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Bell Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bell Lodge is a residential care home providing personal care for up to 15 people with dementia physical disabilities and/or sensory impairments. At the time of inspection there were 11 people being supported at the service.

People's experience of using this service and what we found
Risk to people's safety and health were not always identified, assessed and managed appropriately. People did not have all the appropriate risk assessments in place to keep them safe. Their records did not identify how risks were managed. Repositioning charts, safety checks and food and fluid charts were not in place for people who required them.

The provider did not have effective systems and processes in place to ensure oversight of the service. The environment required improvements to keep people safe

Infection control required improvement. We saw a number of poor practices including the unsafe disposal of used personal protective equipment (PPE). Areas of the service did not have cleaning schedules in place, and we found gaps in the recorded cleaning schedules.

Medicine management required improvement. We found information missing on people's medicine administration records. We could not be assured people received their prescribed medicines. Protocols were not consistently in place to ensure staff knew when to give a 'as required' medicine.

Unexplained bruising and injuries were not consistently logged or investigated to ensure they did not happen again or make improvements in peoples care and treatment.

Records were not kept up to date. We found gaps in multiple records, some records were difficult to understand, and the handwriting was not clear.

Due to COVID-19 people were not supported by staff who knew them or had all the relevant information available to understand their needs. The provider had not completed a comprehensive contingency plan in case of staff shortages and relied heavily on agency staff within the home.

People did not always receive person centred care. We were not assured that the provider had sought health care support for people in a timely manner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (Published 17 October 2020) and there was a

breach of regulation 17; Good Governance. The provider do not completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

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

We reviewed the information we held about the service. However, due to the COVID-19 outbreak and people being moved out of service we did not inspect the other key questions and this impacted on gathering information for the key question caring. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

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, medicines, infection control, staffing and oversight of the service 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Inspected but not rated**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bell 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 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.

Inspection team
The inspection was completed by one inspector.

Service and service type
Bell Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

Bell Lodge had a COVID-19 outbreak which affected the staffing and levels of care they were able to complete.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We were unable to speak to people who used the service due to the outbreak of COVID-19 and people were being moved to alterative placements. We spoke with four members of staff including the registered manager, assistant manager and care workers.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at equipment information, fire procedures, staff training and quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Not all risks to people had been identified, and the monitoring and management of people's identified risks required improvement. For example, we found limited records in place to show that the necessary checks were carried out to ensure they were safe and no risk assessment had been completed. The risk assessments in place for the use of stair gates did not identified or consider if people were at risk of climbing or falling over the top of them. There were no risk assessments for people who needed to use equipment for their safety. This put people at risk of harm.
- People at risk of dehydration or malnutrition did not have their food and fluids recorded or monitored to ensure they had adequate food and fluid intakes.
- People with identified risks of pressure damage to their skin did not have clear strategies or monitoring in place to reduce this risk. For example, there was limited repositioning checks in place and skin integrity checks had not been updated or recorded for over four months. This put people at risk of developing further or avoidable skin damage.
- People were at risk of being scalded from the hot water taps. The health and safety executive [HSE] states that providers 'should assess potential scalding and burning risks in the context of the vulnerability of those being cared for. Hot water should not be hotter than 44 °C.' Water temperatures were not checked to ensure they were at a safe temperature and no risk assessment had been completed for individual people.
- The environment required improvement to keep people safe. For example, we found radiators had very sharp edges, a sponge had been put under a leaking radiator with no information of when to change or check the sponge or who was responsible for managing this risk.
- People who had sustained an injury due to a fall did not have the appropriate records in place to guide staff in the correct management of that injury. For example, we did not see any evidence of bruises or injuries being recorded on a body map or any investigation being completed to identify where and how the injury had occurred. One person who had fallen and cut their head, and bruised their knee had no body maps completed that detailed the size, colour or monitoring of those injuries. Another person who had also fallen and had a cut behind their ear did not have this injury logged appropriately. This put people at increased risk of harm.

The provider failed to ensure people's risks to their health and wellbeing were being assessed and managed appropriately to reduce harm and serious injury. This is a breach of Regulation 12 (1) (2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

- The provider had not submitted any safeguarding notifications for over 12 months. Due to the limited

information available during the inspection, we could not clarify if any incidents had occurred that would require notifications.
● Staff had received training in safeguarding and understood how to recognise signs of abuse.

Using medicines safely
● Medicine administration records [MAR] did not always contain all the relevant information. For example, some did not have the person's name, date of birth or known allergies logged. There were no codes recorded for not giving medicines on people's MAR Charts. This put people at risk of not receiving the correct medicines.
● The transcribing of medicines was not always completed in line with best practice. MAR charts had not been signed by two people when staff transcribed the medicine onto the MAR and one person's medicine had been recorded twice. This put people at risk of being over medicated.
● Not all 'as required' [PRN] medicines had protocols in place. Some protocols did not contain sufficient information to support staff to understand when to administer this medicine. One person had been given their PRN medicines every day for over one month, with no evidence of healthcare advice being sought to ensure there was not an underlying issue.
● Stock counts of medicines did not consistently tally with amount of medicines that should be on site. This meant the provider could not be assured people were receiving medicines as prescribed.

The provider failed to ensure that proper and safe management of medicines were being completed and followed best practice. These are a breach of Regulation 12 (1) (2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Preventing and controlling infection
● Infection control required improvement. There were gaps in the cleaning records, and we saw no evidence of shared rooms being cleaned after people used them.
● The disposal of personal protective equipment (PPE) was not in line with best practice. We found a large overflowing plastic bag with discarded PPE within it left in an open bathroom. This put people at risk from the spread of infections.
● People were not supported by staff who had received the necessary training. For example, we found four staff had not completed infection control training within the last 12 months. This put people at risk of harm from being supported by staff who were not fully trained to support them.
● Staff were at risk of cross infections. We found no procedures or cleaning records for the cleaning of the mobile home, staff shared to sleep in.
● Some furnishings within the home were stained due to the material being difficult to clean. Chairs had not been placed 2 meters apart to support social distancing rules.

The provider failed to adequately assess the risk of, and preventing, detecting and controlling the spread of, infections. These are a breach of Regulation 12 (1) (2)(h) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing and recruitment
● People were not supported by staff who knew them well. Due to the COVID-19 outbreak at the service, there were only two permanent staff members available to work at the home. The majority of staff on duty were agency workers who had not previously been to the service. The provider had failed to ensure agency staff had received the necessary training and information necessary for them to effectively support people.
● The provider did not have a comprehensive contingency plan in place to ensure staffing levels remained safe in the event of a COVID-19 outbreak.

● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The provider failed to ensure there were sufficient numbers of suitably skilled and experienced staff on each shift. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staffing.

Learning lessons when things go wrong

● Incidents and accidents had not all been recorded in the accident book. This meant that lessons could not be learnt or shared as the information the registered manager accessed was not fully completed.

Inspected but not rated

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has been inspected but not rated.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. We found that staff had been using J cloths to wash people rather than a flannel. Everyone's care plan stated they used a commode in their room at night. We found no evidence that people had the option to use a toilet instead.
- People had 'set' bath days, once a week. We found no evidence that people had the option or choice of changing the day or having a bath more than once a week.
- People who were self-isolating in their rooms did not have activities offered to them. This meant people were isolated, which could be detrimental to their physical and mental wellbeing.
- Care plans did not always contain up to date information. One person's care plan did not fully detail their health condition and how it impacted their day to day life. This put people at risk of not receiving the support they required.

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

- People's care plans did not contain evidence of their involvement. We found no evidence of people agreeing to information being shared with other people. For example, staff regularly shared information with families, however we had no assurances this was agreed with the person.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were at risk of not receiving safe care. The provider did not have systems in place to make sure all risks had been assessed, monitored and mitigated. Lessons had not been learnt.
- The provider's quality governance systems had not identified when poor care was being provided. Care records, such as repositioning and continence care records, had not been regularly reviewed. This meant people had continued to be at risk of receiving poor care and had come to harm as a result.
- We found no evidence on audits being completed to identify any gaps or shortfalls in record keeping. The issues found on inspection had not been previously identified by the registered manager, therefore no actions had been implemented or lessons learnt. We have reported our findings regarding, the gaps in records identified in the safe domain.
- We found records were disorganised, care plans were not always legible or kept up to date. One person's care plan had been misplaced for a number of days. This meant staff did not have the information required to support the person adequately.
- The environment required improvement. We saw bathrooms were cluttered and were not able to be used by people. We found risks associated with furnishings and unlocked doors.
- When additional support was needed, we have no assurances that support was sought. For example, when people's health deteriorated quickly, staff did not get healthcare support in a timely manner. This put people at risk of avoidable harm and further health issues.
- People with deteriorating health conditions did not receive prompt healthcare support.

People were placed at risk of harm as adequate systems and processes were not in place to assess, monitor and improve the quality and safety of the care provided. These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We saw limited evidence of people, relatives and staff being involved in the development of the service.
- We did not see any evidence of feedback being requested from people or relatives about their care or the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had responded to previous complaints appropriately. However, we saw no evidence of any recent complaints made by people, relatives or staff.
- The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably skilled and experienced staff on each shift.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure peoples risks were assessed and managed appropriately. The provider had failed to ensure the proper and safe management of medicines. The provider had failed to adequately assess the risk of, and preventing, detecting and controlling the spread of, infections.

The enforcement action we took:

Notice of decision to restrict admissions.
Notice of proposal for postive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have adequate systems and processes in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Notice of decision to restrict admissions.
Notice of proposal for postive conditions.