Belmont Cedar Park Limited

The Cedars Nursing Home

Inspection report

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Date of inspection visit:
27 April 2021
30 April 2021
02 June 2021
14 June 2021

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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
The Cedars Nursing Home is a care home providing personal and nursing care to for up to 40 people. At the start of the inspection 28 people aged both under and 65 years old were living at the home at the end of the inspection 26 people lived in the home. The home consists of an adapted building with a purpose-built extension.

People's experience of using this service and what we found
Risks to people's safety were not always monitored or reviewed. People told us their care needs were not met in a timely way. People were not always supported by staff who had the skills and knowledge to do so. People who needed support to eat and drink were at risk of dehydration and malnutrition as records did not clearly demonstrate that people had sufficient amounts to eat and drink. People's medicines were not always managed in a safe way. People were not protected from the risk of cross infection. Staff did not always recognise different types of abuse and how to report it. The provider could not be assured the staff group had sufficient knowledge and skills to support people.

The provider had inadequate systems in place to monitor and review the service provision. The provider had failed to sustain improvements of the service. This is the second time in two years the service has been placed into special measures. The leadership at provider level and management level within the home was unstable and lacked consistency. Staff morale was low and staff did not feel supported by the provider to fulfil their role to provide good quality care for people. The provider had hired an interim manager to oversee the service and ensure people's safety, until a permanent manager could be recruited.

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 requires improvement (19 March 2020).

Why we inspected
We received concerns in relation to standards of care and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

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 safety and the leadership of the service at this inspection. You can see what enforcement action we have taken at the end of this report.

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

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.

The Cedars 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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector on the 27, 30 April and 02 June 2021 and two inspectors and one assistant inspector on 14 June 2021.

Service and service type
The Cedars Nursing 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 however this person was not registered with the Care Quality Commission. On 14 June 2021 the manager was not in post and an interim manager had taken on this role. A registered manager 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 and professionals who work with the service. 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 all this information to plan our inspection.

During the inspection
We spoke with six people who used the service and one relative about their experience of the care provided. We spoke with 18 members of staff including the interim manager, the regional manager, the manager, deputy manager, head of care, agency nurses, agency care staff, senior care staff and care staff, a domestic assistant, an administrator and the maintenance person. The provider had appointed the manager as their nominated individual although this arrangement changed during the course of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the nominated individual during our inspection process. We observed care taking place in communal areas to help us understand the experience of people.

We reviewed a range of records. This included aspects of 14 people's care records and medication records. We looked at agency staff induction to the service and staff handover. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at information forwarded to us including staff rotas and training as well as quality assurance records.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of potential harm as associated risks were not consistently monitored or reviewed. For example, where people required a texture modified diet, staff told us, and records showed that food given to people was not in line with health care professional guidance. The provider could not be assured food offered to people was safe.
- Staff lacked direction and guidance during their shift. Staff did not fully understand their responsibilities and accountabilities. For example, we observed people did not have sufficient amounts of fluids throughout the day to keep them healthy as staff relied on one staff member to do this, without recognising shared responsibility. From care records we viewed, people were not always supported to receive their target fluid amount. One person had only received 185mls of fluid by 15:00hrs, a target fluid amount had not been calculated, however in previous records it showed the person was required to have between 1000mls to 1200mls. Where two people had a catheter, the level of urine had not increased within a five-hour period. One of these people had only output 500mls of urine within 18 hours. This put people at significant risk of harm.
- Staff had not followed the provider's policy when a person had sustained a head injury. This placed the person at potential risk of harm. We alerted the interim manager, who sought medical assistance. We also raised a safeguarding alert with the local authority.
- Where people lived with dementia or were unable to call out for help, these people did not have their basic care needs met. This included failing to support a person to reposition to prevent deterioration of a wound.
- Some people were identified as at high risk of developing skin damage. One person's care plan indicated they were cared for and supported on a special air flow mattress to manage this risk. No such mattress was in use. This was in place upon our third visit, however records failed to indicate to staff the correct air flow mattress setting for this person. It is important air flow mattresses are set correctly to effectively relieve pressure and prevent skin damage and therefore staff need to have this information and detail available to them.
- A person living with a dementia and walking with purpose was seen exiting an unsecured storage room. The room contained hazards including a trolley of cleaning materials as well as a mop and a bucket of water. Unrestricted access to these items had placed the person at risk of injury and harm.
- We saw a person transported in a wheelchair by a staff member without any footrests in place. Staff told us this was because of a shortage of wheelchairs. This was disputed by management. Transferring people without using footrests is unsafe and risks the entrapment of people's ankles and therefore potential injury.
- There was no clear clinical oversight of people's nursing needs. Checks to ensure clinical tasks were being completed as required were not undertaken. For example, we found inconsistencies with the management

of people's wound dressings, and weight loss management.
● Medicines such a topical creams and ointments were not always administered or applied safely and recorded correctly. There were gaps of up to five days in medicine administration records, during which there was no evidence of prescribed creams being applied to ensure people's healthcare needs had been met.
● When this inspection commenced medicines prescribed on an as required basis did not have protocols in place to provide guidance as to when these should be either administered or, in the case of creams, applied. This issue had been rectified when we returned on 02 June 2021.

Preventing and controlling infection
● We were not assured that the provider was admitting people safely to the service. One person was admitted into the home without any record of a recent COVID-19 test to ensure the person's test result was negative and did not risk bringing the virus into the home.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Bins were available within communal facilities around the home. Some of these were not foot operated as required. This potential cross infection risk was brought to the attention of the manager. A bin in a communal toilet was overflowing with its contents on the floor. Records to evidence cleaning had taken place in communal facilities were either not in place or not always completed. We saw replacement bins had been obtained during our inspection visit on 14 June 2021.
● A bathroom on the first floor was cluttered and contained equipment including hoists. This was highlighted in an external audit of the service in February 2021 arranged by the provider. This observation made two months prior to the inspection had not been addressed. On the final day of this inspection we brought to the attention of the deputy manager a used shaving razor located on a communal hand washing basin and toiletries stored within a bowl, on a shower and within a cupboard. There was no means of identifying who these toiletries belonged to.
● We were not assured that the provider was promoting safety through hygiene practices of the premises. Some items of furniture were damaged such as tables in lounge areas. Some frames around toilets to promote independence and mobility were rusty. This means they could not be cleaned effectively. Mattresses to protect people from falls from their bed were also ripped, which made them difficult to keep clean.
● We were not assured that the provider was preventing visitors from catching and spreading infections. COVID-19 testing was taking place prior to visitors seeing their loved ones however visitors' temperature were not always recorded. On the 14 June 2021, we saw this practice had improved.
● We were not assured that the provider was accessing testing for staff. The provider had made recent changes to the staff's weekly testing regime, and staff told us this change meant some staff missed their testing date.
● Some people needed to isolate for 14 days as set within national guidelines in place at the time. The timeframe of the isolation was on display for information and staff had additional personal protective equipment (PPE) available outside these people's bedrooms. Staff were seen to put on and remove PPE as required when assisting people who were in isolation. Hand gel was available in the reception area.

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

People were at risk of harm as their care and treatment was not provided in line with best practice. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2028 (Regulated Activities) Regulations 2014.

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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.

Systems and processes to safeguard people from the risk of abuse
● Staff did not always recognise different types of abuse or understand their individual responsibilities to prevent these. We saw examples were people's basic care needs were neglected, and people's requests for support were not responded to.
● Following our inspection visits on 02 and 14 June 2021, we raised further safeguarding alerts to the local authority due to the concerns that we observed.
● The culture within the home was not open and transparent in addressing concerns. The deputy manager told us they were not aware of the safeguarding concerns and the investigations that were underway.
● The local authority safeguarding team made us aware of several safeguarding concerns that had been raised for people living in the home. The interim manager told us they would involve the deputy manager in addressing the safeguarding concerns and would work with the local authority who investigated these.

The provider had not ensured people were always protected from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2028 (Regulated Activities) Regulations 2014.

● Some staff had recognised abuse, as we had received whistleblowing concerns from staff raising concerns regarding poor care.

Staffing and recruitment
● People were placed at risk of harm as the provider had failed to ensure staff were suitably trained to support people who required a texture modified diet, in relation to International Dysphagia Diet Standardisation Initiative (IDDSI). For example, one staff member was responsible for preparing people's thickened drinks; the staff member told us they had not received any training in this area and had not worked in care before.
● Agency staff had not been adequately inducted into the service to ensure they understood their role and responsibilities and understood the computerised system to accurately record the care given to people.
● People we spoke with commented on having to wait at times to have their care and support needs met due to the unavailability of staff when they needed assistance. Some people had a call bell available to them while other people did not, this meant those people could not request assistance.
● Throughout the day on 14 June 2021, we heard some people, who remained in bed, calling out for help; these people did not have a call bell to hand and staff were not visible in the area to respond to their calls. On one occasion, we assisted a person to reach their call bell to ring for assistance. We found that after the staff member had provided assistance, they had placed the call bell out of reach and the person continued to call out for help. We raised this with the regional manager and interim manager who expressed their concern and advised they would address this. We also raised a safeguarding alert to the local authority.
● There was a high use of agency staff, which was not managed effectively, and which caused a lack of accountability and consistency in people's care. The regional manager said, "There are enough [staff], but we don't have the quality. There is no leadership, nurses should be checking [the care staff]."
● A large number of longer standing staff had left their employment at the home over recent months. On the 14 June 2021, there was only 36 hours a week covered by permanent nursing staff for the day shifts. The rest

was staffed by agency nurses, where the majority were new to working in the service, or only worked there infrequently. Staff shared with us their concerns of the high turnover of staff and was expecting more staff would leave in the future.

● 50% of care staff scheduled to work were agency staff; the majority of these had only worked a few shifts at the home. The majority of permanent care staff, with the exception of five senior care staff, had worked in the home between one and three months. A senior carer told us they did not know why they unable to retain the newer care staff.

● On 11 June 2021, the nominated individual gave us assurances that sufficient staff would be working in the home over the weekend period. However, a staff member told us that on Sunday 13 June 2021, they only had four care staff, when there should have been eight, as staff did not arrive for their shift that afternoon.

The provider did not have suitably qualified, competent, skilled and experienced staff in place. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people we spoke with were complimentary about the staff working at the home. One person described the staff as "very nice".

● Following the inspection the interim manager advised they were looking to stabilise the staff team, and create a core group of agency staff, to bring consistency of care, until a full permanent staff team could be recruited and trained.

● The nominated individual told us they had hired an experienced staff member to provide training and undertake competency checks for the staff team. This person commenced employment after our visits.

Learning lessons when things go wrong

● The concerns we identified on this inspection are of a similar theme to the concerns we identified in July 2019. The management team were unable to demonstrate how they had taken learning from that inspection to improve the safety of people living in the home.

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 requires improvement. At this inspection this key question has now deteriorated 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; Working in partnership with others

- This service was removed from special measures following the inspection in February 2020, however, the provider had failed to further improve the quality of care, or sustain improvements.
- The management of the service had been inconsistent since the July 2019 inspection when the service was rated inadequate. There had been seven managers in post during this time. The most recent manager, being an interim manager, who started work on 14 June 2021 and was employed to support the home temporarily until a permanent manager can be recruited.
- There was no registered manager in post, as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no application in process for a manager to apply to become registered.
- There had been six different Nominated Individuals since the July 2019 inspection, with the most recent Nominated Individual only being in place since May 2021.
- The governance and oversight of the service was inadequate and had not ensured the service provided safe care and treatment for people.
- The provider had recruited a regional manager in March 2021, however they had not visited the service until 14 June 2021, or made any checks of the service provision. Therefore, opportunities to identify and drive forward improvements to benefit people could have been missed.
- The provider had engaged a company to carry out a 'mock inspection'. This found the provider to require improvement. Although shortfalls had been identified these were not acted upon by the provider.
- The local authority and Clinical Commissioning Group (CCG) were working with the manager to address the quality of the care within the home. The agencies found between May 2021 to June 2021 there had been no improvement to the standard of care. However, since the arrival of the interim manager, improvements in meeting people's basic care needs had been made
- The provider's Statement of Purpose giving guidance and information about the service provided was incorrect. Information regarding the management arrangements was out of date by over two years. We had not received an updated statement of purpose at the time of writing this report.

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

- Engagement with people, staff and families was poor. The provider could not demonstrate how people and staff had been involved in the running of service.

● Staff morale had declined, and many staff we spoke with raised concern for the future of the home. One staff member said, "The interim manager seems good, but we've heard it all before."
● Staff told us they felt unsupported by the provider. One staff member said, "When the consultancy service left in January [2021] we were left with nothing. There were promises of better support and training, but that didn't happen."

The provider had not maintained or sustained systems and processes to monitor and improve the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 nominated individual was open and honest and acknowledged our concerns for people's quality of care at the home. We acknowledged they were putting measures in place to address this, such as hiring an interim manager to support the home and drive improvement, along with recruiting a staff member to provide training and competency checks.
● Following our inspection, the interim manager provided us with updates about the improvements being made to people's care.
● The rating from the previous inspection was on display at the home as required. Information regarding the rating on the provider's web site was not clear prior to our inspection. We brought this to the attention of the manager and improvements were made before our second day at the home.

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 Staff did not recognise all types of abuse and how to report this. People were exposed to neglect.

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 People's care and welfare needs were not met. Staff lacked the skills and knowledge to support people safely. Agency staff usage was high, which brought inconsistency in people's care and treatment.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was inadequate governance and leadership, which impacted on the safe care and treatment of people who used the service.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training and support to forfill their role.

The enforcement action we took:

Cancellation of registration