Martin Jay & Joanna Jay & Thom Wight

Cherry Lodge

Inspection report

23-24 Lyndhurst Road
Lowestoft
Suffolk
NR32 4PD

Tel: 01502560165

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Cherry Lodge is a residential care home providing accommodation and personal care to up to 27 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 24 people using the service.

The service is spread across a ground, first and second floor, and a passenger lift was in place to access each of the floors. There were communal areas that people could access, including a lounge and dining areas.

People's experience of using this service and what we found
Actions to identify, investigate and report allegations of abuse were not sufficient. Incidents which indicated abuse had occurred had not been reported to the local authority safeguarding team. Reportable incidents had not always been referred appropriately to ensure external scrutiny of the home.

Risks to people were not robustly assessed and mitigated. Staff did not always have the information they needed to provide safe care because risks associated with people's care had not always been fully assessed. This included risks relating to falls, diabetes, behaviours of distress, and choking.

Improvements were needed to infection control practices in some areas of the service. Staff were observed to wear appropriate personal protective equipment (PPE) but disposal of this was not always in line with best practice to reduce the risk of infection.

Records did not reflect staffing numbers were adequate at all times, including in the event of an emergency. Staff received training relevant to their roles, but we were not assured that were applying the learning in the delivery of care. There was no system in place to check this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The system in place for recording people's nutritional intake did not support the staff to clearly monitor what people had eaten daily, including any snacks to encourage weight gain. Some referrals to specialist teams such as falls prevention and dementia support had not been promptly actioned.

The provider had not considered best practice for creating dementia friendly environments and we have made a recommendation about this.

Governance systems were not robust. The service was not using governance processes effectively to learn lessons or improve the service. The inspection identified six breaches of regulation as systems and processes were either not in place, or not robust enough, to ensure people's care needs were identified and

people received safe care and treatment.

Medicines were managed safely, and staff were recruited with suitable checks in place.

We observed caring interactions between staff and people. Staff told us they were very fond of and cared about the people at the home. Staff knew people well and had established positive relationships with them. Feedback from 9 people using the service confirmed that they felt positive about staff and comfortable with them.

The registered manager and provider were responsive to the inspection findings and feedback and took some action after the inspection for the more urgent concerns identified. However, there were many on-going improvements which will need to be made to ensure people receive a safe and effective service.

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 6 March 2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service was alleged to have been a victim of abuse. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of abuse. This inspection examined those risks.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'All inspection reports and timeline' link for Cherry Lodge on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding procedures, management of risk, staffing, consent, governance and reporting procedures.

We imposed conditions on the provider's registration, which means we receive monthly data and action plans from the provider to assess if improvements are being made in a timely manner.

Follow up
We will request an action plan from 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 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? 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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cherry 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
Two inspectors and 2 Experts by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

At the time of our inspection there were 2 registered managers in post, 1 of whom was the provider.

Notice of inspection
This inspection was unannounced.

What we did before the 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
We spoke with 9 people who used the service and 1 relative. We observed the interactions between staff and people using the service. We reviewed the care records of 5 people who used the service and multiple medicines records. We reviewed 3 recruitment records. We spoke with 8 members of staff including the provider who was also a registered manager, registered manager, 2 senior staff, 2 care staff, the cook and 1 housekeeping staff.

Following the inspection, we reviewed records relating to the governance of the service, including incidents and accidents, training records, and audits. We also received feedback from a further 5 relatives, and 3 staff, which included care and senior care staff.

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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- Safeguarding processes had not been established to protect people from the risk of abuse. Systems to identify, investigate and report allegations of abuse or neglect were not sufficient.
- The local safeguarding team had not been made aware of a number of incidents. Failing to notify relevant authorities means the opportunity for external scrutiny and support to the service was not actioned. Therefore not all practical steps had been taken to mitigate risks of harm to people using the service.
- Staff were not aware of their individual responsibilities to prevent, identify and report abuse.
- Because reporting procedures were not robust, there was a lack of oversight to demonstrate incidents were reviewed promptly to ensure lessons were learnt.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection
- The risks to people's health, safety and welfare had not always been assessed.
- No assessment had been carried out by the provider to test if staffing numbers could cope with an evacuation during the night. There were personal emergency evacuation plans in place. However they did not demonstrate safe evacuation would be possible given the number of staff on duty at night, the layout of the building and the number of people who needed support to move. We asked the fire service to visit, and they advised of some deficiencies which the service has 6 months to comply with.
- Where people had diabetes, there was no information recorded which demonstrated the warning signs and indicators of a person becoming unwell due to their condition and actions staff were to take. This was also the case for people who were at risk of choking; there was limited information about the signs and indicators of a person choking and actions staff should take.
- Where people experienced periods of distress, risk assessments were not in place to guide staff in how they should support people at these times.
- Where people were at high risk of falls, care plans and risk assessments were not in place which demonstrated how risks could be minimised and monitored. Monthly falls data did not include all falls which had occurred or the actions to take to prevent further falls. Where there was information for staff it was minimal and lacked detail. For example, 'regular checks'.
- Where people were at risk of weight loss, food charts did not always show that additional calorie intake, such as snacks, were being provided. Fluid charts were poorly completed. The provider could not demonstrate people were sufficiently hydrated as records were not complete.
- The home was found to be mostly clean in communal lounges and bathrooms on the days of our

inspection, however we found the main kitchen was unclean with debris on shelving and under cutlery storage. Fridge seals were visibly unclean, opened food was not always dated and we found some out of date food in the fridge.
● Staff were not always disposing of used personal protective equipment (PPE) safely in the correct waste stream. Some clinal waste bins were not foot operated as these had broken. This increases the risk of cross contamination.
● We could not be assured that the provider had taken prompt action to rectify electrical work deemed as needing urgent attention in June 2023. Whilst evidence was provided to show urgent work had been completed, this was 6 months after it had been identified as a risk. No evidence was provided to show other work requiring further investigation or recommendations for improvement had been carried out.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to the seriousness of our findings, we asked the registered manager to implement risk assessments within 24 hours, and they completed this.
● There were fire safety checks to ensure fire-fighting equipment and emergency lighting/escape routes were safe.
● There were checks in place to ensure safe water systems to prevent legionella bacteria, however, staff had failed to check cold water temperatures correctly in line with Health and Safety Executive (HSE) guidance. We brought this to the attention of the registered manager who promptly addressed the issue.

Staffing and recruitment
● We could not be assured that staff deployed were sufficiently skilled to identify, report and act on concerns they may encounter in their day to day work in supporting people.
● Staff has been provided with training in how to report concerns about people's safety to the appropriate professionals. They, and the registered manager, had failed to use the knowledge from the training to make referrals to the local authority safeguarding team and protect service users.
● There was no evidence to show that staff's understanding and competency was assessed by the registered manager following training. The provider had not ensured that staff training programmes were embedded and that this was reflected in the way staff provided people with care and support.
● We noted shortfalls in staff applying training and knowledge in relation to safeguarding, assessment of mental capacity, record keeping, and risk.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with told us they felt that staffing was adequate most of the time with some room for improvement. One person said, "Sometimes there are more staff than others. But I don't wait to get help, the staff manage their time very well." Another said, "One more [staff] might be good but if I want anything I just ask and they come and sort me out. I've never used my call bell. I will say this, the staff manage their shifts very well."
● Staff were recruited safely and Disclosure and Barring Service checks (DBS) were in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● There were systems in place for the safe storage, administration and management of medicines.

● Records demonstrated people received their medicines as required.
● Staff who were responsible for administering medicines were trained and their competency checked. We observed part of the lunch medicines round and found this was done safely by the allocated staff member.

Visiting in care homes
● There were no restrictions on visiting and the provider was working within current government guidance. Relatives we spoke with confirmed they were able to visit their loved ones as they wished. One relative told us, "I visit regularly. There are no restrictions I'm aware of."

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Care records did not always include capacity assessments on each area of people's care where they needed assistance with making decisions, for example with medicines, or sensor mats which enable staff to monitor people's movements.
● In addition, there were no capacity assessments or best interest decisions in relation to the close observation of people to ensure the care being delivered was the least restrictive and in line with the MCA.
● Staff had received training in MCA and DoLS, but our findings indicate there were significant gaps in knowledge.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had made applications for DoLS. However, we asked the registered manager to review other people living in the service who may require a DoLS due to their high-level needs.

Adapting service, design, decoration to meet people's needs
● We noted the service was in need of redecoration where paint had become worn and chipped. New flooring had recently been laid in the communal areas. The October 2023 newsletter advised people that once the flooring was laid, the maintenance staff would start on redecoration.

● The provider had not considered good practice relating to positive environments for people living with dementia, such as designing and decorating premises in a way that supports people. For example, doors, seats, and handrails being in a contrasting colour.

We recommend that the provider consider best practice for creating dementia friendly environments.

● People's private bedrooms contained their personal items including memorabilia, which reflected their choice and individuality.
● The service, including communal spaces were accessible to people using the service, such as those who used equipment to mobilise.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Best practice guidance was not always referred to or used to increase the effectiveness of people's care and protected characteristics. This included best practice guidance for people living with dementia and relating to specific health conditions such as diabetes.
● Staff did not always make prompt referrals to people's health professionals when there were concerns about a person's physical and mental wellbeing deteriorating. Referrals to specialist falls and dementia support teams were not made promptly to ensure people's needs were fully assessed and risks reduced.
● The GP visited the home, however, people's records did not always show the date of the visit or the professional guidance given to manage peoples care needs.
● Staff meeting minutes from April 2023 showed staff were informed to ensure people were supported with their oral health as required, including mouth and denture care. The registered manager showed us evidence that a local dentist was planning to visit the service to give advice on oral health.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care plans and risk assessments relating to consistency of food and drinks were sometimes contradictory.
● Speech and language team (SALT) guidance relating to consistency of one person's food could not be located at the time of our inspection and had not been uploaded into the person's care records which poses a risk that the person might receive incorrect food types. This was addressed following our visit.
● people's food and fluid charts id not fully identify how much people had eaten to reduce any assessed risks relating to dehydration and malnutrition.
● People told us they got enough to eat and drink. We observed people had access to drink, meals and snacks throughout our inspection visit.

Staff support: induction, training, skills and experience
● Staff told us they received the training they needed to meet people's needs. This was confirmed in records. However, we were concerned that due to the shortfalls identified in this inspection, such as safeguarding people from potential and actual abuse, significant improvements were needed in the monitoring of staff's understanding of the training received and how they used this in their practice.
● The local authority were planning additional training for managers and staff in safeguarding, and record keeping.
● Staff we spoke with confirmed that they received an induction when they started working in the service, which incorporated The Care Certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- Systems and processes did not effectively monitor quality or keep people safe. The provider could not demonstrate how they were assured people recieved well-managed good quality care which minimised poor care and risk of harm as far as possible. As a result the provider missed opportunities to learn from incidents and accidents to improve overall.
- The quality audit system consisted of tick boxes and did not identify what evidence had been reviewed, learned from and used to improve the service. Where concerns were identified there were no timeframes to manage risks. For example, environmental safety risks were not addressed with urgency.
- Staff did not maintain accurate and complete care records including monitoring people's needs. Risk assessments and care plans did not contain detail to demonstrate care was being provided consistently and in people's best interests. Mental Capacity Act records did not adhere to associated legislation. The care records did not guide staff in the current best practice guidelines for providing support to people.
- Although staff told us they had team meetings and we saw the minutes, improvements were needed to ensure communications were clear, understood and all staff had appropriate support to speak up when they had concerns.
- Staff told us they did not always feel supported to raise concerns. Information received did not always demonstrate an open supportive team culture where people felt able to discuss their work and raise queries.
- The provider's whistleblowing procedure did not guide staff on their role and responsibilities and how they would be supported if they raised concerns of poor practice.
- Despite providing training, the provider failed to ensure it was being put into practice, was understood and being actioned by all staff. More robust oversight in relation to staff training and competency was required. This included safeguarding people from harm and timely reporting to external agencies.

This was a breach of regulation 17 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 registered manager had not reported to CQC all incidents as required by law.

We are looking at potential failures to notify and will report on our findings once completed. These potential failures are subject to further investigation by CQC as to whether any regulatory action should be taken.

● The provider had a duty of candour policy and procedure in place, but this was very brief in content. The registered manager did not demonstrate they understood the requirements of the duty of candour.
● Whilst most people's relatives told us they felt they were informed of incidents, we found there had been a delay in informing some relatives following recent incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider produced a newsletter for people living at the service and their relatives. This identified how views were being listened to. Suggestions had been made from a resident meeting in September 2023. People were asked for their views about the service in satisfaction questionnaires.
● Despite the shortfalls in this report, people we spoke with were happy with their care and felt safe with staff who supported them. The majority of relatives told us they felt involved with their relatives care and were welcomed into the home by staff they knew well.

Working in partnership with others
● The provider had not always worked in partnership with others, for example, reporting procedures were poor and incidents affecting people's safety had gone unreported. However, the service had accepted support offered from the local authority following their visits to drive improvement. This included plans for training and workshops for staff in areas such as recording, and safeguarding.
● A staff member told us how the service had good relationships with others involved in people's care, including health care professionals. They also said they were re-developing community relationships, such as a local public house, where people had attended for meals pre-pandemic.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not working in line with the Mental Capacity Act 2005, to ensure people's care was lawful. Mental capacity assessments and best interest decisions were not always in place. 11 (1)

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the CQC of reportable incidents. 18 (1)

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to people's care were not always sufficiently detailed or managed. Infection control procedures required improvement, including disposal of PPE. 12 (1) (2) (a) (b) (h)

The enforcement action we took:

Impose conditions

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 Safeguarding incidents had not always been identified or reported. We were not assured staff were reporting concerns. Actions had not been taken promptly to mitigate risks relating to sexual safety. 13 (1) (2) (3)

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's oversight and monitoring systems and processes were not robust and failed to appropriately manage risks to people. Accurate, complete and contemporaneous records were not reliably maintained. 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We could not be assured that staffing numbers were adequate as the calculation for this had not been correctly assessed. The layout of the building had not been considered which further impacted staff numbers. 18 (1)

The enforcement action we took:

Impose conditions