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

Summary of findings

Overall summary

About the service
Conifer Lodge residential care home providing personal care and accommodation for up to 20 older people. There were 17 people living at the service at the time of our inspection.

People's experience of using this service and what we found
People could not be assured they would receive safe care. Measures were not in place to protect people from falls from height, scalds and falling furniture. Incidents that occurred within the service were not always reported to the appropriate authorities including the Care Quality Commission.

People's safety and well-being were at risk. The provider and registered manager failed to make the required environmental improvements identified during our previous inspection. They failed to identify further risks to people from the environment that were found during this inspection.

The provider and registered manager did not have effective systems and process in place to safely monitor the service.

People's care needs were not always assessed and risks to their health were not always safely monitored.

People were at risk of infection and medicines were not managed safely.

Staff did not receive effective support and guidance from the provider or registered manager.

People and their relatives were provided with little opportunity to share their views of the service. People's personal information was not securely stored.

Staff were kind and considerate to people and treated them with respect.

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.

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 requires improvement (published 22 November 2018) and there were two 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 we found not enough improvement had been made and the provider remained in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to the safety, security and suitability of the environment, managing people's medicines, and assessing and reviewing people's care needs.

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 and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
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.

Inspection team
The inspection was carried out by one inspector over three days.

Service and service type
Conifer Lodge Residential Home is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, the registered manager from the providers other service, care workers and a member of the kitchen staff.

We reviewed a range of records. This included three people's care and medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also looked at training data. We contacted the fire service to discuss our findings and request a fire audit of the premises.

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.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not protected from the risk of avoidable harm because the environment was not safely managed. We found several wardrobe and radiator covers were not secured to walls. One bedroom did not have a radiator cover, and two bedrooms had no window restrictors fitted. This put people at risk of harm from toppling furniture, scalding and falls from height.
● People had unrestricted access to rooms which posed risks to their safety including a mains electrical cupboard, linen room and a food stock room. A disused toilet was unlocked containing an old bed. There was no emergency pull cord and the handrail and cistern lid were broken. We raised this with the provider on the first day of inspection.
● The patio area in the garden was slippery and unsafe. We were informed this area was not used during the time of the year we inspected. However, the patio door lock was broken, and could not be secured. This meant people had access to the area and were at risk of injury.
● People's risks were not always assessed or reviewed when their needs changed. For example, one person who had been at the service for three weeks at the time of our inspection had no care plan or risk assessment in place. Staff told us they were unaware of the person's needs. One staff member told us, "I don't know [named person] well. I am getting to know them day by day." This meant there was no advice or guidance for staff on how to provide safe care to this person and protect them from harm.
● Whilst a fire risk assessment was in place this had not been updated for four years. Staff were not trained to use the fire alarm system and following mock evacuations of the premises there were no recordings to demonstrate their effectiveness. This meant there could be delays to people being evacuated safely from the service in a timely manner.
● Notwithstanding our findings, people told us they felt safe. One person told us, "I get the care I need, and I am safe. I trust the staff." One relative told us, "I feel my [named relative] is safe."

Using medicines safely
● Medicines were not always safely managed. For example, one person's administration record stated there

should be 10 tablets in stock. We checked the stock and found there were 11. This meant the person did not receive their medicines as prescribed on one day.
● Records to monitor people's diabetes were inconsistent. Charts to record blood sugar levels had not always been completed. One person's record showed on one day the level had been taken twice daily and on two other days only once. The week prior to our inspection the level had not been recorded for two days. Staff could not explain this pattern of recording. The registered manager from the sister service told us they would immediately review the persons care plan.
● Systems and processes for disposal of medicines were not followed. During our inspection we found one medicine identified for disposal had not been recorded in line with best practice, or securely stored away.
● Audits we reviewed did not identify the shortfalls found during the inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the environment and medicines were safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse because the systems and processes in place were not effective. The registered manager had not reported two incidents to CQC and the local authority safeguarding team as required. One person had been administered medicines for four days against medical advice, and another person had fallen causing an injury to their head. These incidents were reported following our inspection.
● Staff had received training to recognise the signs of abuse. Whilst they knew their responsibility to report concerns they were not confident action would always be taken if they reported these to the management team.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safeguarding procedures were safely managed. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding Service Users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not always protected from the risk of infection. We found a used hairbrush in one corridor and one toilet required cleaning. Shower heads had not been descaled and in one bathroom the drain needed replacing as it was rusting.
● One relative told us, "On two occasions when I have visited there was no hand wash in the visitor's toilet."
● We requested cleaning records however, they were not provided to us during the inspection.
● Staff were observed to be wearing personal protective equipment when carrying out personal care.

Learning lessons when things go wrong
● Lessons were not learnt and appropriate action was not taken to reduce risks to people when things went wrong. During the previous two inspections of the service concerns were raised over the safety and management of the environment. The provider could not demonstrate these had been fully addressed during this inspection, and where action had been taken this had not been embedded. For example, whilst some wardrobes had been secured to walls some had not. This meant the provider did not recognise the importance of making improvements required in a timely way and people remained at risk from avoidable harm.
● Staff understood their responsibilities to report accident and incidents to the registered manager but

opportunities to learn from these were sometimes missed. For example, following a fall one person's care plan and risk assessment had not been reviewed. This meant the person continued to be at risk from further falls,

● A number of staff told us they had not been informed about incidents during handovers that occurred during previous shifts. When we reviewed handover logs we found these did not reflect events accurately. One person who was being administered regular pain relief following a fall was described in the log as 'fine'.

Staffing and recruitment

● There were enough staff to meet people's needs. Rotas confirmed a consistent level of staff were routinely deployed. Staff responded to calls bells in a timely way during our inspection.

● Safe recruitment practices were followed. Staff files contained all the necessary pre-employment checks to assure the provider that they had employed appropriate staff at the service.

● Employees' Disclosure and Barring Service (DBS) status had been checked. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The service did not always work in partnership with health care professionals to maintain people's health. One person who had fallen was reported to be 'sleepy and 'very sleepy' for the two days following the incident. The service failed to identify the person may have had a head injury. No action was taken to seek further advice from a healthcare professional.
- Records showed one person to be in pain for four days following a fall. We advised the provider to contact the GP during our inspection and the person was prescribed additional pain relief. This meant the person's pain was prolonged unnecessarily.
- During the inspection the registered manager from the sister service informed the inspection people had not been referred for nail care treatment for a year. This put people at risk of infection and discomfort. Following the inspection, a referral was made to a chiropodist where 14 people were identified as requiring treatment.
- People's needs were not always fully assessed prior to moving to the home and did not include enough information to inform care plans and risk assessments. Staff were not always aware of people's needs when they moved to the service. This meant the service may not be able to meet people's needs safely.
- Care plans were not consistently reviewed to reflect people's changing needs. One person was assessed to need additional support with eating and drinking however, their care plan did not reflect this change.
- Staff held mixed views on their knowledge of people's needs. Two staff told us they did not know people's needs well and one said they did. This meant people may not always receive the care and support they need.

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

- Bedrooms doors did not always display signage for people to identify their own rooms. One bedroom was next to the linen room. These doors could not be distinguished between which room was which, and they were both unlocked.
- The dining area could only seat thirteen people despite their being eighteen people at the service.
- Signage was displayed informing staff it was their 'responsibility to check every door and window was locked'. However, we found numerous doors and windows unlocked during the inspection. This meant the process for ensuring the security of the service was ineffective.
- No plans were in place for any improvements to the design and décor of the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure the premises were secure and suitable to meet the needs of people living with dementia. This placed people at risk of harm . This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's bedrooms were personalised to their choosing.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not have a choice of meals. On the day of our inspection the only option for the lunchtime meal was 'lasagne, fries and garlic bread' and, 'rhubarb crumble and custard'. We were informed the menu would be reviewed to provide people with alternatives.
● Menus were not displayed in communal areas and not available in other formats for example, pictorial form.
● People's nutritional needs were met, and they appeared to be well nourished. People had access to drinks and snacks throughout the day.

Staff support: induction, training, skills and experience
● Staff received an induction and mandatory training, however, there were no systems in place to observe and provide regular feedback to staff regarding their performance.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff had undertaken training about the MCA and understood the principles of this legislation and how to apply it their role. For example, staff sought people's permission before care and support was offered. Staff took time to explain to people what they were doing and why.
● Systems were in place to identify people who required a DoLS assessment and appropriate applications were made.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always well-supported, but staff were caring and treated people with respect.

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

- Plans of care did not always reflect the current needs of people, and staff were sometimes wholly reliant on each other to share their knowledge to support people. This meant people may not always be treated and supported consistently.
- People were supported by staff with kind and compassionate care. Numerous interactions we observed confirmed this. One staff member told us, "I treat people like I do my parents." One resident likes to be called by their preferred name. I always make sure I do that." However, another staff member told us, "I feel most staff genuinely care whilst some are just here for the money."
- We saw staff spending time with people in the communal areas. One staff member said, "I get time to have a sit and chat with people." However, another staff member said they did not always have time.
- One person told us, "I am well looked after, staff are very helpful and know what they are doing." One relative told us, "I visit daily, and I feel the staff love the residents."
- People were encouraged to make day to day decisions regarding their care. Staff were patient with people, so their decisions could be communicated and understood.

Respecting and promoting people's privacy, dignity and independence

- Confidential information was stored in filing cabinets that could not be secured. This meant there was a risk to people's personal data being breached as unauthorised persons could gain access to it.
- Staff protected people's confidentiality. Conversations held with people, and between staff were discreet.
- People and relatives told us their privacy and dignity were upheld. One person told us, "Staff always make sure bedroom and toilet doors are closed." One relative told us, "Staff are very mindful of dignity when supporting my [family member]."
- Visitors were warmly welcomed to the service and could attend at times convenient to them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were not always developed in a timely way when people moved to the service or routinely reviewed when people's needs changed. This meant staff were not fully informed of people's needs to provide consistent care and support. For example, one person who had moved to the service three weeks prior to our inspection had no care plan or risk assessment in place.
- Whilst relatives we spoke with felt they were involved in their family members day to day care, people's care records did not always reflect their views.
- Staff provided personalised care respecting people's known wishes and preferred routines and choices.

Improving care quality in response to complaints or concerns

- Informal complaints were not always followed up. One relative told us, "I have pointed out the light is broken outside of the main entrance. There is a low wall there and I have nearly fallen over it on one occasion, but it hasn't been fixed yet."
- A complaints procedure was openly displayed, and no formal complaints had been received prior to our inspection.
- We saw relatives had made compliments how their loved ones had been cared for whilst living at the service.

End of life care and support

- Where people were being cared for at the end of their life; a care plan was in place. People's end of life wishes had been recorded. However, these were not always updated as people's needs changed. One person's record showed they needed increased support with their food and fluid intake, but their plan had not been updated to reflect this.
- Staff were attentive and compassionate to people, and their relatives whilst caring for people at the end of their life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service was not aware of the AIS. However, people were supported with their communication needs, and plans of care reflected these.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Activities were regularly held at the service. On the day of our inspection there was a 'sing a long' taking place. People were enjoying themselves and staff joined in. Where people did not wish to participate their choice not to was respected.

● People were following their own interests. One person was listening to their music and another person were reading daily newspapers.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to have robust systems in place to assess, monitor and improve the health and safety of people using the home. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 (Good Governance)

● There were significant shortfalls in the leadership and management of the service. The provider and registered manager failed to make the required improvements to ensure people received a safe service.
● Where the provider had made some improvements following our previous inspection, these were not sustained. For example, a commitment was made to carry out monthly maintenance checks, and six-monthly audits to the safety of the environment. However, the last recorded check was over three months prior to the inspection and a six-month audit was not undertaken.
● We identified further environmental safety concerns during this inspection and neither the provider nor registered manager were aware of these. This meant the risk to people's health and welfare had increased following our last inspection.
● People were at risk of not receiving safe care. The provider failed to ensure a robust process was in place to assess people's needs prior to moving to the service. Staff told us they were unaware of some people's needs placing them at risk of unsafe care and treatment being delivered.
● Staff were not provided with clear guidelines on how to support people. For example, care plans were not always reviewed, and one person had no care plan or risk assessments in place.
● People's changing needs were at risk of not being met. Daily notes were not detailed, and handover documentation provided little information to staff of incidents from each shift.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The provider did not have adequate systems and processes in place to support staff in their role.
● Staff were not always given opportunity to share their concerns and did not always feel listened to. When they did action was not taken. For example, one staff member told us a handrail in one person's bedroom

was broken. They said it had been reported numerous times by them, and the persons relative, but had not been repaired. This placed the person at risk from falling. When we informed the provider, they took immediate action to repair the handrail.
● Staff told us they did not always receive supervisions. One staff member told us, "I cannot remember the last time I had a supervision."
● Staff morale was low. One staff member told us, "We [staff] are just left to our own devices. There's no structure in the home." Another said, "I dread coming here and other staff have said they are not happy too."
● People could not always share their views of the service. Resident and relative meetings were not held. Surveys were not routinely undertaken and when they were, comments were not followed up or the results displayed. One comment stated, 'I am not always told when health professionals visit my [family member], and laundry is always left in passageways.' There was no evidence action was taken or a response to the complainant was provided.
● There was no process in place to respond to people's informal complaints and feedback from surveys. This meant the provider could not demonstrate whether action had been taken to address these.

The registered manager and provider failed to ensure there were effective systems and processes in place to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm . This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

● The registered manager did not demonstrate they had the capability and competence to carry out their role effectively. They instead relied on the registered manager from the providers sister service, and the provider to facilitate most of the inspection.

This is a breach of Regulation 7 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Requirements relating to registered managers.

● The provider informed us during the inspection they would make changes to the management of the service. The registered manager from the providers sister service agreed to immediately manage the service alongside the current registered manager. They told us they intended to make an application to become the joint registered manager of the service. We felt confident that this manager had the necessary skills and competence to bring about the improvements to the service in a timely way.
● We did find the provider and registered manager open, honest and transparent throughout the inspection and told us they understood the significant improvements needed to ensure the service became compliant with CQC's regulations.

● The provider and registered manager had failed to notify CQC and the local authority of two incidents that could indicate abuse or improper treatment of people at the service.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Notification of other incidents.

Continuous learning and improving care
● The provider and registered manager had failed to act effectively to address previous failings. There were no plans in place that demonstrated the importance of making improvements to the service which meant the shortfalls in the service were not being addressed.

Working in partnership with others

● The provider and registered manager failed to work collaboratively with other agencies including health professionals. Whilst they sought guidance and recommendations initially agencies were not subsequently consulted with to ensure people's changing needs were safely monitored.

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 and registered manager told us they understood, and would act on, their duty of candour responsibility.

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons did not always notify the appropriate authorities of incidents that occurred in the service .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons did not ensure the premises were secured or always suitable to meet the needs of people living there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not have the necessary skills, competence and experience to manage the service safely.

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 registered persons did not ensure the environment and administration of medicines were safe to protect people's health and safety. Systems were not in place to protect people from abuse and the risk of infection.

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 The registered persons did not ensure systems and processes were effective to monitor the risks to people's health and well being, improve the quality and safety of the service, and securely store people's records.

The enforcement action we took:

Warning Notice.