Gospel Standard Bethesda Fund

Studley Bethesda Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Studley Bethesda Home is a residential care home providing personal care to 7 people aged 65 and over at the time of the inspection. The service can support up to 13 people in one adapted building.

People's experience of using this service and what we found

During this inspection, we identified breaches in relation to safe care and treatment, person centred care, safeguarding and good governance. We also made a recommendation about the management of some medicines.

People were not protected from risk of abuse. Unexplained injuries were not consistently investigated. Some staff felt that the registered manager did not take concerns raised about unexplained injuries seriously.

Risk to people was not always assessed and managed in a way that kept people safe from harm. The safety of the environment was not always considered as people's needs became more complex. Accidents and incidents were not investigated robustly and actions to reduce future risk to people were not always implemented.

People received their medicines as prescribed, however medicines were not always stored safely.

We were not assured that staffing levels were sufficient to meet people's needs overnight. Recruitment checks for staff were completed appropriately.

Care practices did not always promote people's choice and dignity. We observed that some aspects of care in the home followed a task led approach rather than a person-centred approach.

Peoples changing needs were not always considered when supporting them with social and spiritual activities.

The staff team at the home were divided, some staff spoke of a closed culture which impacted people's safety and wellbeing.

The registered manager did not always manage quality assurance and their regulatory responsibilities appropriately. Quality assurance systems had not identified the concerns we found as part of this inspection.

The service worked collaboratively with other healthcare professionals to promote good health outcomes for people. The registered manager managed complaints and compliments appropriately.

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 Good (14 March 2018).

Why we inspected

We received concerns in relation to risk management and support for people living with dementia. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end 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 safe care and treatment, person centred care and good governance.

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

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 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 always well-led. Details are in our well-Led findings below.	**Inadequate**

Studley Bethesda Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Studley Bethesda 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed the information we had received about this service since the last inspection, this included feedback from staff and statutory notifications. 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.

During the inspection-

We reviewed four care plans, medicines records, staff files and other documents relating to people's care and the management of the service.
We spoke with one person living at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to review documents relating to people's care and management of the service away from the home. We spoke to seven members of staff including care staff and the registered manager. We spoke to two relatives of people living at the home.

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 good. At this inspection this key question has now deteriorated 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

•People were not always protected from risk of abuse. We saw three people had unexplained injuries recorded however there was no record of the action taken by the registered manager to ascertain the cause of these injuries.
•Two people had repeated injuries of a similar nature around their hands, wrists and forearms. There had been no action taken by the registered manager to assess if these injuries were related in cause.
•Another person had had seven entries on their body map from 10 to 22 August 2021. These injuries included red mark on upper back, sore area on right cheek, scratch marks inner thigh, and sores to left and right groin. There were no investigations into how these marks were sustained.
•Staff told us that they noticed marks on people but were not told how they had happened. One staff member said, "I come back in and people have bruises and I don't know how that happened, other staff don't complete the paperwork, it's not looked at". We asked staff if they raised these concerns with the registered manager and were told, "We put it on body maps, handover and tell the registered manager about the bruises, but she dismisses it and says she does come out in bruises, its gobsmacks me, if that was my mother."
•Some staff members told us staff did not always listen to people's choices or respond appropriately when people were in distress. "[Person's name] thinks someone is shouting at her, [staff member] takes them all into the lounge, shuts the door, it doesn't matter how much [person] screams and shouts, she will not let her out. She just goes over and tells them that they need to listen."
•We shared these concerns with the area manager; they are currently investigating these allegations.
•We received three whistle-blowing concerns prior to this inspection and staff continued to raise their concerns with us during this inspection. Some staff told us they felt frustrated that the registered manager did not listen to their concerns to make people safe and told us they felt singled out as causing conflict. One staff told us, "We have gone to the manager and she dismisses it, nothing happens."

Failure to have effective systems in place to investigate potential abuse was a breach of Regulation 13

Assessing risk, safety monitoring and management
•Risk to people was not assessed and managed in ways that kept people safe from harm. We saw one person who was identified in their risk assessment to be at risk of falling on the stairs, their care plan indicated they did not have capacity to manage this risk independently. When we inspected the service there was no lock on the door to the stairs or any other preventative measures in place to prevent this person from falling on the stairs.
•We raised this concern with the registered manager, who told us they had placed a sign on the door to

remind staff to keep this door closed and they believed the weight of this door was a sufficient deterrent to this person. The registered manager informed us that a lock has been fitted following our inspection.
•The same person was at risk from leaving the service without staff knowledge. It was recorded that this person had been previously been found outside or leaving the home twice, however some staff told us it had happened more often than this. The service had recently activated an alarm on the fire door so that staff would be aware if this person left the service, however staff told us that this was difficult to manage due to often supporting another person when the alarm sounds.
•During our inspection, the kitchen was not locked and was accessible to anybody living in the service. There were no staff in the kitchen or adjoining dining room at the time. This put people who were living with dementia at risk of injury from sharps or scalding. Staff told us they had previously found an individual living at the service in the kitchen, without staff support, attempting to lift heavy objects such as a microwave. The unlocked kitchen also increased the risk of poor food hygiene. Staff told us there had been several times where a person living at the service had 'interfered' with food products, this included spooning compost from plants into sugar bowls, or touching food that was to be served to others living at the service.
•Some staff told us they were concerned by the risks to people. One staff said, "Because [person's name] has an issue going into kitchen at night and there have been incidents. I am alone and raised concerns and I have been made to feel uncomfortable about raising concerns. They [management] said we have never had to lock doors before but there have been so many incidents and it's not safe."
•We raised these concerns with the registered manager, they told us additional locking mechanisms had been fitted to both doors since our inspection.
•We saw from daily notes, that three people at times showed significant signs of distress and anxiety. Two of these people did not have risk assessments or care plans in place that guided staff on how to identify triggers of anxiety or how to assist and reassure people when they became distressed. We saw one person did have a care plan in place, however this was not personalised to this person and contained generic statements such as "Those with dementia can be hyperactive, agitated and confused and these symptoms can extend into the night causing sleep disruption." This was not reflective of the specific individuals triggers and symptoms.
•There were nationally recognised risk management tools in place, such as the 'Malnutrition Universal Screening Tool' (MUST) however these were not always used correctly. We reviewed four people's MUST assessments, each of the MUSTs we reviewed had incorrect calculations. For example, we saw one person had lost 4.6kg in two months, however their weight loss score and percentage weight loss was recorded as 0, this resulted in their overall risk being calculated incorrectly and no action being taken. Another person had lost 7.2kg in one month, their percentage weight lost, and weight loss score was also recorded as 0. Incorrect use of this tool meant there was an increased risk people would not receive the correct support or actions taken.

Learning lessons when things go wrong
•Incidents and accidents were not well managed within the service.
•Incidents and accidents were recorded in a folder, however the measures in place to prevent a reoccurrence were limited or had not been considered. For example, one person had screamed out and been found on floor on their back in the dining room. They reported to have pain on top of their head and a red mark. They were assisted up with a hoist and taken to their room and given pain relief. There was no evidence of staff safely managing risks associated with head injury, or investigation into how this happened or how it could be prevented by putting additional safety measures in place.
•We found one notification in May 2021, of an incident where a person had fallen out of their wheelchair and hit their head causing a head injury that had to be glued in hospital. Investigation completed following this injury was not sufficient. There was no evidence to suggest that cause of the incident had been investigated or additional measures to prevent reoccurrence had been considered how this happened or what measures could be taken going forward to keep people safe.

The failure to provide safe care and treatment to people by mitigating risks, investigating safeguarding concerns and learning from previous incidents was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
•We were not assured that there was always enough staff to support people's care needs. The service had one waking night staff and one sleep in night staff. Staff told us that they didn't wake some members of staff if they needed support at night due to those members telling them not to. This meant that at times, there was only one member of staff overnight.
•Staff told us they were struggling to manage people's increased dementia needs with one member of staff at night. We saw evidence that a few people often became anxious or disorientated overnight and would be up frequently throughout the night. One person would bang on other people's doors waking them up. We saw entries recorded including, "Last night [person's name] was up, woke everyone up and emptied pad into the sugar pots. [Another person's name] was taking their Zimmer frame and putting it behind his door to stop [person's name] going in but we had to explain it wasn't safe as we couldn't get in."
•We shared these concerns with the registered manager and area manager, they told us that they would put in place an additional staff member overnight to assess if this was needed long term.
•One person told us, "The staff are off and on, some are ok, generally ok, younger staff are the best, some older staff get a bit miserable."
•Recruitment checks had been undertaken when new starters were employed to ensure they were of suitable character to work with vulnerable people.

Using medicines safely

•Medicines were not always managed safely. The service did not complete regular stock checks of 'controlled drugs'. Controlled drugs are medicines that The Misuse of Drugs Act 1971 places certain controls on. This meant that the service was not regularly checking that stocks matched with what was to be expected, this increased the risk of missing medicines going unnoticed.
•One person had a topical medicine self-administration form in place. They had been assessed by the registered manager as being safe to administer, however this had not been reviewed since October 2019 to ensure it remained safe.
•Medicine Administration Records (MARs), indicated that people received their medicines as prescribed.
•Staff received regular checks to ensure they remained competent to administer medicines.
We recommend the provider consider current guidance on storing controlled medicines in care homes and managing risks associated with medicines.

Preventing and controlling infection
•We were not always assured that PPE was stored safely. During our inspection we observed that aprons were hung over grab rails and boxes of masks were left open and exposed. This had potential to reduce the effectiveness of staff's PPE.
•We observed staff were using PPE in line with current guidance.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
•We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• 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.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 practices did not always promote people's choice and dignity. For example, we observed a bath chart displayed with people's names recorded against different days of the week. We asked staff about this and were informed that people were allocated days rather than offered daily choices.
•Daily notes indicated that care was not always person centred. Daily notes for one person read '[person's name] was shouting for more fruit saying she was hungry, and staff had starved her. She shouted for more fruit and it was explained to her she had already eaten it, leaving the dining room she went to her room." Another person's care plan stated they were an early riser as this had been their daily routine, however it was recorded to reassure them and help them settle down again, rather than respect their chosen routines and cater to this.
•People were not always supported to meet their spiritual needs in a way that was accessible to them. Two people living in the home were finding listening to religious sermons through a speaker system distressing. There had been no alternative options explored to support these people to honour their religious beliefs in a way that was accessible to them.
•Some staff told us people were made to listen to sermons despite people showing obvious signs of distress. Staff told us when this had been raised to management nothing had been changed. One staff member said, "[staff member name] is aggressive when you speak about this and says [person's name] should be forced to listen to the sermons. But [person's name] is so distressed by the sermons and where they are coming from." Another staff said, "They [staff] won't turn it down and they think they have the right to say the residents have to sit in the lounge and have to listen." One staff member said "the other night [person's name] was listening to the service, she asked me four times to turn it off.
•We shared these concerns with the registered manager and general manager who immediately commenced an investigation into these allegations.

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

•We observed that people listened to a morning sermon, but other activities were sparse. In the afternoon people were sat in the lounge area, some sleeping. One person told us, "I am not doing anything this afternoon."
•Staff told us that people did not get the opportunity to engage in other interests they may have. Staff commented, "There's not enough, the activity sheet is rubbish, they may get puzzles, they say the residents are not interested. They don't go anywhere out of the home, only to chapel... There's nothing for them", "The

only one they do puzzles with is [person's name]. Nobody else gets anything," and "There isn't any activities, there's no stimulation"
•We saw that one person's risk assessment stated an action to reduce their agitation levels and improve their quality of life was to partake in social activities but there was no evidence recorded that this had been increased for them.
•We raised this with the registered manager, they told us that there was an activity timetable in place, but it was difficult to get people to participate.

Failure to design care in a way that considered peoples individual needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
•We saw people's communication needs were recorded in their care plans.
•People had access to religious texts in adapted formats such as large print.
•Policies and procedures, for example, the services complaints policy, were not always available in adapted formats. This meant that some people were not supported to access important information in a way that was appropriate for them. The registered manager told us they had discussed this with the general manager, and that they were planning to create more accessible versions of these documents as soon as possible.

End of life care and support
•People had an end of life decisions recorded in their care plans, these included 'Treatment Escalation Plans' which detail the level of medical treatment people would like to receive.
•There was an end of life care plan in people's notes. These documents had space for people to record any spiritual, emotional or social wishes they may have at the end of their life. However, we saw that a number of these had been left blank, where they had been completed, detail was limited.

Improving care quality in response to complaints or concerns
•The registered manager had recorded compliment cards in a folder. We saw these thanked staff for care provided.
•We saw that where complaints had been raised these had been responded to appropriately.

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

•Staff gave mixed feedback about the culture of the service. Some staff told us they felt well supported by the registered manager. However other staff told us they felt unsupported and there was a divide between the staff team.
•Some staff told us that the registered manager had two family members and other staff with long standing relationships working in the home. Staff felt when they raised concerns about these family members, the registered manager did not take the concerns seriously or investigate them appropriately. This left some staff feeling unsupported and unable to raise concerns internally.
•There was mixed feedback from staff about the leadership within the home and the support they received. One staff told us, "I felt supported, particularly the management has been supportive and ready to address concerns." Other staff commented, "You can walk in for your shift and the registered manager doesn't speak to you.", and "It needs a better manager running it."
•We shared these concerns with the area manager, who commenced an investigation following our inspection.
•During our inspection, we received some allegations about staff members using language towards people that was not respectful. We have informed the registered manager and area manager of these allegations; they are currently investigating these concerns.
•People were not always supported as individuals, or in ways that maximised their choice and respected their home environment. For example, one person was not able to have their breakfast at a time they chose and had complained to the registered manager about this. One staff said, "If [staff name] finds out they had their breakfast early they won't be happy and tells us off that they shouldn't have it then, but the person has been up early." This did not demonstrate a person led approach but indicated a staff dominant, task led approach.
•The registered manager had not always taken action to ensure that the service took a person-centred approach to people's care, for example, the registered manager was aware that some people found listening to religious services through the loudspeaker distressing, but had not taken action to address this.
•One person living at the service told us they were aware of who the registered manager was saying, "She's nice, I get on well with her. She's the chief, but not here at weekends."

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements; 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; Continuous learning and improving care

•Quality assurance system in place were not always sufficient. Whilst there were some quality auditing processes in place, these had not identified the concerns we found during out inspection. The registered manager completed monthly home audits and reporting the results of these to the area manager however these had not identified the concerns that we found regarding staff culture, safeguarding, medicines management and person-centred care.
•The registered manager did not always complete investigations in a way that was robust and supported the safety of people living at the service. Actions taken following accidents and incidents did not identify a route case of incidents and measures put in place were not always sufficient to reduce the risk of reoccurrence.
•We found one incident which required a notification to CQC which had not been completed by the provider. Notifications are incidents that the provider are required to inform CQC about by law. The registered manager has now submitted this notification.
•The previous CQC report was not displayed clearly by the provider. This had been obscured by a number of documents and was not clearly visible to people using or visiting the service.
•A complaints procedure was in place to manage concerns raised.

The failure to assess, monitor and improve the quality and safety of the service effectively is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•The service sought feedback from people and staff through regular meetings at the home.
•The registered manager told us they sought feedback from people and their relatives and via annual surveys, however these had not been completed since the beginning of the COVID-19 pandemic. Staff surveys had been completed in October 2020
•People's relatives told us they were happy with the management of the home, one person told us "I think [registered manager] does a wonderful job."

Working in partnership with others
•We saw evidence that other health and social care professionals were involved in people's care where required.

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 9 HSCA RA Regulations 2014 Person-centred care Peoples care was not always reflective of their current needs or preferences. Regulation 9 (1)(3)(b)(h)

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 Systems in place did not always effectively investigate potential abuse Regulation 13 (2)(3)