Cooper Residential Homes Limited

Bethel/Bethesda Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bethel/Bethesda is a residential care home providing personal care to 22 people aged 65 and over at the time of the inspection. The service can support up to 34 people.

The service is in one building which had been divided into two sides. One side is known as Bethel, and the other Bethesda. All people living at the service have their own bedrooms. Some people had a sink in their bedrooms, while others had a sink and a toilet. Bethel and Bethesda each have shared bath/shower room, a dining room and lounge area. There is not a garden, but there is a courtyard which people could access.

People's experience of using this service and what we found
People living at the service were not safe. Not everyone had their care needs and associated risks assessed. This meant staff were not aware of how to safely care for people and to minimise risks people were exposed to.

Staff failed to wear personal protective equipment (PPE) in accordance with government guidelines. During our inspection, staff were observed warning others to put face masks on as CQC were inspecting in the building.

Maintenance checks were completed but staff failed to risk assess equipment before it was used. This meant people living at the service were not exposed to unnecessary risks of harm.

The service was not well-led. The registered manager and nominated individual did not have oversight of the service. Governance systems and processes were not in place to ensure care was safe, and opportunities to improve the service were missed.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

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

Rating at last inspection
The last rating for this service was good (published 30 June 2019).

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 COVID-19 and other infection outbreaks effectively.
We received concerns in relation to staff not wearing PPE and regarding the safety of the environment. As a

result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bethel/Bethesda 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 providing safe care and treatment to people living at the service; the safety of the environment; and how the service was led and governed at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

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.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Bethel/Bethesda Residential 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 carried out by two inspectors. An Expert by Experience carried out telephone calls to relatives of people living at the service. 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
Bethel/Bethesda Residential 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 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.

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. 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 spoke with two people who used the service about their experience of the care provided. We spoke with 13 members of staff including the registered manager, senior care workers, care workers, house keepers and kitchen staff. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a health professional who was visiting the service.

We reviewed a range of records that were available. This included 12 people's care records and two people's medication records. Records and documents relating to the management of the service were in a number of locations and staff were not able to locate these documents when requested.

After the inspection
We requested a range of information including people's medication records, policies, procedures and audits, but this information was not provided by the registered persons during the inspection. There was not any person available to answer questions or seek clarification regarding the evidence found during the inspection. After the inspection evidence of some audits and policies were provided.
The Expert by Experience spoke with seven relatives of people using the service to find out their experiences of the care their family members received.

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

- Staff failed to wear PPE in line with government guidance. Staff including seniors were observed not wearing any PPE (e.g. face masks, aprons or gloves). A staff member was overheard telling others to put face masks on as a CQC inspector was in the service. One staff member told us face masks were only used when visiting health professionals were in the service and not when supporting people. This placed people living at the service at significant risk of contracting and transmitting COVID-19 and other viruses.
- Staff did not know when to use PPE. Staff were unsure about what PPE they should wear and in what instances. One staff member told us "what is the guidance, I really don't know what I should be wearing its changed that much." Staff were observed wearing different combinations of PPE when providing direct care to people. This placed people living at the service at significant risk of contracting and transmitting COVID-19 and other viruses.
- Not all staff had received training on COVID-19 or PPE use. Two staff members told us "we've had no training (on PPE), its common knowledge on how to put on and take off PPE." Another staff member told us "I know how to do PPE, but I've not had any training here." This placed people living at the service at high risk of contracting and transmitting COVID-19 and other viruses.
- People were not self-isolating. The bedroom door of a person recently admitted to the service was wide open when it should have been closed. Written documentation for another person identified they were moving around communal areas when they should have been self-isolating.
- PPE was not disposed of safely. There were bins in bathrooms for PPE, but they were not clearly labelled or coloured yellow for infection control purposes, and not all bins used had lids on them. This meant staff were disposing of used PPE in open bins that may then be incorrectly handled and could have exposed others to the risk of contracting and transmitting COVID-19.
- Cleaning was completed, but every other weekend there were no staff onsite to do so. A member of staff told us cleaning tasks took low priority on the weekend due to ensuring people's care needs were met. This meant cleaning of high touch points and bathrooms were not regularly completed. This increased the risk of exposing people to COVID-19 and other viruses.

Assessing risk, safety monitoring and management

- People's care needs and risks were not consistently assessed. We reviewed 12 people's care plans and risk assessments and found six people had no care plans or risk assessments in place. One person's relative felt staff did not understand their care needs and told us "[person's name] has never been assessed." This meant staff did not know what care people needed and did not have any guidance to ensure they met people's care needs safely.

● Care plans and risk assessments were not regularly reviewed. For example, one person's care plans had not been reviewed since August 2020, another had not been reviewed since December 2020. Information was not current or reflective of people's needs which meant staff did not always know what people's needs were and what care they required.
● Relevant information about people's needs was not always available. One staff member told us they had to contact a person's relative as there was no information about them. This meant staff did not know how to safely care for the person. People were exposed to unnecessary risk of harm as staff caring for them did not know about their health needs.

The registered persons failed to ensure staff were wearing PPE in accordance with government guidance during a global COVID-19 pandemic and failed to ensure people's needs and risks were assessed. This placed people at significant and ongoing 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 failed to ensure equipment was safe. We observed a wheel on a wheelchair falling apart whilst a person was using it. This was raised with staff who said the wheelchair would be put with other broken equipment. Staff failed to assess equipment before it was used placing people at serious risk of harm and injury.
● The environment was unsafe. Throughout the service there was damage to the environment such as rotten floorboards, chipped floor tiling and frayed carpets. There was evidence some of these concerns had been raised by staff, but the registered persons failed to ensure repairs were made and the service was safe.
● External doors were unlocked which meant people living with dementia could leave the building unnoticed. Doors to areas such as the boiler room were left unlocked and housed exposed piping and electricity boxes that people living at the service could access.

People were living in an environment that was unsafe and unsuitable to their needs. Staff were failing to check equipment before it was used and continued to use equipment that was faulty. This placed people at risk of unnecessary harm. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At the time of inspection staff recruitment records were requested but not provided. After the inspection recruitment audit records were provided which documented relevant checks had been completed prior to staff commencing work at the service.
● Some staff told us they had received online training. A newer member of staff told us however they had received no training at all since starting and was providing care and support to people living at the service. This meant there was a risk people living at the service were being supported by people who did not have relevant training, skills or knowledge to care for them.
● We asked for training records of staff at the service, but we did not receive this information. We were therefore unable to check how staff were trained.

Learning lessons when things go wrong
● It was unclear how lessons were learnt or how they were shared with staff when things went wrong. From our inspection there was no assurance or evidence to demonstrate lesson learning and debriefs took place.

Using medicines safely
● Protocols were not always in place for covert medicine. We found staff attempted to give one person medicine hidden in food or drink, but we did not find evidence this had been agreed by the GP. This was

found to happen on one occasion but as we did not receive all medicine administration records (MARs) requested, we were not assured this was a one-off occurrence.

● Staff completed MARs. Staff completed MARs when they administered medicines. Staff told us if people refused medicines it was documented, and the GP was contacted for advice. We found this happened after reviewing a person's MAR.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now 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 were not involved in planning their care. Relatives told us they had not been involved in helping to plan their relative's care plans. One relative told us they were not sure if staff fully understood their relative's needs which impacted negatively on their wellbeing.

● Care plans were not personalised and did not assess people's individual characteristics such as their sexual orientation or religion. This meant there were risks that staff may not have been aware of certain things that were important to people and may not have supported them in a way that was reflective of their needs.

● Call bells and assistive technology such as pressure mats were in place and used at the service. Call bells were not always accessible or safely placed for people to use, however. For example, call bells were tied together with string and suspended across bedrooms which were trip hazards to people with limited eyesight and mobility.

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

● Activities were not readily available. Some evidence of people partaking in parties (e.g. Valentine's Day and St. Patricks Day) were viewed after inspection, along with a record of one person's activity engagement. While this demonstrated activities were offered, it was not on a daily or regular basis. A person's relative told us "there were two activities persons. Both have left and there is no one, staff have no time." Another person's relative told us "I have no idea of what activities have happened during lockdown. She has barely been out of her room."

● During inspection a staff member had arranged a bingo session with people, but mostly people were observed sat in their bedrooms or in the lounge areas. One person living at the service told us their television was broken and they were lonely. Some people's relatives told us they were not sure of what activities were offered to people.

●People were supported to contact their relatives through the COVID-19 pandemic. Relatives told us people had been supported to make telephone calls, but there had been no access to face time calls. Visiting measures were in place to allow relatives to see people living at the service.

People were not receiving personalised care. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● We were not assured how the service adapted information to ensure all people were able to access it. This could have impacted upon people's opportunity to raise complaints or make choices as information was not available for them to access and use.

End of life care and support

● People did not always have end of life care plans in place. This meant staff were not aware of people's wishes and what should happen for people when they approach the end stages of their lives.

● At the time of inspection there was not anyone receiving end of life care at the service.

Improving care quality in response to complaints or concerns

● The service's complaints and compliments procedures were requested and made available for review following the inspection.

● People told us they felt able to complain. One person's relative told us they had made a complaint about an element of care, but they were not sure if their complaint had been resolved. Other relatives told us they had never needed to raise a complaint before. We requested evidence of how complaints were managed but this was not provided.

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 good. 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.

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

- The registered manager and nominated individual did not have oversight of the day to day running of the service. They did not have processes in place to monitor the service. For example, the registered manager and nominated individual did not know staff were failing to comply and use PPE in accordance with government guidance.
- Information was not shared with staff. Staff were not provided with updates and were asking CQC inspectors for information. Staff told us they felt insecure and uncertain about how the service was being managed.
- Staff were very concerned for the service and their livelihoods at the time of inspection. Staff motivation was low, although staff members told us they were "like a family" and supported one another. There was lack of leadership at the service and staff were seeking answers and support from CQC inspectors during inspection.
- The registered persons were not always honest and open with CQC and the local authority. We found CQC and the local authority had been given at times, contradictory information which made it difficult to establish a true reflection of what was occurring at the service.

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

- A business continuity plan was in place, but staff were not aware of it. Registered persons had failed to ensure senior staff were aware of continuity and contingency plans to ensure running of the service would not be impacted if they were unavailable.
- Contingency plans were not in place to ensure the management of the service. The registered manager and deputy manager were absent from the service during the inspection. Senior care staff left in charge did not know what they needed to do in some instances. For example, senior care staff were unclear about whether to admit a visiting health professional and sought advice from CQC inspectors.
- The provider was unable to fully undertake their role and responsibilities and delayed taking action to manage the absence of the registered manager and the deputy manager. This meant there was no leadership to ensure staff were supported, and people's care needs were managed safely and effectively.
- The registered manager did not understand their role and responsibilities. Notifications that should have been made to CQC had not occurred. This meant CQC did not always have current information regarding what was happening at the service.

● Staff did not feel their concerns were listened to. Staff told us they raised concerns with management about problems, but nothing was ever resolved. For example, daily walk rounds identified a floorboard outside a person's bedroom was rotten/broken but this had not been fixed for over a year.
● Information requested was not made available at the time of inspection. The registered manager was asked to provide a range of policies, procedures and documents but was not able to produce them. None of this information has been provided by the registered manager. We were therefore not assured of how the service was being managed.

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
● People's relatives told us they were informed of incidents at the service. One relative told us "[person's name] fell out of bed and they phoned to tell me straight away." Another relative however told us they had not been made aware of their relative being taken to hospital. Another relative told us they felt the service were not always open and honest.
● Information regarding the service's duty of candour policies and processes was requested, but this was not provided at the time of inspection.

Continuous learning and improving care
● Information was requested but it was not provided. We therefore had no evidence of how the service continually learned or continued to improve the care people received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● It was unclear how people using the service, their relatives and staff were involved in shaping the service. The registered persons did not provide any supporting evidence of how the service was being developed.
● People's relatives did not receive consistent communication. Some people's relatives told us they received emails and telephone calls from the service. Others told us they never received contact and had to approach the service directly for updates. People's relatives consistently told us they had only been able to telephone their relatives. The use of technology such as face time and iPads were not used at the service.

The service was not well-led and the registered persons had no oversight of how the service was being managed. Processes and systems were not robust or in place to identify areas that needed improvement, and to affect change to improve the quality of care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The service worked in partnership with health and social care professionals. Staff told us they shared information and sought support with health professionals as necessary. Relatives told us the service contacted the GP and other health professionals in a timely manner if it was required.
● A visiting health professional advised information about people's treatment plans was not written down by senior staff members. To ensure nothing was missed they would always send the treatment plan via email.

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 Staff failing to wear personal protective equipment (PPE) in accordance with government guidance. Failure of staff to follow safe government guidance around management of COVID-19.

The enforcement action we took:

Urgent NoD served 4 June 2021. Admissions restricted, conditions imposed to ensure staff were wearing PPE appropriately and regular reports on progress to be provided.