Bentley Lodge Care Home Ltd

Bentley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bentley Lodge Care Home is a nursing home providing personal and nursing care to 51 people aged 65 and over at the time of the inspection. The service can support up to 56 people. The service supports older people who may have a physical disability, sensory impairment or who are living with dementia. People are accommodated either within the main building or in the new purpose built extension.

Since 12 October 2020 ten rooms within the home were contracted as 'Discharge to Assess' beds. These beds were for people discharged from hospital, as they no longer required an acute bed, but who required a period of up to six weeks assessment or rehabilitation. People referred could be living with dementia or have complex health needs. The discharge to assess beds were all located on the same ground floor corridor in the main building. Each of these bedrooms had an ensuite bathroom and there was a communal shower room on the same corridor.

People's experience of using this service and what we found
People and their relatives told us overall, their physical needs were met, and they liked the staff who were kind. However, they also said people's emotional and welfare needs had not been met. A relative said, "Staff do what they have to do and then go – there is no chit chat" and that social interaction was "virtually nil."

Processes, systems and staff practices to protect people from the risk of acquiring an infection were not adequate. This placed people at risk of acquiring an infection. There had been a failure to ensure the environment and equipment provided for people were always safe and properly maintained. The provider had failed to mitigate some identified risks to people. This placed people at risk of harm.

Staff did not have sufficient time to provide compassionate care. There was a focus on the provision of practical care tasks for people, but not enough focus on their welfare and sense of well-being. People had not been adequately supported to maintain relationships with their loved ones or their independence. People's emotional needs had not been met. People were not always involved in decisions about their care and their preferences were not always respected.

People accommodated in the 'discharge to assess' beds had been subjected to unnecessary restrictions on their movement once their 14 day self-isolation period had ended. People's medicines were not always managed safely. This placed people at potential risk of harm, from not receiving their medicines correctly. There had been a failure to provide enough suitable staff. This placed people at risk of not receiving their care in a timely manner.

There was evidence safety and safeguarding incidents were investigated when things went wrong. However, actions taken to improve people's safety were not fully effective.

Management responsibilities were not clear, there was not sufficient oversight and risks to people had not

always been assessed or acted upon. Processes to learn and improve were not robust. The culture during the pandemic had not been person-centred, open, inclusive or empowering and had not achieved good outcomes for people. The provider had sought relatives' views on the service, but it was not clear what actions had been taken in response to their feedback.

Links with the local community had been maintained during the pandemic. The service worked in partnership with other agencies.

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

Rating at last inspection
The last rating for this service was good (published 15 December 2017).

Why we inspected
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.

We had received concerns in relation to people's safety, staffing and support for the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led. During the inspection we identified further concerns in relation to the key question of caring, so we included this key question within the inspection.

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 requires improvement. This is based on the findings at this inspection.

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

Since the site visit, the manager has reacted positively and started to take the actions required to address the issues identified.

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, safeguarding, staffing, dignity, person-centred care and good governance at this inspection. Two warning notices were served on the provider in relation to the breaches of safe care and treatment and good governance.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bentley Lodge Care 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
The inspection was completed by two inspectors working on-site and an assistant inspector working off-site, who spoke with staff. An Expert by Experience spoke with people's relatives off-site. 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
Bentley Lodge Care 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.

The service had a manager registered with CQC. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had left the service on 10 November 2020 and has since de-registered with CQC. A new manager commenced work at the service on 16 November 2020, they will be referred to throughout the report as "the manager".

Notice of inspection
This inspection was unannounced. We spoke with the service prior to entry to ensure there was no-one isolating with confirmed or suspected COVID-19 and to ensure the inspectors complied with the service's policy on the use of personal protective equipment.

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.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and ten relatives about their experience of the care provided. We spoke with 12 staff, including care staff, cleaners, nurses and the manager.

We reviewed a range of records. This included eight people's care records and 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.

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.

Preventing and controlling infection

● There was not an overall infection control policy, there were policies on washing hands, cleaning and outbreaks. Staff did not have access to comprehensive, up to date infection control guidance.

● Processes to prevent visitors from catching and spreading infection were not robust. We were not assured all visitors were screened for symptoms of acute respiratory infection before entering. Our temperatures were not taken on arrival at the service and our details were not taken for contact tracing. There was no partition or floor markings to divide visitors from people during internal home visits, therefore there was a risk of them touching each other. Visitors were seen outside at open windows, not socially distanced two metres from their relative. As these visits were not supervised, visitors could have made physical contact through the open window and transmitted any infection.

● Neither staff nor people were observed to consistently maintain a social distance of more than two metres within the service. Four staff were observed sitting closely in a small staff room eating and they were not socially distanced. Three of them were sharing the same meal, which was an infection control risk. Staff's breaks were not sufficiently staggered, to enable them to socially distance in break rooms.

● Staff did not use the personal protective equipment (PPE) provided effectively, to safeguard themselves and people. There were no designated stations to enable staff to don (put on), doff (remove) and dispose of used PPE in accordance with guidance. PPE and clinical waste bins should be located close to where staff need to don and doff the equipment. Staff accessed PPE from the communal bathrooms, which increased the risk of the spread of infection. We observed some staff wore their masks below their nose, which made the mask ineffective. Two staff had received 'train the trainer' infection prevention and control training, which they had cascaded to staff. Staff had not fully applied this training which placed people and themselves at risk of acquiring an infection.

● The provider had not ensured there was robust COVID-19 testing for people and staff. Not all people had been tested every 28 days in accordance with 'whole home testing' guidance. Not all staff were tested every week, as only staff at work on the test days were tested. People and staff had been placed at risk through a lack of effective COVID-19 testing.

● We identified the provider was not following appropriate infection control procedures required of care homes. Although the building was cleaned regularly, not all equipment was clean. We saw a toilet with staining in the bowl. An upstairs shower room had mould in the shower. Equipment, such as hoists, were stored in bathrooms which meant they required cleaning both before and after use. These were infection control risks for people.

● Staff were not following safe procedures for managing laundry. We found bags of dirty laundry and piles of clean laundry on the floor of the laundry room. This was an infection control risk.

● There was a lack of sufficient signage for staff regards how many people could be safely accommodated in rooms, such as staff rooms at the same time, or how to safely socially distance people in the communal areas. We observed staff were not socially distanced in a staff room on their break. We observed staff

sometimes placed people less than two metres apart in the communal rooms.
● Hand gel sanitisers were located throughout the service, but we found a number of them were empty. This meant people and staff could not effectively clean their hands.
● There were no risk assessments for Black, Asian or Minority Ethnic (BAME) or vulnerable staff to identify individual risks to staff from catching COVID-19.
● We could not be assured the provider had undertaken relevant risk assessments to assess the risks if agency nurses had worked in any other home, to prevent the risk of cross-infection.

We found no evidence people had been harmed however, processes, systems and staff practices to protect people from the risk of acquiring an infection were not adequate. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the manager took immediate action to start to address the issues identified and submitted an action plan to CQC, this reduced the risk of repetition.

Assessing risk, safety monitoring and management
● The potential risks to people related to fire had not been managed safely. One person, who could not mobilise independently, had been placed in a room which was not suitable for their needs if a fire broke out. This person had been placed at risk in the event of a fire. We found a large number of boxes in a room adjacent to the front door and the large amounts of clothing in the laundry, was a potential fire risk. Following the site visit CQC spoke with the fire service about our findings and they liaised directly with the manager to assure themselves of the measures taken in response to our feedback for people's safety.
● The provider had not appropriately managed risks related to Legionella. This is a bacteria that causes Legionnaires' disease, which can be fatal. The provider's Legionella management plan identified seven actions to be completed. The provider could not demonstrate these had been completed within the required timeframes to ensure people were safe. There was a lack of evidence that required safety checks, such as temperature checks and weekly flushing of water outlets had been completed as needed. Without these checks, people had been placed at risk of contracting Legionella's disease.
● Not all equipment was in working order. Some people's airflow mattresses, which relieve pressure on people's skin, were not working. This had left them at risk of developing pressure ulcers. One person, who had a pressure ulcer when they were admitted told us they could "feel the springs of the mattress." This person had been placed at risk of their pressure ulcer deteriorating.
● People had not always been provided with the equipment they needed. Two people identified as mobile and at risk of falls did not have sensor mats in their bedrooms, to alert staff they were up and potentially at risk of falling.
● A number of the communal shower rooms required repair and could not be used, there was a lack of evidence to demonstrate how long they had required repair. The provider had not ensured the communal shower rooms had been adequately maintained for people to be able to use safely.
● Risks to people had been assessed but they were not always managed safely. The registered manager had identified there was a risk of staff rushing people's care and not taking sufficient care, resulting in skin tears. They had addressed this with staff and relevant training was provided, however records showed, people were still regularly sustaining skin tears.
● People's call bells were not in easy reach for some people. Before lunch, we found two call bells had been disconnected, so could not have been used to summon assistance.

The failure to ensure the environment and equipment provided for people were safe and properly maintained and the failure to mitigate identified risks was a breach of regulation 12 (Safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager wrote to us after the inspection to outline the actions taken in relation to the fire risks identified, this reduced the risk of repetition.

Systems and processes to safeguard people from the risk of abuse

● People in the 'discharge to assess' beds had been subjected to unnecessary restrictions upon their movement which meant their human rights had not been upheld. People admitted to a care service during the pandemic should self-isolate for 14 days. However, staff told us everyone in the discharge to assess beds was in self-isolation. Some people in these beds had been resident for over 14 days, so should have been able to mix with other people in the home. One person confirmed to us, they had not been out of their bedroom during their stay.

● We could not be assured people in the discharge to assess beds had consented to these restrictions. Deprivation of Liberty Safeguards applications had not been made for people who could not consent to restrictions upon their movement due to their mental capacity.

● Following the site visit, CQC raised a safeguarding alert with local authority about the risks to peoples' safety and rights identified at the inspection.

The failure to prevent the use of restrictive practices was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager provided an action plan after the inspection, outlining the actions they had taken to address this for people, which reduced the risk of repetition.

● Records showed staff were up to date with their safeguarding training and those spoken with demonstrated an understanding of the signs of abuse and how to report any concerns.

Staffing and recruitment

●There were not sufficient numbers of suitable staff rostered to keep people safe and meet their needs. We heard call bells ringing constantly during our inspection. A relative said "[Person] often tells me that [person] rings the buzzer to use the bathroom and by the time they [staff] come [person's] had an accident." As there were no call bell audits, the provider could not demonstrate call bells had been responded to in a timely manner.

● The discharge to assess beds had placed additional pressure on staff. We saw nurses managing a person's admission and two discharges for people, as well as a GP round on the day of the site visit. We saw staff were constantly busy.

● The provider used a dependency tool to calculate the required staffing level. However, they had not adequately assessed each person's needs which were higher than those calculated. For example, the dependency tool showed no-one had high or very high needs, but the handover sheet, showed a significant number of people required two staff. Therefore we were not assured the number of staff provided was sufficient for peoples' actual needs.

● The number of nurses employed had reduced from seven in September 2020 to five, this included the deputy manager. The nursing roster was covered with the use of the deputy manager and agency nurses. However, this meant the deputy manager had no supernumerary time for them to carry out their managerial role.

● A member of care staff was rostered to do the laundry two days a week. On other days the laundry was completed by the care staff and cleaning staff on shift. On the day of the site visit there was no-one allocated

to do the laundry. A relative told us, they did all of their loved one's washing because "they [staff] don't do it properly." Another relative commented, "Clothes have gone missing" and told us their loved one was sometimes wearing the wrong ones. There were not enough staff to ensure laundry was managed safely or effectively.

● There were no administrative staff, so the manager and senior staff answered the phones, in addition to their other duties. A relative told us, "When you try to contact home, it's a long time before anyone picks up and it's worse at weekends." During our inspection, at lunchtime, we heard a phone in the dining room kept ringing. This interrupted people's lunch experience.

● There were not enough maintenance staff to ensure repairs were completed in a timely manner to keep people safe. For example, a number of the shower rooms were out of order, there was a broken bedrail, a washing machine was broken, and some air mattress machines were not working.

● We were not assured that staff annual training was effective. Staff were not given sufficient training to enable them to meet the needs of people living with dementia or those who exhibited behaviours that challenge. We observed one person was very distressed during the inspection and there was a lack of written guidance for staff about how to support them.

We found no evidence people had been harmed however, the failure to provide sufficient suitable staff had placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us after the inspection of the actions being taken to ensure staffing requirements and training were reviewed.

● The provider had followed safe recruitment practices for their permanent staff. However, there was a lack of evidence to demonstrate the provider had ensured pre-employment checks were completed by companies supplying nursing agency staff. The manager had already identified this issue and had taken measures to ensure this was addressed.

● We could not be assured the provider had ensured applicants verbal and written English language skills and comprehension were sufficient to communicate with people and other professionals. A relative gave an example, of where an ambulance had been called for their loved one and it was the paramedic who updated them, as staff could not understand the information sufficiently, to relay it. The manager has advised they are making arrangements to support staff with their English skills.

Using medicines safely

● People's medicines were not managed safely. Some people were on time-specific medication, for conditions such as Parkinson's disease. The time these medicines were given was not recorded. Although the manager told us after the inspection the nurses gave people with Parkinson's disease their medication at the correct time, there was a lack of evidence to confirm this.

● People's liquid medicines were not always dated when opened. This placed people at risk of being administered medicines which were ineffective. People's topical cream medicine administration records (MAR) had not always been signed, to demonstrate the medication had been applied.

● When people required their MAR to be handwritten, the record was not always signed by two staff in accordance with guidance, to ensure the information had been correctly written.

We found no evidence people had been harmed however, the failure to ensure peoples' medicines were managed safely placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed their medication training. Two staff had medicine refresher training booked. All staff administering medicines had their competency to do so assessed.

Learning lessons when things go wrong

● There was evidence safety and safeguarding incidents were investigated when things went wrong. Learning and themes were identified, and actions taken. However, these were not always fully effective and risks to people, for example from skin tears, continued.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● Not everyone in the home had the opportunity to have safe visits from families in line with national guidance. The manager told us only people receiving end of life care and two other people had face-to-face visits inside the building. These two people had been assessed as in need of visits, due to their challenging behaviours. The manager told us they needed to complete risk assessments for other people before they could have indoor visits. Other people could only have visitors outside through their window. A relative told us, "[Person] was moved upstairs and no-one can go up, so no visitors." The importance of visitors for people's health, well-being and quality of life had not been recognised and facilitated.

● People had not been adequately supported to maintain their independence, particularly those accommodated in the discharge to assess beds. Some of whom had been admitted to improve their independence in relation to activities of daily living, such as showering and mobilising. Staff told us people in these beds had not come out of their bedrooms during their stay, which could be up to six weeks. A relative told us, their loved one had, "no movement beyond [person's] room – no exercise" . Another relative commented their loved one was, "very active and now feels restricted". During the pandemic the home's physiotherapist had been stopped, so people had not been supported to meet their rehabilitation needs.

● The provider had not fully considered people's protected characteristics in relation to how their care and treatment was provided. A number of people were living with dementia. There was a lack of evidence to demonstrate how their needs, for example, in relation to either their environment or their care needs had been met. A relative told us their loved one had items which were of significance and comfort to them, but they were "not convinced these items are used".

The failure to ensure people's relationships and independence were maintained was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager provided an action plan after the inspection, outlining the actions they were taking to address these issues for people, which reduced the likelihood of repetition.

● People's emotional needs had not been fully considered when scheduling staff. The provider had furloughed the activity staff, during the pandemic and had rostered one team leader to provide activities for two days a week. There was a lack of evidence to demonstrate people's needs for social stimulation had been met. We observed people were not stimulated and relatives confirmed this had negatively impacted people's welfare. A relative told us, "There is not much social interaction or stimulus – unlike earlier [pre-pandemic] when there were activities every day." Another relative said, their loved one, "has withdrawn a lot. They are embarrassed by their own lack of language".

The failure to ensure people received person -centred care that met their needs had impacted upon their welfare. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager provided an action plan after the inspection, outlining the actions they were taking to address these issues for people, which reduced the likelihood of repetition.

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

● Although most people and relatives said staff were polite and kind, staff did not have sufficient time to provide people with compassionate care. We observed, and people's relatives confirmed, staff did not have sufficient time to talk with people and care was rushed. One person cried when we spoke with them and told us as they felt "so lonely," saying the only time they saw staff was when they assisted them with personal care, meal times or cleaned their room. A person's relative told us, "It's acceptable, but regrettable that [person] can't be with [staff] who make [person] more at home."

● We noted care records detailed the practical tasks completed for people, but there was a lack of evidence to demonstrate staff had spent quality time with them or noted and responded to their mood.

● People's relatives told us not all staff's English language skills were sufficient to facilitate effective communication. We found staff did not always understand our questions and we had to repeat or reword them to enable staff to understand them.

● Records showed the registered manager had spoken with staff about the need to be more caring and gentler with people when moving them and not to rush. The number of skin tears sustained by people, demonstrated not all staff were consistently caring and gentle when they moved people.

The failure to ensure people received person centred care had impacted upon their welfare. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager provided an action plan after the inspection, outlining the actions they were taking to address these issues for people, which reduced the likelihood of repetition.

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

● Some people had been moved from their rooms to others to create the discharge to assess service. We did not see evidence people were adequately consulted about the move. A relative said, "It's tragic [person] had to change rooms." They said their loved one "was advised rather than consulted" about the move and told they could, "not over-rule" the decision. They told us, when their loved one's bedroom was downstairs, they could see them from the garden and the person had regarded their downstairs room as their "home".

● People's preferences about their care had been documented, for example, in relation to whether they preferred a shower or bath and how often. However, there was a lack of evidence to demonstrate these preferences were consistently met. One person's records showed they liked a shower once a week, but during November 2020, up to the date of our site visit they had showered once. People in the discharge to assess beds did not have access to a working shower if they preferred, or if they were unable to use the bath in their ensuite. People had limited choices about this aspect of their care.

The failure to ensure people were enabled to participate in decisions about their care and meet their preferences for their care was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

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

- There was a lack of robust accountability and oversight of the service. The provider told us "a lot of communication was verbal rather than through emails". There was a lack of evidence to demonstrate the provider and the registered manager had jointly agreed the identified risks and actions required in order to drive improvements for people.
- There was a lack of support for the registered manager. Due to staff shortages, the deputy manager was deployed to provide care and there were no on-site administrative staff to support with this aspect of their role.
- Quality and safety risks had not always been fully assessed or addressed. The provider had not ensured processes were adequate to protect people from risks due to fire or Legionnaires' disease.
- Where safety issues had been identified, actions had not always been identified or taken to address them. For example, the monthly fire door inspections from November 2020, identified some doors were "not closed during alarm test", there was no comment as to what action would be taken. The November 2020 mattress audit highlighted actions required for eight beds, but there was no action plan. The November 2020 health and safety audit noted there were no radiator covers fitted in the corridor of the new extension, which placed people at risk of burning if they fell on them.
- The registered manager had analysed monthly the numbers of falls, accidents, medicine errors and safeguarding's within the service. This included the actions taken and learning points. We noted the same themes were identified each month, in relation to the number of falls people experienced and skin tears sustained. Actions were taken in relation to speaking with staff about their responsibilities and the provision of relevant training, but these had limited impact in terms of reducing the number of incidents for people. There was a lack of evidence to demonstrate any action had been taken to address any underlying factors, leading to incidents, such as insufficient staffing.
- There was evidence monthly monitoring took place of people with pressure ulcers, to assess their cause and the actions taken to promote their healing. Action had been taken to identify any trends in pressure ulcers, however, the risks to people from faulty air mattresses had not been identified and addressed.

The failure to assess, monitor and mitigate risks relating to the health and safety of people was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the site visit, the manager offered to voluntarily halt admissions to the service for an initial period of

two weeks, which was then extended to the end of December 2020, to enable them to focus on addressing the issues identified during this inspection.

Continuous learning and improving care

● Quality assurance arrangements were not consistent or effective at driving improvements in the service. There was insufficient auditing of the service and those that were completed were not fully effective. For example, the infection control audit completed the day of our site visit, scored the service 89.81%. The audit failed to identify the infection control issues identified by us the same day. Staff completed records of the cleaning completed, but there was a lack of evidence to demonstrate how the quality of their cleaning was assessed. People's care plans and records had not been audited to assess if the delivery of people's care met their identified needs and preferences.

● The staff training matrix indicated a significant number of staff were not up to date with their required training. However, other evidence provided demonstrated staff had completed some of this training. Processes in place to monitor what training staff had completed were not sufficiently robust to ensure staff with the right skill mix were deployed each shift.

● Call bell response times were not audited to assess how long people had to wait for their care. The provider could not demonstrate people received care in a timely manner.

● Both relatives and health professionals told us the quality of the WIFI and IT hardware provided were not adequate for people to have video calls throughout the building.

● An undated service improvement plan was provided, however this only included environmental improvements. There was no evidence to demonstrate who wrote it, who was responsible for the identified actions or when these were to be met. The only action noted to improve the experience of people living with dementia, was to paint the rooms and doors with different, bright colours. The service improvement plan did not identify or address the issues we identified.

The failure to assess, monitor and improve the quality of the service provided was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager has since the site visit informed us they are introducing new audits which they will coach staff on how to complete thoroughly.

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

● A negative culture had developed within the service during the pandemic. There was poor practice and potential breaches of people's human rights. Restrictive practices had developed in response to the potential risks from COVID -19. Although people's physical needs had been met, they had not received person centred care. People's independence and mental wellbeing had been negatively impacted by the restrictions and culture within the home.

● There had been a reduced number of visitors and professionals to the service during COVID-19, as the service's physiotherapist had been stopped at the start of the pandemic and only two people's relatives had been allowed to visit them inside the building. The reduction both in the number of staff within the service and visitors, had reduced the opportunities for external oversight.

● Most people's relatives were positive about the management of the service, commenting, "before lockdown it was reasonably well run" and that they had found management "helpful".

● There had been a lack of consistent management for the service. During 2020 there had been three different managers. The most recent manager commenced their role on 16 November 2020. The incoming manager had not received a handover of the current risks and challenges.

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

● Records demonstrated people's relatives had been informed when things went wrong, and incidents happened.

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

● Relatives had been sent a short COVID-19 survey in June 2020. Overall people were satisfied, however, when people had provided feedback with regards to improvements they would like in relation to laundry and garden chairs, there was a lack of evidence to demonstrate what actions had been taken.

● There was evidence the service had contact with the local Chaplain, who provided a weekly letter which was shared with people who had previously attended the home's church service. There was also a group of community volunteers who wrote to people. This showed links had been maintained with the local community during the pandemic.

● There had been two staff meetings, one on 4 June and one on 16 September 2020. As no minutes were provided for the September meeting, we could not assess the extent to which staff had been asked to provide their views at this meeting.

Working in partnership with others

● The service worked alongside a range of statutory stakeholders, including the GP, commissioners and Social Services. The manager has worked collaboratively with external agencies since the site visit, to address the issues identified.

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 There had been a failure to ensure people received person centred care that met their needs, this had impacted upon their welfare. People were not enabled to participate in decisions about their care and meet their preferences for their care These were breaches of regulation 9(1)(3)(b,f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to ensure people's relationships and independence were maintained was a breach of regulation 10(1)(2)(b,c).

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 The failure to prevent the use of restrictive practices was a breach of regulation 13 (4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to provide sufficient suitable staff was a breach of regulation 18(1(2)(a).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to ensure processes, systems and staff practices protected people from the risk of acquiring an infection. There had been a failure to ensure the environment and equipment provided for people were safe and properly maintained and a failure to mitigate identified risks. Peoples' medicines were not managed safely. These were breaches of regulation 12 (2)(a,b,d,e,g,h).

The enforcement action we took:

We have served a warning notice on the provider.

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 failure to assess, monitor and mitigate risks relating to the health and safety of people or to improve the quality of the service provided was a breach of regulation 17(2)(a,b).

The enforcement action we took:

We have served a warning notice on the provider.