

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Date of inspection visit:
25 November 2020
07 December 2020

Date of publication:
05 March 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Eden Lodge Residential Care Home is a care home providing personal care to 21 people, some of whom were living with dementia at the time of the inspection. The service can support up to 60 people in one adapted building across one floor.

People's experience of using this service and what we found

People were not always protected adequately against risk of harm. Risk management had not improved since our last inspection. Risks were not always assessed or reviewed. Incidents were not always recorded or reported appropriately. Staff were not always provided with the information to support people with their medicines in a safe way. There were poor infection control practices. Staffing levels were not matched to people's needs.
There was very little leadership and oversight of the service was poor. There was insufficient risk management and quality monitoring. Auditing was not robust and there were missed opportunities for learning and improving the quality of care.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. People's needs were not assessed or planned for adequately.

We have made a recommendation to the provider around the documentation of consent and people's capacity.

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 inadequate (published 06 March 2020) and there were multiple breaches 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 regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 28 and 30 January 2020. Breaches of legal requirements were found around regulation 12 (safe care and treatment) and regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC issued a warning notice for these breaches of regulation. The provider completed an action plan after the last inspection, detailing what action they would take to improve and by what date.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as inadequate. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eden Lodge Residential 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 keeping people safe, care delivery, staffing levels, safeguarding, leadership and oversight of the service at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Eden Lodge Residential 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.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Eden Lodge Residential 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 the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 four people who used the service about their experience of the care provided. We spoke with ten members of staff including, the supporting manager, the administration manager, senior care workers, care workers, the cook and the housekeeper. We spoke with one visiting healthcare professional. We reviewed a range of records. This included eight 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 were reviewed.

After the inspection
We sought further information from the provider to inform our inspection judgements. This included staff training data and policies. On 3 and 7 December 2020 we spoke with three further members of staff on the phone and three relatives of people using the service.

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 inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risk management remained poor. People's risks in relation to their health and care needs were not being assessed, mitigated or managed effectively in order to keep people safe.
- We found there was a lack of understanding around risk assessments. Risk assessments were in place where they were not needed, for example people had risk assessments for pain. However, we identified people who were at risk of choking who had not been assessed for this and no guidance for staff was in place.
- People who had experienced multiple falls did not have risk assessments in place around this. People staying for respite did not have risk assessments in place.
- We found some radiators to be very hot and water in a bedroom to be scalding. We raised this with the management and they promptly rectified this.
- People's vital information was not always available. For example, we found not everyone had personal plans for evacuating in an emergency. People's allergy information was inconsistent. This meant people were at risk of not being supported safely.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure people were adequately protected from the risk of inspection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- People continued to be at risk of infection due to infection prevention and control practices not always being adequate.
- On the days of inspection, whilst most areas of the home looked visibly clean, other areas of the home

smelt unpleasant and the dining room was not cleaned between meals.
● Best practice guidelines were not always being followed to help mitigate the risk of COVID-19. For example, personal protective equipment (PPE) was not always worn correctly and people newly admitted to the home were not being isolated in line with recommendations. We also observed staff interacting with people without appropriate PPE.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Medicines management continued to be unsafe.
● Protocols were still not always in place for when people were prescribed medicines to be given as and when required. This meant staff may not know when to offer these medicines to people, leaving people at risk of not receiving medicine when they required it or being supported to take unrequired medicines.
● A person was supported to receive medicine via a skin patch. On the last inspection we found there was no documentation in place to record the location of where the patch was being placed and guidance was not being followed around how often to alternate the locations. This left the person at risk of skin irritation and inflammation. We found documentation was now in place, however recording was inconsistent leaving the person still at risk.
● Controlled drugs were not always stored or recorded correctly.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always being safeguarded from the risk of abuse.
● New members of staff had not all been trained in safeguarding, this meant they may not recognise and report safeguarding concerns.
● There was a lack of confidence amongst staff that concerns would be appropriately acted on if they raised these with management. However, staff did know who to escalate safeguarding concerns to externally in order to protect people.
● Safeguarding concerns were not being consistently reported or acted on appropriately.

The provider failed to ensure that people were safeguarded from abuse. This is 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.

Staffing and recruitment□
● The service did not have enough staff to meet the needs of people.
● Staffing dependency was not being calculated correctly and did not clearly assess people's needs. It was

recognised by the service that staffing was below the required amount to meet people's needs, but action had not been taken.

● Staff absences were not always covered, and staff felt more staff were needed. Staff were unable to take breaks due to being short staffed.

● Recruitment records had improved since the last inspection, however there was still a lack of documentation to evidence safe recruitment and induction processes were being followed. This meant the provider and registered manager could not assure themselves that prospective staff were suitable to provide a regulated activity.

The provider failed to ensure safe they had a systematic approach to determine the number of staff required. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider did not have a very robust system in place to ensure lessons were learnt.

● Whilst there was a monthly analysis of incidents, accidents and falls, these were not completed consistently and there was very little documentation of investigations to establish causes.

● There was no evidence of reflective learning to improve the quality of care provided.

● This meant people were placed at risk because issues with the quality of care were not being identified and there was no opportunity for the improvement of care.

Inadequate

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to ensure people had person-centred plans in place. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People's needs, and choices continued to not always be assessed sufficiently, and care was not always delivered in line with best practice.
● Admission assessments had not improved enough to ensure staff had the information to safely support people new to the service.
● People did not always have care plans in place to guide staff on how to support them in an individualised way. For example, people living with diabetes did not have a diabetes care plan in place.
● Care assessments for people did not always consider the full range of people's diverse needs. This lack of assessment could mean that people's diverse needs were not being met.

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

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure they had trained and competent staff. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There was a lack of adequate support in place to ensure staff were able to complete their roles effectively. Staff said, "I don't feel supported, I do speak to the manager and owner, but they aren't helpful."
● Staff were given an induction. However, staff records remained inconsistent, so the provider could not assure themselves all staff had received a full induction.
● Training for staff had improved since the last inspection, but not all staff had received training in areas such as safeguarding and moving and handling. This meant the provider could not assure themselves all

staff had the knowledge and skills to support people.
● The provider had now implemented a system to assure themselves they were checking staff competency in specific areas, such as hand hygiene and medicines administration. However, records showed these had not been completed for all staff.

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

Supporting people to eat and drink enough to maintain a balanced diet

● People were being supported to eat and drink, but risks associated with people's eating and drinking continued to lack consistent monitoring and recording.
● Information about dietary needs were inconsistently recorded in the people's records and kitchen records did not contain information about everyone's dietary needs. This put people at risk of receiving food or fluid which was inappropriate for them.
● Weight monitoring was inconsistent and was not always being escalated when required.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) 2014.

● People said they enjoyed the food. One person said, "The food is lovely here, I have nothing to complain about".

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 when this is in their best interests and legally authorised under the MCA.

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● At our last inspection we found people did not have access to their room at all times. We found at this inspection it had been addressed to some extent, however it could be further explored to meet people's individual needs.
● Improvements had been made to the mental capacity assessment paperwork and records of best interest decisions. However, they were still incomplete, for example missing dates and signatures. They also did not always include relevant people, some having only documented that staff had been involved in the decision-making process.
● The provider had now implemented a system to assure themselves they were not depriving people of their

liberty unlawfully.

We recommend the provider reviews the guidance with regards to consent and the Mental Capacity Act 2005 Code of Practice to ensure they keep accurate documentation.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare when required and the provider sought input from relevant professionals such as occupational therapists to ensure people's wellbeing.
- The provider had implemented a red bag system in place in case of emergency, although people who were living in the home on a respite basis did not have their information in there.
- A visiting healthcare professional said the care staff were always very helpful and contacted them when required.
- People had oral health assessments and care plans in place.

Adapting service, design, decoration to meet people's needs

- People were able to personalise their own rooms as they wished.
- Throughout the home there were signs to help people orientate themselves and there was consistency in decoration to help people identify bathrooms. There were sensory boards along the corridors for people who were living with dementia.
- People had a choice of communal areas and quiet spaces to spend their time in. People did have access to outside space, although this was limited during the pandemic.

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 inadequate. At this inspection this key question has now remained the same. 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.

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

At our last inspection the provider had failed to ensure managerial oversight and effective quality monitoring and auditing. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At the time of the inspection the registered manager was absent, and the service continued to lack oversight.
● There remained a lack of effective systems in place for quality monitoring and risk management, which led to errors and risks going unidentified. For example, water temperature checks had not been completed since July 2020 and we found water to be scalding. This meant people were at risk of not receiving adequate care and support to keep them safe.
● The volume of old and conflicting information held in people's care records did not promote a person-centred approach and made it very difficult for staff to deliver safe and quality care.
● Reporting of incidents, including safeguarding concerns, remained inconsistent which led to them reoccurring as no action was taken. This meant that people were not supported to achieve the best outcomes.
● There was a lack of confidence in leadership. There was a supporting manager in post, however their role had not been clearly defined and staff were unsure about the current management structure.

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
● There remained a lack of understanding around the duty of candour, which meant the service was not always operating in an open and transparent way.
●Incidents and safeguarding concerns were not always investigated or acted on appropriately and the relevant people were not always informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives we spoke with described a worrying lack of communication. One said, "They had sent us an

email at the beginning of the pandemic to say we are going to be in regular contact, but we have not heard anything since." Another said, "I had been told we were going to receive photos and updates but never did."
● During the pandemic relatives found visiting to not be a very nice experience, they described having to stand at the gates as the service did not arrange for seated outside visits. One relative said, "They do care, but I feel sometimes that my [relative] is not at the front of the queue."
● A visiting professional spoke highly of the services communication with them however we continued to find evidence indicating information was not always shared, particularly around potential safeguarding incidents.
● Staff meetings were now being held more frequently, however we did not find evidence of staff involvement and opportunities for them to provide feedback on the service.

Continuous learning and improving care
●The provider had not implemented effective systems and processes to be able to improve care on an ongoing basis.
● There remained little evidence to indicate learning from incidents was occurring, especially as not all incidents were investigated. This meant opportunities to improve the quality of care were missed.
● There was no evidence of reflective learning and information shared in staff meetings was not always accurate. For example, information around isolation periods for new admissions during the COVID-19 pandemic.
● A relative said they had returned a questionnaire and had raised concerns but had not been contacted by the service to discuss this further. This is an example of a missed opportunity for the service to improve care.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective oversight of the service. This placed people at risk of harm. All of the above demonstrates how the provider remains in breach of regulation 17 (Good governance) of the Health and Social care Act 2008 (Regulated Activities) 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people were safeguarded from abuse. Reg 13 (1) (2) (3)

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 to ensure care and treatment was provided in a safe way for service users. Regulation 12 (1)

The enforcement action we took:

We imposed a condition to restrict admissions as well as reporting conditions.

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 failed to have proper and safe management of medicines. The provider failed to ensure safe infection control practices. The provider failed to ensure water temperatures are being monitored. Regulation 12 (2) (g) (h) (d)

The enforcement action we took:

We issued a warning notice.

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 systems and processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

We imposed a condition to restrict admissions as well as reporting conditions.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure safe they had a systematic approach to determine the number of staff required. The provider had failed to ensure provided the appropriate training and support to staff. Regulation 18 (1) (2) (a)

The enforcement action we took:

We imposed a condition to restrict admissions as well as reporting conditions.