Bradbury House Limited

Cypress Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cypress Lodge is a learning disability service providing personal care to up to 10 people. The service provides support to people with learning disabilities, autism, and mental health needs. At the time of our inspection there were eight people using the service.

Cypress Lodge is laid out over two detached buildings, Cypress Lodge and Willow Cottage. Both buildings provide level access to communal gardens, kitchens and lounges. Private accommodation is laid out over two floors in each building. People have access to the hub, a large building with tables, chairs and a chalk board. The manager's office is located on the ground floor of Cypress Lodge.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Right care:
The service was not always caring; staff were observed smoking in the designated smoking area in peoples' garden. We heard one staff member speak with a person in an undignified way and the environment did not promote people to live dignified lives. People had been supported to attend funerals for loved ones.

Right support:
The provider failed to act and reduce the risk of avoidable harm to people; we identified concerns in relation to fire safety, environmental maintenance and risks of burns from hot surfaces. Medicines were not always managed safely and there were insufficient numbers of suitably qualified staff deployed across the service.

Right culture:
The provider failed to establish checks and audits and use them effectively to identify shortfalls, errors and omissions. There was no registered manager at the time of our inspection. The manager was working to improve the service and introduce new ways of working.

Based on our review of safe, well-led and caring, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The environment required maintenance work, medicines were not always managed safely, and we heard a staff member speaking to one person in an undignified way.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice. There were systems in place to identify and report potential safeguarding concerns and staff we spoke with were confident about how they would identify potential abuse.

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 rating for this service was good (published 29 August 2018).

Why we inspected
The inspection was prompted in part due to concerns we received about potential abuse and unsafe staffing levels. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
We issued a letter of intent and the provider responded with an action plan to address our most serious concerns.

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, caring 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 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 Cypress 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, safe staffing and good governance at this inspection.

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 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.

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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

Cypress 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 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 team was made up of two inspectors and one bank inspector, who was a registered nurse.

Service and service type
Cypress Lodge 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. Cypress Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
The first day of this inspection was unannounced, the second day was announced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. 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
During the inspection we spoke with seven staff including the manager, care staff, agency staff and area manager. We spoke with six people. We reviewed various records in relation to the running of the service, including three staff recruitment files, various audits and checks, medicines records and care plans.

After the inspection
We continued to clarify our findings with the manager and spoke with the nominated individual, who provided assurances about some of the high risk concerns we found.

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.

Assessing risk, safety monitoring and management

- The provider failed to protect people from the risk of avoidable harm in the event of a fire, and act to reduce the risk of a fire occurring. The provider commissioned a fire risk assessment that identified various shortfalls, including high and medium risk items. The provider failed to rectify these shortfalls, within the required timeframes. This increased the risk a fire would occur, and that people would not be evacuated safely.
- The provider placed service users at increased risk of avoidable burns from hot surfaces. We identified radiators, accessible to people, the provider had failed to risk assess, or introduce measures to mitigate the risk, such as radiator covers.
- The provider failed to act and undertake maintenance works to improve environmental safety. For example, in the month prior to our inspection, the manager identified damaged flooring in the entrance to one person's living accommodation, posed a trip hazard. The manager reported this risk, however, at the time of our inspection, this hazard remained.
- The provider failed to ensure potentially harmful cleaning items were stored in line with their risk assessment.

Preventing and controlling infection

- The provider's failure to maintain the environment, meant cleaning may not always be effective and help to reduce and prevent the spread of infection. For example, in communal areas we found cracked tiles, and missing worksurface edging.
- During the inspection, we observed areas of the service were visibly unclean; we saw debris and an unknown residue in one person's shower room, and in another person's shower, we found a non-slip matt discoloured with an unknown brown residue.
- Cleaning schedules did not show the environment was cleaned on a regular basis; cleaning records for the week prior to our inspection had gaps on four days out of seven.

Using medicines safely

- The provider failed to ensure one person's prescribed controlled drugs were stored safely. The logbook, used to record stock levels of controlled medicines, was not accurate and incorrectly recorded the balance of stock as zero, when there were four items in stock. This meant, for example, that if the controlled drugs went missing, the provider might not be aware, and would not be able to report this in line with their responsibility to do so.
- The provider failed to ensure medicines were consistently stored within the safe temperature range of up to 25 °C; in one medicine room, we found the range was breached on eight occasions in one month, and on a further 20 occasions in the following month. The provider failed to ensure action was taken to reduce the

temperature and ensure it remained within a safe range.
● The provider failed to implement a process, such as body maps, to ensure peoples' medicines patches were applied and repositioned in line with manufacturers' instructions.

The provider failed to manage and assess potential risks to people. There was an additional failure to ensure medicines were consistently managed safely. This placed people at risk of avoidable arm. These shortfalls were a breach of regulation 12(1)(2)(1)(2)(4)(7)(8) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, we contacted the local fire service and local safeguarding team and informed them about our concerns in relation to fire safety.
● In response to fire safety risks we identified, we wrote to the provider and requested an action plan to determine what would be done, and by when, to improve safety for people living at the service. The provider responded with an action plan to reduce these risks.
● In response to potential burns risks, and the failure to store potentially harmful cleaning products in line with their risk assessment, we wrote to the provider after the inspection. We received assurances and radiator risk assessments within the required timeframe.
● Staff had ensured people understood the reasons why visitors to the service needed to wear face masks. We saw posters people had made asking people to wear a mask when visiting their home.
● The registered manager told us PRN protocols were in the process of being updated. When staff administered PRN medicines, this was recorded, the reason why and the effectiveness. This meant it was easy for the service to review the person's medicines.

Staffing and recruitment
● The provider failed to ensure staff received training relevant to their roles. We reviewed the current staff training matrix. Staff received the induction programme when they joined the service, however the annual refresher training was frequently out of date.
● We found staff had not always undertaken their mandatory training. For example, the majority of staff had not completed their infection prevention and control (IPC) training, and no staff had completed their hand-hygiene training.
● Staff were not always supported to access training that was specific to peoples' support and health care needs. For example, some people using the service had assessed mental health conditions, and behavioural requirements, relevant training was not always undertaken by staff.
● The provider failed to ensure staff received end of life training. At the time of our inspection, no staff had completed end of life training, despite the service recently providing end of life care.
● The provider failed to use a systematic approach to assessing staffing levels. There was a staffing dependency tool available for use, that was not being used at the time of our inspection.
● The manager confirmed the minimum staffing levels. However, these levels did not consider that staff were also expected to clean the communal areas, assist people cleaning their living accommodation and support people with cooking. Comments from staff included, "I think we end up doing more clean[ing]', another described their role as, "Just domestic work". There were no cleaning staff employed at the service.
● The minimum required staffing levels did not consider how staff would have sufficient time to support people with their one to one hours, and complete additional cooking and cleaning duties. One person said, "I want more activities, but they can't happen all the time because there are no staff."

The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had booked training for some staff with outstanding training requirements.
● Background checks were completed prior to applicants being offered employment. For example, the provider completed checks with the Disclosure and Barring Service (DBS) and previous employers.
● During our inspection, we requested copies of interview records for two employees. At the time of publication, we had not received the information requested.

Systems and processes to safeguard people from the risk of abuse
● The manager operated systems that ensured potential safeguarding concerns were reported to the local authority safeguarding team.
● The service worked with people and supported them to express potential safeguarding concerns. For example, when people did not communicate verbally, photographs and images were used to aid communication.
● Staff we spoke with were confident about how they would identify and report potential safeguarding concerns. One staff member said they would report, "Anything that is not right; verbal abuse…any sort of hitting, anything to me which is ill treatment, even swearing [and] laughing at people."

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)

● At the time of our inspection two people had DoLS authorisations in place. The manager tracked and monitored DoLS applications.
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Learning lessons when things go wrong
● The manager had recently introduced a weekly handover to reflect on what had worked well, and review areas for improvement.
● Incidents and accidents were recorded by staff. There was a system to review incidents and accidents and identify patterns or trends to help prevent a reoccurrence.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- During the inspection, we observed staff smoking in a designated smoking area situated in peoples' communal garden. People had not been consulted about staff smoking in their garden.
- On one occasion, a person was looking for a biscuit and required staff support to access the biscuit tin. We observed two staff together, smoking in the designated smoking area. This meant no staff were available to support the person to access the biscuit.
- During the inspection, we heard one-person was spoken to in an undignified way by a staff member. We reported our concerns to the manager who took immediate action.
- The provider's failure to maintain the environment and communal gardens, did not support people to live dignified lives.
- One person said they would like staff to stop using their phones and interact with them more often. In response to this feedback, the manager confirmed staff would not be permitted to take their phones on shift with them in future.
- The manager had recently supported staff to implement a person-centred approach to menu-planning. People were involved with planning the menu for the week ahead and used pictures to help them do this.
- Some people had recently experienced bereavements. Members of the management team had supported these people to attend funerals and purchase a suit for the occasion.
- To promote peoples' independence, the manager was supporting people to become more involved with running the service. For example, there were plans for a person to assume some responsibilities in relation to running service events, another person was involved with maintenance oversight.
- People had recently enjoyed a fundraising event where they threw water over the manager.

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

- The shortfalls we found were widespread and systemic.
- The provider failed to implement systems and use them effectively, to monitor and improve the quality and safety of care provision in the service. For example, the provider failed to identify that high and medium risk fire hazards had not been rectified within required timeframes.
- Service level health and safety checks were not robust or accurate. The checks had not identified concerns relating to the environment, such as missing radiator covers and associated risk assessments.
- Service level medicines checks had not identified the shortfalls we found at this inspection.
- The provider failed to identify service level checks were not always undertaken effectively to identify shortfalls, errors and omissions.
- The provider failed to ensure maintenance, requested by the manager, was completed in a timely way. For example, at the beginning of February 2022 the manager requested drawers in a communal kitchen were repaired. The drawers remained broken at the time of our inspection. Additionally, one door stopper was damaged, and this meant a fire door was being, "Held up with a chair for two months since it was last looked at."
- The provider had not checked the quality of care provision in the service since April 2021, and had not followed up outstanding actions from the previous check. For example, the April 2021 care quality assurance report identified two staff members required food hygiene training. At the time of our inspection, staff had still not completed the training, despite a deadline date in May 2021.
- Peoples' confidential records were not always stored securely. For example, on the first day or our inspection, we found three peoples' records on the table in a communal area. This meant these records were accessible to unauthorised people and visitors.

The provider failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety. This was a breach of regulation 17 (1)(2)(1)(2)(3) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Statutory notifications were submitted in line with requirements. Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.
- At the time of our inspection, the service had been without a registered manager for approximately ten months. A recently appointed manager was in the process of applying for their registration with the Care Quality Commission (CQC).

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

● There had been no recent surveys or meetings for people since June 2021. We spoke with the manager who said people did not want a regular resident meeting.

● Staff meetings were held monthly. However, the provider could not be assured staff feedback was acted upon as there was no function to support this, for example an action plan.

● The manager knew people well and we observed that people felt comfortable to approach and speak with the manager during our inspection.

● Staff spoke positively about the manager. Comments from staff included, "One of the best managers I've ever had; I feel I can come in and talk about anything and she'd listen" and, "I have never seen a manager so hands on the floor. [Manager] is so open to ideas, even though I'm agency."

Continuous learning and improving care

● The manager said there had been no recent formal complaints and confirmed informal complaints were often quickly resolved with people. We asked to review the informal complaints and were told these were not recorded. This meant the provider could not be assured they were aware of the issues affecting people and act on these complaints to improve the service.

● The newly appointed manager was introducing new ways of working and had identified areas for improvement. Most recently, the majority of care plans had been reviewed and redesigned to ensure they were complete, and information was more easily accessible to staff.

● The manager told us staff had recently started working more effectively as a team. One staff member said, "It is a supportive place now."

Working in partnership with others

● The manager confirmed the service was strengthening working relationships with professionals. Staff had recently worked with a social worker and psychiatrist.

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 manager was aware of their responsibility to act openly and honestly when things went wrong.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service.

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 failed to manage and assess potential risks to people. There was an additional failure to ensure medicines were consistently managed safely. This placed people at risk of avoidable arm.

The enforcement action we took:

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