HC-One Limited

Cedar Court Residential and Nursing Home

Inspection report

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18 October 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Cedar Court Residential and Nursing Home is a residential care home providing personal and nursing care to 39 people at the time of the inspection. The service can support up to 52 people.

The care home is split into three floors. On the last day of the inspection there were 19 people receiving nursing care on the first floor and 20 people receiving residential care on the middle floor.

People's experience of using this service and what we found
There were widespread failings of the leadership and governance of the service. Quality assurance systems and processes were ineffective as they failed to identify the concerns we found during the inspection. The service failed to learn from incidents or to respond to and manage risks, increasing the risk of harm to people.

People did not always receive their medicines as prescribed and medicines were not always stored safely.

There were not always enough staff recruited or deployed to provide safe care to people. Where agency staff were used, these were not regular staff that knew people well.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way. However, whilst we observed staff offer people choices, mental capacity assessments and best interest decisions for people that were unable to make choices had not always been undertaken.

Staff were observed to wear personal protective equipment (PPE) in line with current government guidance. The service was clean and free from any malodours. Visits to the service were promoted and managed safely.

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 rated inspection for this service was good (published 17 October 2019).

Why we inspected
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 received concerns in relation to medicines, governance and safe care and treatment. 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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. 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 Cedar Court Residential and Nursing Home 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 and the leadership and governance of the service.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 Court Residential and Nursing 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 Health and Social Care Act 2008.

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 undertaken by four inspectors, a specialist nurse advisor and an 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 Court Residential and Nursing Home is a 'care home'. 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. Cedar Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and three relatives about their experience of the care provided. We spoke with eleven members of staff including the regional director, area directors, a registered manager from another service (supporting the service at the time of the inspection), clinical lead, senior carer, carers, kitchen assistant, home manager, maintenance staff and two domestic staff. We observed staff providing care to people.

We reviewed a range of records. This included eight people's care records and 39 medicines administration records. A variety of records relating to the management of the service, were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely.

- Medicines systems and processes were not safe. People were at risk of harm as they did not receive time critical medicines as prescribed. This included medicines for the management of cardiac conditions, diabetes, infections and neurological disorders. One person did not receive their insulin for five days. Another person missed medicines to manage symptoms of their health condition on six occasions.
- Medicines were not always safely stored. We found a significant amount of medicines in an unlocked area. These were accessible to people receiving care at the home. There was a risk of harm and overdose to people should they access these.
- Medicated patches delivering a specific dose of medicine through the skin into the blood stream were not always applied as prescribed. One person's pain relief patch was applied a day late with the following patch applied a day early, meaning there was a gap of only five days between application and not seven as prescribed. This placed the person at risk of receiving an overdose of their prescribed medicine.
- Medicines audits were undertaken but were ineffective. They identified some of concerns we found, however there was no evidence action had been taken to address these. This meant people continued to be at risk of not receiving their medicines as prescribed putting them at serious risk of harm and a deterioration of their health conditions.

There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.

- People had experienced, or were at significant risk of, avoidable harm, neglect, abuse and discrimination as risks were not safely managed. The practices at the service placed people at risk of harm and did not protect them from actual harm.
- One person was known to be at risk of harming themselves and putting their life in immediate danger. The provider failed to assess this risk or put measures in place to reduce the likelihood of this occurring until we requested this action to be taken. The provider did take action during the inspection to ensure this person was safe.
- We saw one person was using a bed that was too small, they were at risk of falling. The service had failed to undertake any risk assessments or care plans for this person. They were at risk of falling from height and sustaining skin damage as these risks were not managed. The provider took action following concerns raised by inspectors and provided a bed extension and a crash mat and commenced observations to get a baseline of the person's need and any associated risks.

● One person was not eating or drinking sufficient amounts. Staff were recording the daily food and fluid amounts but did not take any action when intake was not sufficient and when fluid targets were not met.
● Diabetic management plans were not always reflective of people's current needs or where not followed by staff.
● The provider did not always learn from concerns, accidents, incidents and adverse events. People's risk assessments and care plans were not always reviewed following accidents and incidents to consider measures that could be put in place to prevent them from happening again. There was a process for sharing learning with staff during team meetings and staff supervision. However, this had not been effective.

There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
● Staff knew how to whistle-blow and raise concerns. However, they told us they did not always feel listened to. Two staff told us they had raised concerns with the registered manager about staffing levels, but no action had been taken. One staff member said, "It was like talking to a brick wall."
● Staff told us most people with nursing needs required the support of two staff to attend to their personal care needs. They told us there was often only two care staff to meet everyone's needs. A staff member told us, "It is not safe on the weekend, I raised it so many times."
● The service used a combination of regular and agency staff. There was no consistency in the agency staff attending the service. Staff told us agency staff did not know people well. One staff member said, "We have had a lot of agency in that have only been in the job one day, so don't feel it's safe, it puts more pressure on the staff." Another staff member told us, "All the changes in staff are distressing for people."
● One person we spoke with told us they had to wait a while for staff to attend to them.

There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service did not always work within the principles of the MCA. Appropriate legal authorisations were in place to deprive a person of their liberty. However, mental capacity assessments and best interest decisions were not always completed or recorded. One person was taking very little amounts of food and fluids. Staff had not considered the persons capacity to make this decision or consulted with their family and healthcare professionals to make a best interest decision as they should have done.

● During the inspection the management team undertook a review of medicines systems and process. They liaised with healthcare professionals and pharmacists to improve the safety of the medicines systems and processes. The providers dependency tool was reviewed, and staffing was increased to a safe level. Where agency staff were used the management team told us they aimed to ensure this was consistent to reduce risks to people.
● The management team were in the process of reviewing people's needs and had taken action to address areas of concern we identified. This included consulting with healthcare professionals. Some staff were assigned the role of food and fluid champions to ensure people met their food and fluid targets each day or to take action when they did not.
● Staff were recruited in a safe way and were only offered employment following checks to ensure, as far as possible, only staff with the right skills and experience were employed.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Visits were facilitated in line with current government guidance. People told us their friends and relatives were made welcome and there were no restrictions on visiting.

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.

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

- There were widespread failings relating to the leadership and governance of the service. Quality assurance systems and processes either failed to identify the concerns we found in relation to medicines, staffing and risk assessments or had identified concerns but failed to address them.
- The registered manager also managed another care home. Staff told us the registered manager was frequently not at the service.
- Staff did not feel supported by the registered manager. They felt staff morale was low.
- People did not always receive personalised care as care plans and risk assessments had either not been completed or not been reviewed to ensure they were reflective of people's preferences and wishes.
- People were not always supported by staff who knew them well and how they liked their care to be delivered. Regular staff we spoke with knew people well but told us agency staff did not know people's needs.

Quality assurance systems and processes failed to effectively monitor the quality and safety of the service. This placed people at significant risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; 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.

- Relatives and staff told us there were times when they did not feel the service was safe. Three people's relatives raised concerns about care and support. One relative told us they did not feel staff checked on their family member enough, they arrived one day to find they were nearly falling out of bed and at another time they found them food round their mouth and down their clothes. Another relative told us care staff did not seem to know their family members needs and when asked, they said they were not the ones looking after them that day. Despite raising these concerns with the registered manager, these issues had not been responded to appropriately.
- The provider's systems for managing risks and quality performance included 'daily walkarounds' to identify any risk to people or areas for improvement. These had not taken place for over a month. Managers had failed to identify unrestricted access to an unlocked storage cupboard containing significant amount of medicines. This put people at risk of significant harm.

● Managers had failed to identify when some people did not have enough to eat or drink and required a review of their care and support or when people were at risk of falling or harming themselves.
● People told us they were not routinely asked for feedback or involved in developing or reviewing their care plan and risk assessments.
● We received negative feedback from three people's relatives about the care and support not always meeting their family members needs and about their frustration having to constantly raise the same issues.

Quality assurance systems and processes failed to effectively monitor the quality and safety of the service. This placed people at significant risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us staffing levels had increased during the inspection and provided positive feedback about the changes implemented during the inspection to improve the quality and safety of the service. The provider recognised the recruitment difficulties faced by the care sector and had taken action to increase recruitment and to attract new applicants.
● The provider took action in response to the concerns we identified and deployed senior managers and a manager with experience of working with services who were failing to meet regulations. We were told this additional support would continue until all concerns had been addressed and safe practices embedded into the service.
● A full and comprehensive audit of and review of all medicines and risk assessments commenced during this inspection. Senior managers updated the clinical risk register and were addressing all areas in priority (highest risk) order. This included the management of nutrition and hydration.
● Systems and processes were in place to seek people, staff and relatives' views through satisfaction questionnaires. We were told these had recently been sent out and the responses were being returned and then would be analysed and used to drive improvement.
● Staff we spoke with were motivated to achieve good outcomes for people and to provide person centred care. They knew people well and understood the things that were important to them. Some staff were frustrated they could not always provide the care and support people required. Domestic staff understood their responsibilities to maintain good standards of hygiene to reduce the risk of infections.

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's policy set out the services responsibilities in relation to duty of candour. Managers we spoke with understood their responsibility to act on the duty of candour.

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 There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and processes failed to effectively monitor the quality and safety of the service. This placed people at significant risk of harm

The enforcement action we took:

Warning Notice