Conifer Lodge Limited

Conifer Lodge Residential Home

Inspection report

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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

About the service
Conifer Lodge residential Home is a residential care home providing personal care for up to 20 people aged 65 and over. At the time of the inspection there were 15 people receiving care.

People's experience of using this service and what we found
People were not provided with safe care.

People were exposed to the risk of acquiring infectious diseases including Covid-19 because infection control procedures were not managed safely. The service has had two previous outbreaks of Covid-19. Despite this, lessons were not learned and, government guidance not followed to minimise the risk of further outbreaks. Personal protective equipment (PPE) was not always disposed of safely and, the service was not cleaned every day. Not all staff had received infection control training.

People were exposed to the continued risks of harm and abuse and, action was not taken to prevent further incidents occurring. Incidents were not investigated or reported to agencies including local authority safeguarding teams and CQC.

Some people's care needs and risks were not met because they were not assessed when first admitted to the service or when their needs changed. Staff were unable to support and monitor people safely because there were not enough of them on duty all the time.

Environmental risks were not addressed. An electrical wire was hanging loose from a toilet ceiling and, it was unclear whether it was connected to the mains. Hazardous material had also not been secured safely.

Safe recruitment procedures were not always followed which posed risks to people's welfare. Staff were not supported in their roles and, when they raised concerns they were not always listened to. Supervisions, appraisals and team meetings were not undertaken.

The service was not well-led. Leadership and oversight of the service was poorly coordinated and relationships between managers and the nominated individual were not cordial. Records to support effective quality assurance of the service were not in place.

People were not always supported to have maximum choice and control of their lives. Policies and systems in the service did not support this practice.

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 15 January 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 not enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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

We planned to undertake a targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 safe care and treatment and Regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

However, the registered manger informed us immediately prior to the inspection of serious concerns in the service. These included, but were not limited to, infection control, assessing and monitoring risks of people's safety, staffing, reporting and recording incidents and, safe management of the service. We therefore carried out a focussed inspection to examine the risks identified inspecting the whole of the safe and well-led key questions. The overall rating for the service has not changed following this inspection and remains Inadequate.

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 people's safe care and treatment (Infection control practices, lack of care plans and risk assessments to monitor people safely, safeguarding people from harm and abuse, and staffing staffing), reporting serious incidents and poor management of the service at this inspection.

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

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider 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?

People and the service was not safe.
Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not well-led.
Details are in our well-led findings below.

Inadequate

Conifer Lodge Residential 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
One inspector carried out the inspection.

Service and service type
Conifer Lodge residential 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 two managers 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
We gave 24 hours' notice of the inspection following concerns we received by one of the registered managers at the service.

What we did before the inspection

We reviewed information we had received about the provider since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used this information to plan our inspection.

During the inspection
We spoke with four relatives about their experience of the care provided for their family members. We spoke with nine members of staff including the nominated individual, registered managers, senior care workers, care workers and the housekeeper and chef.

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 five people's care records and several medication records. A variety of records relating to 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 spoke with professionals from a number of agencies following the concerns identified at the inspection.

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 remained the same. This meant people were not safe and remained at risk of harm.

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. We issued a warning notice requiring the provider to become compliant with this regulation.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Preventing and controlling infection; Learning lessons when things go wrong

- People were placed at serious risk of acquiring infectious diseases. Despite the service having had two previous outbreaks of Covid-19, government guidance was not followed to minimise the risk of further outbreaks. The provider and registered managers confirmed there was no infection control or Covid-19 policy in place.
- Covid-19 individual risk assessments were not in place. These should be used to record the specific risk to people from acquiring infections and any action needed if they became infected.
- Procedures were not in place to, where possible, socially distance people in the service. One person displaying Covid-19 symptoms was sitting with non symptomatic people in the communal dining room. The provider explained social distancing measures were not considered unless a positive Covid-19 test had been confirmed. This is in direct conflict with current guidance to minimise the spread of infection.
- There were no arrangements in place to ensure the service was cleaned daily. Rotas for weeks commencing 17, 24 and 31 August 2020 confirmed a cleaner was only deployed for three or four days, and cleaning schedules confirmed this. When we discussed this with the provider and registered managers, they told us they had not increased daily cleaning in response to Covid 19, including high touch areas such as door handles and hand rails. This meant cleaning arrangements were not sufficient to reduce potential risk of the spread of infection.
- Whilst staff were observed to be wearing appropriate Personal Protective Equipment (PPE) it was not always disposed of safely in line with current guidance. Used items of PPE were discarded in waste bins in corridors unsecured. This meant there was a risk people and staff were unnecessarily exposed to potential infection.
- Government guidance states used laundry must be double bagged, tied and stored securely. We found open bags of used laundry outside people's rooms next to clean laundry, and people's personal care products. This meant people and staff were at risk of cross contamination between clean and used laundry.

Assessing risk, safety monitoring and management; Managing medicines safely

- People's needs, and risks were not consistently assessed, managed or monitored safely. This meant

people were at risk of receiving unsafe care.
● Staff were not always provided with the information they needed to support people according to their needs. Two people who moved into the service on the 29 May 2020 and 26 July 2020 had no care plan or risk assessment in place. One staff member told us, "We have to 'wing it' until we get to know people's needs as there are no risk assessments or anything in place."
● Where people's risks had been assessed these were not reviewed when their care needs changed. One person had two serious falls in August 2020, however, their risk assessment and dependency needs assessment was last updated in July 2020. This meant the person remained at risk of further falls because staff did not have the information required to support the person safely.
● People were not always monitored safely. The registered managers told us two people required continuous monitoring to protect people from their behaviours. Staff told us on a number of occasions both people had been found entering other people's rooms which resulted in harm and distress. Appropriate action was not taken following these incidents, and people remained at risk.
● Registered managers informed us all care plans and risk assessments were not reflective of people's current needs and needed a review.
● Whilst improvements to the safety of the environment had taken place following our previous inspection, people and staff remained at risk from environmental risks. People and staff were exposed to the potential risk of electrocution. An electrical wire, hanging loose from a toilet ceiling, had not been secured. When we spoke to the provider, they were unaware if the wire was connected to the mains.
● A cupboard containing products hazardous to people's health was unlocked. This meant there was a risk to people ingesting harmful products.
● Medicines were not always managed safely. Records showed and staff told us one person had been administered twice the prescribed amount of warfarin. This was not identified until the following day, when the service contacted the GP. The medication was ceased until the person's International Rationalised Ratio (INR) in the blood had returned to a safe level. Not following the prescribed dosage for this medicine can lead to serious health complications.

Systems and processes to safeguard people from the risk of abuse;
● During our previous inspection incidents had not been reported to CQC and the local authority safeguarding team. At this inspection we found no improvements had been made and reporting arrangements had deteriorated further.
● People were at continued risk of being exposed to harm and abuse because systems and processes to manage safeguarding and whistleblowing concerns were not followed. Incidents and allegations of abuse were not investigated, recorded or reported to partner agencies and CQC.
● Both registered managers informed us of several safeguarding incidents which had occurred in the service during the three months prior to the inspection. Appropriate action had not been taken in response to these incidents.
● Incidents included serious injuries, alleged abuse by staff and, people causing harm to others due to their behaviours. For example, one person had two incidents resulting in fractures to their bones, and a significant skin lesion to their arm. Another person, witnessed by a staff member, choked due to another staff member forcing liquid into the person's mouth despite their difficulty in swallowing and, people who posed risks to others were found in people's bedrooms.
● Registered persons did not investigate or take it seriously when care staff reported their concerns for people's safety. One staff member reported two incidents of abuse involving the same staff member, and no action was taken. This meant the person continued to be a risk to others. CQC alerted partner agencies to these concerns so action could be taken to safeguard people.

Registered persons failed to ensure people were protected from abuse and improper treatment. This is a

breach of Regulation 13(1) Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Recruitment

● Systems and processes for safe recruitment of staff were not in place. Where employment checks had identified concerns, which could pose risks to vulnerable people, no action was taken to assess their suitability for the role, or risk assessment put in place. This meant people were placed at risk of receiving unsafe care from staff whose previous practice had given rise to concern.

Staffing

● There were not enough staff deployed to meet people's needs in a timely way or keep them safe. The level of care people required could not be met with the current staffing deployment. When we requested information on how staffing levels were determined none were provided.

●The registered manager told us, "We have vacancies for five care assistants, a housekeeper, cook administrator and activities co-ordinator." They went on to say, "We haven't got enough regular staff so are dependent on agency staff which causes shifts to not run smoothly as they do not know people well." Despite the concerns we identified there were no plans to recruit to the staff vacancies in the service.

● Staff rotas confirmed there were only two members of staff on duty at night on 27 and 28 July 2020, 26 and 30 August 2020 and 02, 07, September 2020. Two people were identified as requiring one staff member to monitor them and three people were receiving end of life care. There were only two members of staff on duty in the day on 17 August 2020 and, three members of staff on duty in the day on 28, 30, 31 July 2020 and 1, 17 August 2020.

● A relative told us, "There is a lack of staff to monitor people. My [family member] was involved in an incident where another resident inappropriately 'touched them'. I wasn't made aware at the time which I was annoyed about. I don't blame the staff as there isn't enough of them to watch what's going on."

The provider failed to ensure there were enough staff to safely meet people's needs. This is a breach of Regulation 18(1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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 remained the same. The service continued to demonstrate widespread significant shortfalls in leadership and governance.

At our last inspection the provider systems and processes were either not in place or robust enough to demonstrate that registered persons could provide a safe service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice requiring the provider to become compliant with this regulation.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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;

- The service was not well-led with leadership and governance poorly coordinated. Neither registered managers nor the provider took responsibility for the shortfalls identified in the service. There were no plans in place to remedy the shortfalls which meant people remained at continued risk of unsafe and poor care.
- Registered managers and the provider were unable to provide reliable and consistent information to assure the service was or could be safely managed. Serious incidents were not investigated, recorded or reported and action not taken when things went wrong.
- Records of people's care were either not in place or not reflective of their needs. Staff were not always provided with accurate information to support people safely. One staff member showed us a one-page care plan they had devised and carried it around with them in the absence of a formal care plan. They told us, "There isn't a care plan or risk assessment in place for [named person] so I have done my own and refer to that."
- A relative told us their concerns relating to the provider. They told us, "They [provider] do not have oversight of what is going on in the service." I get to know about things that have happened in the service that affected my [family member] a long time after; communication is not very good."
- Quality assurance systems and processes were not in use at the time of the inspection. Audits of key aspects of the service could not be effective as records were not in place to audit against. These included, but were not limited to, safeguarding, accidents and incidents, care plans and risk assessments and health and safety and environmental audits.
- Staffing levels were insufficient to care for people safely. At the time of the inspection there was no plan in place to recruit to several vacant posts including five care assistants and a housekeeper.
- At our last inspection we made a referral to Leicestershire Fire and Rescue Service (LFRS) due to concerns identified with the fire alarm system and staff training how to effectively operate the system. Following an

inspection (LFRS) made several recommendations to the provider including fire procedures, regular testing of the fire panel and fire drills. We found these recommendations had not been consistently followed.

At our last inspection the provider and registered manager had failed to notify CQC and the local authority of incidents that could indicate abuse or improper treatment of people at the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Notification of other incidents.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Notifiable incidents continued to go unreported reported to CQC and partner agencies. This inspection identified at least ten unreported notifiable incidents. The inspector was required again to inform registered persons they had a legal duty to report notifiable incidents to relevant agencies. During the inspection one registered manager refused the provider's request to report a safeguarding concern that occurred while they were not present at the service due to lack of information available. We did not receive assurances the provider or registered managers would reliably report future incidents.

At our last inspection the registered manager did not demonstrate the capability and competence to carry out their role effectively. This was a breach of Regulation 7 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Requirements relating to registered managers.

Not enough improvement had been made at this inspection and the registered manager was still in breach of Regulation 7.

● We identified continued concerns over the capability and competence of the registered manager. Following the inspection an additional manager was recruited to bring about the improvements required. This manager formally registered as a registered manager on 16 July 2020. However, whilst we took account of the impact of the Covid-19 pandemic, and their absences from the service during it, serious shortfalls in both registered managers competence were identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff were not supported in their roles. Staff told us their concerns were not listened to and, records confirmed they had received no supervision or appraisal for six months. For example, one staff member told us they didn't have enough information available to them to support people safely and did not have opportunities to discuss this with the registered managers.

● Staff with pre-existing health conditions did not have risk assessments in place or a return to work meeting following an absence. Staff told us their concerns for their colleagues and how their employer had little regard for their health.

● Action was not always taken when relatives raised concerns. One relative told us, "The provider doesn't listen to my concerns or respond to my emails. They even lost their temper with me on one occasion and, when I telephoned once to try and speak to my [family member], a resident answered the phone."

Continuous learning and improving care; Working in partnership with others

● Following two previous outbreaks of Covid-19 the provider had not followed or effectively implemented

national guidance to minimise the risk of further outbreaks.

● The provider and registered managers did not act on previous failings. There were no plans in place at the time of the inspection to demonstrate the importance of addressing the shortfalls in the service to bring about the improvements identified.

● The provider and registered managers failed to work collaboratively and involve other agencies including local authority safeguarding teams and Public Health England (PHE).

● Following our inspection, the provider supplied an action plan to CQC on how they would address the shortfalls in the management and governance of the service and, to improve the safety and quality of care provided.

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

● Registered persons were not open and transparent when things went wrong. Quality assurance systems were not robust to evidence the provider had carried out their duty of candour. For example, where incidents of abuse had occurred but had not been thoroughly investigated.