Rapport Housing and Care

Barnes Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Barnes Lodge is a nursing home providing personal and nursing care, for up to 101 people. The service provides support to people with complex health needs such as kidney failure, Type 1 diabetes, Parkinson's disease and people receiving care at the end of their life. Some people were living with dementia or deteriorating mobility. At the time of our inspection there were 68 people using the service.

Barnes Lodge is a purpose-built nursing home set out across three floors with two wings on each floor.

People's experience of using this service and what we found
We found people were not safe living at Barnes Lodge. Risks had not been identified and mitigated by staff and as a result people had been placed at risk. There was a lack of comprehensive guidance in place to inform staff how best to support people with their health needs including wound care, insulin dependent diabetes, chronic health conditions and the risk of falls. There was no effective system to learn from accidents and incidents and no system in place to reduce the risk of the incident reoccurring. Incidents of potential abuse had been identified by staff, but not reported or investigated sufficiently.

Medicines management was poor. Audits had not been completed regularly and therefore issues with medicines administration had not been identified. These included medicines not being counted on a regular basis to ensure people had received their medicines and ensuring the correct and relevant guidance was in place for staff to follow.

There were insufficient numbers of consistent staff to meet people's needs and keep them safe. Some people said they had to wait for support and staff did not always know how to support them. There were a high number of unwitnessed falls and bruises that had not been fully investigated to prevent further occurrences. Staff had not been recruited using safe recruitment processes, and staff had not received the training, or competency checks to complete their roles.

People's needs had not been regularly assessed when they were living at Barnes Lodge. When people's needs changed, risk assessments and care plans were not reviewed. An effective system was not in place to share important information about changes, with staff. For example, when advice had been given by a healthcare professional about a person's diet, this had not being followed. People were not always referred to the relevant healthcare professionals for support, when required.

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. People, and their relatives where appropriate, had not been involved in decisions about their care. An effective system for monitoring DoLS authorisations was not in place to ensure people's rights were maintained.

People were not supported to maintain their dignity and respect. Staff told us they had seen staff carry out personal care in a way that was undignified and unsafe, People were not always supported to maintain their physical appearance.

Care was not person centred and records did not support an individual approach. Some people had complex health needs and these were not detailed sufficiently to make sure they received the care they required to maintain their emotional and physical health. Limited activity was available for people to prevent boredom and social isolation. A robust system for responding to, investigating and monitoring complaints was not in place.

The provider had very limited oversight of the service. Quality assurance systems were ineffective. The culture within the staff team was poor which had a detrimental effect on the care provided. Staff felt it was not in their interests to raise concerns, as based on previous experiences, they did not believe action would be taken. We found many serious concerns about the service, yet the provider had been unaware of the issues identified.

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 (report published 19 December 2017)

Why we inspected
The inspection was prompted in part due to concerns relating to the safeguarding of vulnerable adults, and staffing. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we found further serious concerns, so we widened the scope of the inspection into a full comprehensive inspection.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 significant improvements.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, abuse, staff recruitment, deployment and training, mental capacity, dignity and respect, person centred care, complaints, record keeping and effective checks and audits at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following the inspection, we took immediate action to impose urgent conditions on the provider's registration in relation to risk management and management oversight.

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 six 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 of their 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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Barnes 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
This inspection was carried out by three inspectors and an Expert by Experience who made calls to people and relatives. 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
Barnes 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. Barnes Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 6 July 2022 and ended on 12 July 2022. We

visited the location's service on 6 and 7 July and the Expert by Experience made telephone calls to people and their relatives on 12 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, including their safeguarding team, and professionals who work with the service. We also sought feedback from the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and six relatives about their experience of the care provided. We observed the care provided within the communal areas. We spoke with 18 members of staff including the nominated individual, deputy manager, compliance care team support leader, senior marketing and communications manager, senior care workers and care workers including agency staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at five 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 reviewed.

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 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 protected from the risk of abuse. When people had come to harm and experienced distress or unexplained bruising, staff had not acted to ensure people's safety. Although people and their relatives did not tell us they did not feel safe, many people were not able to vocalise their feelings and views to us. Staff told us they would not raise concerns as when they had, no action had been taken. They said they were concerned about repercussions. One staff member said, "Things do get brushed under the carpet. We cry when we go home. If something isn't done something serious will happen – we will get the blame even though we report everything".
- Although most staff knew who to report to outside of the organisation, this had not happened. Serious safeguarding allegations had been identified prior to the inspection that had not been raised by staff. We found people had unexplained bruises and staff did not know how the bruises had occurred. Concerns had not always been raised, recorded and investigated. Staff had recorded in one person's contact record they had a 'bruise on forehead – seems old as greenish – small lump'. The record described the bruise as 'old' but had not been reported earlier. The person had not received support in a timely way as concerns had not been recorded earlier, leading to continuing risk.
- Staff had recorded three incidents in one person's care record. Each record stated the person was screaming and shouting for help. In the box where staff were asked to comment on any triggers or patterns emerging, staff had written each time, 'wanted attention' and 'appears to want attention'. There was no further record either of further concerns or if the person's distress had been investigated further.
- The provider told us they were planning face to face safeguarding training to address any gaps in staff knowledge. However, we found that staff understood safeguarding procedures, but a culture had grown within the service that had meant they had not exercised their responsibility to report concerns as they felt these would not be acted upon.

The registered person failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

- The assessment and management of risk was poor. Sufficient information and guidance was not provided to ensure staff knew how to reduce risks when providing people's care. At times, six out of six staff on one floor were agency staff. High levels of agency staff, who did not always know people's needs, increased the risk of poor care occurring due to the poor guidance provided to staff. This meant they did not have the information they needed to care for people safely, and increased the risk of people receiving poor or inconsistent care.
- Five people were diabetic and required injections of insulin to control their condition. Risk assessments

were inadequate, giving limited information to guide staff on how to recognise signs and symptoms of deterioration in physical health and the risks of long-term health consequences. There was a lack of guidance to inform staff about the signs and symptoms of low or high blood sugar levels. This increased the risk people might not receive correct or timely support when required.

● One person had a chronic health condition and was receiving ongoing intensive treatment for this as a hospital out-patient. The signs and symptoms of their condition deteriorating and what action to take if staff had concerns, were lacking from their care plans and risk assessments. The person needed to follow a strict diet to maintain their physical health. A record of the foods to avoid that were seriously detrimental to their health and the foods to improve their physical health were not documented. The kitchen staff did not have a list of the person's specific dietary needs. There was a risk kitchen staff would include foods the person needed to avoid in their meals as they did not have the information and guidance they needed. Staff did not know the specific foods the person needed to avoid and said the person knew these themselves. However, there was information in the person's care records that suggested they may not always have capacity to make some decisions. Information and guidance was not given to staff why the person need to avoid certain foods and what the risks were to their health so they could provide encouragement and support.

● Unwitnessed falls and bruises were not always recorded or investigated. We saw people with bruises that had not been reported or recorded. One person had a bruise on their face. This was reported by a family member while visiting but had gone unnoticed and unreported by staff. One person had a general body map in their care file with five separate marks such as bruises recorded. A photograph and incident form had been completed by staff for only one of these. This meant the bruises had not been investigated to find the cause and mitigate future risks to the person. People continued to have unexplained bruising.

● People were not effectively protected from the risk of malnutrition. People who required support to monitor their weight, had not received the support they required. One person had lost 3.2kgs of weight within 16 days. There was a lack of monitoring following this to provide assurances the person had not continued to lose weight. The person's weight-loss had not been identified by staff and measures to reduce the risk of malnutrition had not been implemented. Another person who was meant to have their weight checked weekly according to their care records had not been weighed since 25 March 2022.

● Fire risks were not well managed which increased the risks to people in the event of an emergency evacuation. Staff did not get regular opportunities to practice a fire evacuation. Only one fire drill had been carried out during the previous seven months when the deputy manager told us they should be completed every four to six weeks. The provider's fire procedure stated that all staff should attend a fire drill at least annually. This had not happened. The records were not complete, for example, to include which staff attended and if there were any learning points for staff to be aware of.

● Personal emergency evacuation plans (PEEP's) did not provide the detail for staff or emergency services to understand people's specific needs to evacuate safely. One person used oxygen to support their breathing. This important information was not included in their PEEP. This increased the risk people would not be supported in a safe manner in accordance with their assessed needs.

●The information available for such an emergency, including the names and room numbers of the people living in the service was not up to date. One agency staff said they had not received any training or information about fire evacuation from Barnes Lodge. Another agency staff member said they would follow the permanent staff. Sometimes the whole staff team on one floor was made up of agency staff so this meant fire safety was unsafe. This put people, staff, and emergency services lives at risk in the event of a fire. We made a referral to the fire and rescue service during the inspection.

Learning lessons when things go wrong

● The management and oversight of incidents and accidents was poor and had not been used as an opportunity for learning lessons to mitigate future risks.

● Some incidents identified during the inspection had not been recorded or reported. Where they were,

sufficient information was not documented, and investigations were not undertaken by the management team to identify how the incident had happened and what they could do to prevent it happening again.
● People had been found to have bruising that was unexplained. Records did not evidence that these incidents had been investigated to identify possible reasons for the bruises such as the medicines they were taking, or they needed more support with their mobility. Measures were therefore not taken to mitigate the risk of a re-occurrence.
● A health care professional told us, "We find people have had falls (somewhere in the notes) but it's not recorded properly, and no one seems to be able to tell us about it".
● People had lost weight. The lack of monitoring meant there was a lost opportunity to take action in a timely way. Such as to ensure people were receiving the right nutrition, if supplements were needed, for example fortified foods or high calorie snacks, or if they needed more support to eat their meals.
● We identified incidents where people had fallen or there was an altercation between two people when no staff were present. When we checked the staffing rotas, we could see that often these were at times where there were insufficient staff on duty and the needs of people had not been taken into account when deploying staff. Incidents had not been analysed to identify potential reasons and themes, such as staff deployment. This meant action was not taken to prevent incidents and accidents, and incidents continued to happen.

Using medicines safely
● Medicines were not managed safely. People's allergies were not always included either in a risk assessment or on the medicine administration records (MAR). One person had a reaction to a pain patch and had a known allergy to an antibiotic. This information had not been used to update a risk assessment and was not included on the front of the MAR. The MAR recorded, 'no known allergies'.
● One person told us they had not received the medicines they were supposed to take. We checked their MAR and found their medicines had been out of stock for three days. Staff told us another four people on one floor had ran out of some of their medicines and they had contacted the pharmacy. However, this had not been identified before people ran out. Some people had been without prescribed pain relief and diuretic (water) medicines which would have an impact on people's physical and emotional health. Not taking diuretics as prescribed can have serious consequences on a person's health, affecting major organs.
● There were many gaps in the MAR with no explanation why the medicines were not given. Where staff had handwritten a medicine onto the MAR, for example, for a medicine that was prescribed part way through the month's cycle, these were not double signed by staff. This meant checks were not in place to make sure the handwritten entry was exactly as written by the health care professional who prescribed the medicine. Some medicines are time controlled and must be given at specific times. The exact times these medicines were given was not recorded. When people with Parkinson's disease do not receive their medicines on time this can lead to worsening symptoms such as increased tremors, losing balance and difficulty communicating. It is essential this is monitored closely.
● We were told by the deputy manager one person had their medicines administered covertly as they often refused to take important medicines. A member of staff confirmed this and told us how they administered the medicines covertly. However, they could not show us any documentation where this had been agreed with the GP, as the prescriber of the medicines, an essential part of the plan to administer medicines covertly. A mental capacity assessment and best interest decision making process had not been completed to evidence this was the least restrictive practice available. The person's care plan did not record their medicines were given covertly, to provide clear guidance to staff. This presented a risk the person would not receive consistent support that met their needs.
● Where people were prescribed patches to place on their skin, for example, to control pain, the site where these were placed was not always recorded on a body map. Pain patches can cause irritation to the skin if they are placed in the same position after removal. There was a risk people, who may already have frail skin,

could experience a reaction and discomfort.
● Some people needed medicines on a 'as and when' basis, for example pain relief. We found there was not always guidance for staff to follow, to check if the medicine was effective, or to make sure the maximum dose of the medicine in a 24-hour period was not exceeded. This increased the risk people might not receive their medicines when they needed them or according to the prescribing guidance.
● Staff did not regularly count people's medicines to make sure the numbers in stock tallied with the numbers that had been taken according to the medicines administration record (MAR). Regular audits were not carried out by the management team or the provider to make sure people were receiving their medicines safely. There was a clear risk people may not receive their medicines as prescribed.

The registered person failed to assess the risks to the health and safety of people, or do all that was reasonably practicable to mitigate risks. The registered person failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were insufficient numbers of staff to meet people's needs and keep them safe. There was a high volume of agency staff used due to a high number of staff vacancies and staff absence. One person told us staff did not always come quickly when they called using their call bell, "No. weekend is worse – at the moment they are relying on a lot of agency carers, they do come but they don't know what to do when they see to me. They ask me what I want". On the second day of inspection 10 out of 15 care staff on duty were agency staff. A healthcare professional told us, "There does seem to be staff around, the problem is finding someone who knows who we are talking about. It can take a very long time and they don't seem to know people".
● Staff told us of their concerns around staffing levels. The comments we received from staff included, "At the weekends there is not enough of us – weekends we struggle – people have to wait longer for their care – some people get frustrated"; "Staffing is a consistent issue at weekends"; "I feel the residents aren't safe as there are not enough of us to keep watch on them". Staff said they were concerned they would not be able to safely evacuate people in the event of an emergency. One staff member said a number of people required two staff to support with their personal care. Sometimes there were only two staff on shift on the wing, "We had issues recently when we were both doing personal care – whilst doing this another service user was physically aggressive with another resident".
● People's individual assessed dependency assessments, to identify the numbers of staff needed to provide care, did not always match their needs. One person's dependency assessment showed their needs as low. However, the assessment did not consider their high nursing needs and the level of risk associated. Their assessment referred to their having full capacity to communicate any fears and concerns. However, it was clear from their care record they may not articulate things in the way they happened so may need extra time spent to voice concerns.
● The individual dependency assessments did not inform the staffing levels as staff told us these always remained the same. A change to staffing levels had not been considered when people's support needs changed. For example, where people were at high risk of falls, there were altercations between people or when people were nearing the end of their life.
● Barnes Lodge is a nursing home. There was only one nurse on duty across the whole service on each shift, irrespective of the changing needs of people living there and new admissions. We found concerns that people's nursing needs were not recorded and not always met.

The registered person failed to provide enough suitably qualified staff. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● We looked at five staff files to review their recruitment records. We found there were gaps in the employment histories in four out of the five files. These had not been explored during the recruitment process, including at interview. The provider had not ensured only suitable candidates were employed to work with people living at Barnes Lodge.
● Risk assessments had not been carried out to evidence mitigation was in place for employment risks that were identified during the recruitment process.
● Agency proforma records, to show the agency staff working had been suitably vetted, to provide assurance they had the necessary checks to evidence they were suitable to work with people at Barnes Lodge had not been requested from the agency. Checks were not in place for three out of the five agency staff working on the first day of inspection.

The registered person failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● DBS checks had been undertaken and references had been followed up before permanent staff started working at the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There had been a number of COVID 19 infection outbreaks within the service. There was an outbreak during our inspection. Staff were not always clear which people were still isolating and which people had tested negative as per current guidance. This increased the risk of the continued spread of infection.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. We were not asked to provide evidence of taking an LFD test prior to our visit on the first day of the inspection, as per current guidance. This increased the risk of the spread of infection. We were asked on the second day on arrival.
● We were not assured that the provider was using PPE effectively and safely. We saw staff wearing their masks under their chins on a number of occasions during the inspection, against current guidance. This increased the risk of the continued spread of infection.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. Although we could see staff were testing, the records kept by the provider were poorly recorded so we could not evidence staff were testing as regularly as in current guidance.
● 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 promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● Relatives told us they were able to visit their loved ones whenever they wanted, without restrictions. They were happy with the visiting arrangements in place.

Inadequate

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 deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had an assessment of their needs carried out before moving into the service. The assessment provided only the basic details of their care. The information was used to start a care plan, with only the most basic of information about their health and care needs. The deputy manager told us the care plan was then developed by senior care staff when the person moved in. However, this did not happen, so only limited information was available for staff to follow. Many people's care plans and risk assessments had not changed or been updated since they moved in. Due to the high use of agency staff who may not know people's needs well this increased the risk people may not get correct or consistent support. We found evidence of this during the inspection.
- One person was living with Chronic Obstructive Pulmonary disease (COPD) causing severe breathing difficulties. There was no guidance for staff about how this affected the person and what support they required. There was very limited information to support people with their catheter and stoma care. Including what people could do themselves, which elements of care were nursing tasks and which were care tasks or how to provide care to ensure people's comfort, dignity and safety. The permanent staff we spoke with did know people's needs. However, the majority of staff working on shifts were usually agency staff, some who had not worked there before and some who were not in regular attendance.
- People with nursing needs had not always had their care plans and risk assessments completed by the nurses on duty. Due to the registered nurse having limed time as they were required to provide nursing care across the home, they wrote their notes into the multi-disciplinary records, also used by visiting healthcare professionals, but had little or no input into care planning. People were at risk of not having their nursing needs met as staff might not check the multi-disciplinary notes for changes or updates.
- Senior care staff told us they did not have the time to complete and update people's care plans as they had many tasks to fulfil during their shift, including supporting new agency staff.
- We were told by the management team that the staff member responsible for looking after a person's care file was recorded at the front of the file. This would also indicate if the person had nursing needs, in which case a nurse was the responsible staff member for ensuring people's needs and preferences were met. We found only one care file had a responsible staff member listed. This meant the quality of care plans could not be properly monitored to check staff understood their responsibilities in keeping accurate records to make sure people received good quality and safe care.
- People's needs were assessed using recognised tools, including skin integrity, nutritional needs and falls, however these were not updated when people's needs changed. Neither were they used to inform the person's care plan or risk assessments. For example, when people fell, their falls assessment was not always updated, and care plans reviewed to reflect changes and learning from incidents. People were at risk of

receiving care and support that did not meet their changing needs and placing them at risk of avoidable harm.

The registered person failed to ensure people's care and treatment was accurately recorded and updated to meet their needs and reflected their preferences. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff had not received the training, supervision and support to provide a good level of care. Some staff told us they had observed poor practice by other staff when they were supporting people to move. They knew the incidents they had witnessed were unsafe and did not promote people's dignity, or respect. Staff said this had been raised with the management team. The poor and unsafe practice had also been raised in a training session. Staff said no action had been taken. We raised this with the provider who said they had just become aware of this and they were conducting further moving and handling training sessions as well as staff observations.

● Permanent staff training was not up to date. Many staff had not completed refresher training for the areas the provider considered mandatory. 30 out of 76 staff had not updated their safeguarding training. We had many concerns about the response to concerns within the service. 31 out of 76 staff had not updated their fire awareness training. We had concerns about fire safety and staff told us they were concerned they would not be able to evacuate people quickly. We had concerns about some areas of infection control and 31 staff had not updated this training.

● Staff told us they did not think they were given enough support by the management team and the provider.

● Some agency staff said they had not been given a good induction when they first worked at Barnes Lodge. However other agency staff said they had been given an induction. The support to agency staff when they arrived for their first shift was inconsistent which increased the risk of people not receiving the care they required. One agency staff member said, "In my personal opinion staff are trying their best but there is not enough support".

● Agency staff checks had not been completed to ensure agency staff working had the relevant training and experience. Documentation was not in place to evidence what training agency staff had completed, and if this was still in date.

The registered person failed to provide appropriate support, training and professional development. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

● Staff had a basic understanding of the MCA and could describe the basic principles. However, how people's rights were maintained was not always in line with the MCA.
● Some people had been assessed as not having the capacity to consent to living at Barnes Lodge. However, the assessment had not been followed by a decision-making process to evidence living at the service was in the person's best interests and the least restrictive option.
● The information in one person's care plan suggested they may lack capacity to make some decisions. However, there were no mental capacity assessments recorded. A relative had signed all the person's consent forms with no explanation why or their legal status to give consent.
● One person had been moved to another room on a different floor following an incident with another person. There was no evidence consent had been sought to move to another room, nor a mental capacity assessment and best interests process completed. We were told the decision had been made by a member of the management team.
● One person had a capacity assessment completed around the decision to live at Barnes Lodge. The outcome was they had fluctuating capacity. The record went on to say the person was 'selective' about what they retain. This could undermine the person's basic rights as the staff member completing the assessment had voiced a subjective opinion which could alter the outcome of the assessment.
● Some people were subject to a DoLS authorisation. Some of these had expired as they were authorised for a specific period, such as 12 months. One person's DoLS had expired and had not been re applied for. Staff were unaware the DoLS had expired as an effective process was not in place to monitor authorisations regularly. This meant people may continue to have restrictions placed on them without the appropriate process being followed, as defined within the MCA.

The registered person failed to put in to practice the requirements of the MCA, this is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had two choices at mealtimes. There were mixed views about the food. Some people were non-committal and one person said, "The food is OK". Others were not happy with the food provided. One person said, "The food is awful". People told us they did not know they could ask for an alternative if they did not want what was on the menu.
● The kitchen staff had not been notified of some people's special diets to ensure they had the correct nutritional intake. One person's care plan recorded the goal was for the person to enjoy a well-balanced nutritional diet of their choice, and no other information. The person was an insulin dependent diabetic and had other health conditions which limited their food and fluid choices considerably. Their diet choices were limited to maintain their ongoing health. Staff and agency staff were not given the appropriate guidance to be able to support the person to make safe choices.
● Speech and language therapists (SaLT) had advised some people should have had their food and fluids monitored. The provider had assessed others as needing to have their food and fluids monitored. Not everyone with these needs had a food and fluid chart in place. One person's health concerns meant they needed a food and fluid chart in place as this was crucial to their care. No charts were in place. Staff were not aware if they were receiving the correct fluid and nutritional intake to be able to adjust the care and support or seek advice. Where people did have a food and fluid chart in place, these had not been kept up to date by staff. The recordings for some days were incomplete and other days not completed at all. No action had been taken to address this to ensure people were receiving the food and fluids necessary to maintain their health.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access healthcare such as the GP and SaLT. There was limited community nurse input as the nurse on site acted in this capacity. However, there was only one nurse on duty, so their time was limited so people with nursing needs did not always get healthcare that was person centred.

● People's care plans did not always clearly show what support people were receiving from external healthcare professionals, and we found instructions had not always been followed.

● One person was advised by the GP to keep their legs elevated for 30 minutes every 2 hours due to severe swelling. There was no record within the daily notes that staff had supported this. Staff told us the person did sometimes decline to raise their legs and they would record this in the daily records. There was also no record of the person choosing not to elevate their legs. This put the person's health and comfort at risk.

● One person had been assessed by the SaLT to have one scoop of thickener in their fluids to prevent choking and aspiration into the lungs. This advice had not been followed and the person had not had thickener added to their drinks.

The registered person failed to ensure people's care was provided safely and risks were mitigated. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

● The service was purpose built. There was plenty of space for people to move around and a number of communal areas where people could choose to sit.

● There was clear signage so people who may lose their way were helped to get to where they wanted to be.

● People's names were on their room doors to help them know which room was theirs. People's rooms were clean and had personal touches that helped people to feel at home. People had photographs, pictures and their own ornaments.

Inadequate

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity

- The many areas of concern we found when inspecting Barnes Lodge meant that people were not always treated well or with respect. We heard from staff, and also some relatives, that concerns had been raised with the management team and no action had been taken. Many staff told us they had given up raising issues because of this. The lack of oversight by the provider meant they were unaware of the deteriorating culture so failed to take action. People had not been well treated and action had not been taken to provide good quality care that met people's expectations.
- We received mixed views from the people living in the service who were able to voice their views. One person said, "I'm happy and pleased, everything seems to be ok". However, other people did have concerns that impacted on their lives.
- People felt the impact of the high numbers of agency staff and the lack of consistency in providing their care. The comments we received included, "The staff are very nice. There are some I wouldn't employ, one or two. It's worse at night because it's agency and they can be rude. I don't put up with it"; "Staff you get to know leave, got used to some of the old staff but a lot have gone, unfortunately people move on".
- Although relatives were mainly positive about the care their loved ones received, there were some issues raised. Two relatives told us their loved one's fingernails were long and dirty. Another said they had concerns about the laundry arrangements as their loved one had been wearing other people's clothes when they visited. A relative said their loved one had been wearing dirty clothes and when they raised this with staff, were told it was the person's choice not to change their clothes. The relative helped them to change. They told us they raised this with the management team, however, it continued to happen.
- Relatives also gave positive examples of caring approaches. A relative told us about occasions when staff had involved their loved one in their own news. They gave examples of a staff member who got married and brought their wedding dress for the person to see, and another staff member who brought in their new baby.

Respecting and promoting people's privacy, dignity and independence

- Some people were not happy with the care they received and the attitude of some staff. One person told us they had a particularly difficult time with night staff which meant they did not want to stay at the service. They said a night staff had complained as the person wanted to go to the toilet, the staff member said they had only been 20 minutes ago.
- Staff had told us they had seen staff providing care in a way that did not respect people's privacy and dignity. They had raised these concerns with the management team, but action had not been taken. People were at risk of continuing to receive inappropriate care as action was not taken to investigate concerns in a timely way.

The failure to ensure people were treated with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● People were not always involved in decisions about their care. People had not been involved in developing their care plans. There was little personal information about people in their care records, to enable staff to provide care and support that was individual, taking into account their life until coming to live in Barnes Lodge.

● Relatives said they had not been involved in planning their loved one's care. One relative said, "It is reliant on us going in, they don't give regular feedback. I had to ask about the care plan. I haven't seen a care plan".

● A member of staff told us about some agency staff not being able to understand what people wanted. They gave an example of a person asking the staff member to help put their nightwear on at 6.30pm. The member of staff asked why so early and was told by the person it was because they didn't want to ask agency staff as they didn't understand.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People's care was not planned in a way that centred on the individual and met the needs and wishes of people. The detail in people's care plans did not provide permanent staff or agency staff with the information they needed to enhance people's experience by addressing their emotional and physical needs. One person's care plan said they needed full support with bathing and showering. There was no further information about which they preferred or how often and no information about the type of support they needed and how they wanted the support to be offered.
- People's care records were inadequate for the purposes they were intended, to ensure people's assessed needs and their wishes and concerns were known by those providing their care. Care records were not updated when people's needs changed, or when staff got to know people and what they wanted better. One person's care plans had limited information and recorded the person was new to the service and needed to settle in. This was dated 23 March 2022, so over three months had passed. There was an even greater risk the person would not receive the care that met their needs or wishes due to the high numbers of agency staff providing their care.
- One person's care records had a risk assessment filed which clearly did not belong to them. Reviews had taken place over four months recording 'no changes'. No staff had picked up during reviews that the document did not belong to the person and the description did not match the person at all. Some care plans and risk assessments in people's care files did not have a name on them. This, together with the high use of agency staff, increased the risk that people would not receive the care they needed.
- One person had very poor vision and carried out some of their own complex physical health treatments. Their care plan was basic and did not provide any guidance about how much direction they may need or what measures were in place, and when, to ensure the treatments were carried out safely while promoting continued independence. The high use of agency staff meant the person may not receive consistent care to make sure they could maintain the independence they were keen to keep.

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

- There were limited activities to keep people engaged and reduce social isolation. While we were sitting in a lounge area during the inspection, we saw people sitting while an American teen TV series was on that people were clearly not interested in. The menu tab with channel listings was on display across the bottom of the screen so the full screen was not available to see and was distracting if people had wished to watch the show. Staff were popping in and out and did engage with people briefly. At one point three staff were in the lounge but no attempt was made to try an activity with people.
- People were sitting in other lounges where music videos were playing and people were falling asleep, not

appearing to be interested. Staff were sitting in the lounges, talking amongst themselves or writing daily care notes. We saw few activities to captivate people's interest.
● One person told us there weren't any activities to interest them, but said, "Staff are always popping in and out checking on me and asking if I want a cup of tea". However, people were not supported to engage in their individual interests and hobbies to stimulate and maintain their mental agility and reduce the risk of social isolation. For example, one person told us about their love of gardening but were no longer able to do this, "I used to love working and being in the garden and I can't do it now because of my eyesight and I need a frame to help me walk". Staff told us they did not have time to support people with anything other than their personal care needs. One member of staff said, "It's like a conveyor belt, job after job".

The registered person failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● There was no effective system in place to monitor complaints to make sure the provider's complaints policy had been followed and complainants were responded to appropriately. Although complaints had been received, not all had been responded to as set out within the provider's complaints procedure
● Three formal complaints had been received in the last 12 months. There was documentation available for only one of the complaints. This had not been picked up until we asked for the records. A system was not in place to monitor and keep track of complaints and their progress. The handling of complaints was inconsistent. It was clear from one complaint we looked at that one family had not been happy with the responses to their complaints over a period of time. They had contacted a senior manager with their concerns, but a response or outcome had not been recorded.
● The lack of proper investigation and monitoring meant themes could not be picked up so lessons could be learnt to make sure people and their relative's experience of living at Barnes Lodge was good.

The failure to ensure complaints are investigated, responded to and action taken is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● One person had poor vision. None of their records were in large type, and there was no evidence they had been asked if they required this.
● Some people were hard of hearing. Their records did not reflect how best to communicate with them and if they needed any help with hearing aids etc.
● The individual communication needs of people living with dementia had not been fully taken into account within their care plan, and how this would require regular review as people's dementia progressed.

End of life care and support
● Barnes Lodge supported many people at the end of their life due to the nature of the service.
● People did have a care plan for their end of life. Some were basic and provided limited information for staff to know exactly what people's wishes were if their health suddenly deteriorated. Basic detail was

included, however, a person-centred approach to ensure people's wishes were put into effect and followed as soon as possible was not in place.

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 was good. At this inspection the rating has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The management, leadership and oversight of the service was ineffective leading to a significant deterioration in safety and quality. Although some audits were completed, none were regularly carried out and those that were had not been followed up to take action where issues had been identified. Audits intended to be carried out weekly or monthly had only been completed either once, or twice, in 2022. A monthly audit of medicines administration records had only been completed twice in 2022. No record was made of how many records were looked at or if action was taken to address the concerns found. We found many safety concerns with medicines administration and management, which had not been identified by the manager or the provider.
- The provider carried out limited checks to assure themselves that staff were providing care that was safe. We found that care was not safe. We found that people were not provided with care that was of good quality. A quality compliance officer had visited twice in the last 12 months. Once to complete a care plan audit in October 2021. They found areas to improve but did not return to follow up that action had been taken to address the issues. The second time, to complete a cleaning audit in March 2022. They had not returned to check on action taken.
- A manager's walkabout, intended to be carried out every two weeks had been completed only once, in April 2022. Staff told us they did not often see the management team walking around the service or carrying out checks.
- Staff told us the provider's senior managers visited infrequently and when they did visit, they sat in an office doing their work. The senior managers did not walk around the service to speak to people, make checks or observations of safety and quality or carry out audits. There were no audits or monitoring activity in the service by the provider's representatives.
- We found many areas of serious concern during the inspection and these had not been identified by the provider. Care plans and risk assessments did not provide sufficient information about individuals to make sure people received good care that was safe. These had not been checked. The oversight of accidents and incidents by the provider was ineffective. Incidents such as falls had not been fully investigated, prevention plans had not been updated and incidents had reoccurred, either with the same person or similar incidents with other people. People had unexplained bruising that had not been fully investigated. People who were meant to have their weight checked weekly or monthly were not consistently supported with this.
- The provider had continued to take regular new admissions to the service, despite the severe shortage of permanent staff and high agency usage. This meant people continued to receive a less than adequate service. The provider's lack of oversight meant they lacked awareness of the poor quality service they were

providing. The provider agreed to voluntarily suspend admissions following the inspection.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Feedback from people and relatives was mainly good and relatives found the staff friendly. However, staff were clear about their frustrations about not being able to provide a good quality service.

● Staff, including the management team, were overwhelmed by the amount they had to do to improve and the serious issues with staffing. They felt unsupported by the senior management team, although all staff said individual members were pleasant. Staff told us they thought the service had gone downhill, one member of staff said, "I feel as though it is crumbling".

● Senior care workers told us they had too much to do within their shift and could not always keep up and our observations confirmed this. One senior member of staff was responsible for a whole floor, which consisted of two separate wings. At the time of the inspection, there were 30 people living on the middle floor. Some shifts, all care staff were agency staff on the floor. On the second day of inspection, four care staff out of six on the ground floor were agency staff and on the middle floor, five staff out of six were agency staff. The tasks senior care staff were responsible for included administering everyone's medicines, making appointments, attending healthcare professional visits such as the GP, managing the team and supervising staff and agency staff and dealing with concerns as they arose. This meant people may not receive the care they needed in a timely way. There was a greater risk of inappropriate care by staff and agency staff not being observed and action taken quickly.

● Staff told us they got little support from the whole management team. One described how they felt by saying, "This is more of a social space than a workplace for them". Staff told us they had raised concerns about the lack of support and staffing levels with the management and senior management teams but felt they were not listened to. One staff member commented, "I just feel that management need to be more approachable". Another member of staff said, "If you do say something it doesn't go anywhere, nothing gets done".

● We found there was a closed culture which was not always person centred. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse. Staff had not raised incidents they had seen and were not happy about. Staff told us they felt action would not be taken if they did raise concerns as they had experienced this.

The registered person failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The registered person failed to maintain accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) 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; Working in partnership with others

● Infrequent staff meetings had been held. This meant staff did not have the opportunity to raise concerns and the management team could not address staff cultural issues and create a culture of support and respect. Senior care staff did raise concerns about poor staff culture and a feeling of fatigue amongst staff in their meeting, however, the management team did not respond with specific action or offer support to them, yet advised the senior care staff it was their responsibility to manage the team and to 'toughen up'.

● The provider engaged with people through occasional resident meetings. A survey of satisfaction with the service was carried out in 2021, when 16 people responded. Many people were only 'sometimes' happy with the service provided, including the food and if they felt comfortable to discuss concerns with staff.

● A relative survey was also carried out in 2021 by the provider, which focused on the period of COVID-19 national lockdowns. The results showed relatives felt the provider's response to the pandemic was generally

well managed.
● The provider was involved in various networks, including the local authority and skills for care. However, had not used these sources of information and support to their best effect. Learning from different organisations had not taken place to ensure there was a sustained level of care or continued improvement.
● People were referred to health care professionals and the service had a close working relationship with the GP. We had mixed feedback from health and social care professionals about their advice being followed and being kept informed.

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the registered manager had been open and honest, and understood their responsibility to comply with the duty of candour.
● When incidents occurred, incident documentation reminded staff to apologise to people and their loved ones.