Sandylane Limited

Regent Hotel

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Regent Hotel is a care home providing personal care and accommodation to 19 older people who may be living with dementia at the time of our inspection. The service can support up to 29 people across three floors and has lift access and bathroom facilities located on each floor.

People's experience of using this service and what we found
People at Regent Hotel did not receive safe, quality care. People's medicines were not always administered safely and as prescribed. Equipment used to help people transfer was not safe and appropriately maintained. Risks to people's health, safety and wellbeing were not always identified, assessed and appropriately managed. Furthermore, guidance from safeguarding teams was not always followed. Areas of the service were not clean and there were unpleasant odours.

Staff were not recruited safely and the risk of staff working without references had not been assessed and mitigated. Staffing levels were low, which meant people's needs were not always met in a timely manner. People who were at risk of falling did not always receive appropriate supervision. Not all staff had completed required training and did not receive appropriate supervision to ensure they were properly supported and had the required skills for their roles.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Referrals had not always been made to relevant healthcare professionals when people needed them and guidance from health professionals was not always followed. Mealtimes were a poor experience for people, as there was a lack of meal options, people were not informed what they were eating, and people were not offered the opportunity to eat at the dining table.

The provider and the registered manager continued to fail to maintain the safety of the service and improve the quality of care delivered. Shortfalls had not been identified and this included with medicines, risk management, equipment and premises safety, people's personal hygiene, mealtime experiences, healthcare referrals, recruitment records and staff training.

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 and update
The last rating for this service was requires improvement (published 25 February 2023). This service has been rated requires improvement for the last two consecutive inspections and has been rated inadequate at this inspection. At this inspection we found the provider remained in breach of regulations and new breaches of

regulations were also found.

At our last inspection we recommended the provider reviewed and analysed questionnaire responses and take action to implement people's and staff's views. The provider had not acted on the recommendation and had not made improvements.

Why we inspected
We received concerns in relation to medicine errors, staff training, staffing levels, neglect, behavioural needs of people, lack of food and fluids and falsified records. As a result, we undertook a focused inspection to review the key questions of safe, effective, and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. We have found evidence that the provider needs to make significant improvements. Please see the safe, effective, and well-led sections of this full report. The overall rating for the service has changed from requires improvement to inadequate based on the findings of 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 Regent Hotel on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to medicines, risk management, infection prevention and control, mental capacity, staff training, staffing levels, staff recruitment, person-centred care and governance 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
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Regent Hotel

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by 2 inspectors and an Expert by Experience who made calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Regent Hotel is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Regent Hotel is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced. Inspection activity started on 18 July 2023 and ended on 2 August 2023. We visited the location's service on 18 and 25 July 2023.

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 contracts and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 members of staff including care staff, senior staff, and the deputy manager. We also spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 5 people who used the service and 5 relatives. We observed staff interactions and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around the service to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files, and daily records for 6 people and medication administration records for 7 people. We looked at 2 staff recruitment files and reviewed documentation relating to the management and running of the service such as staff rotas, training and audits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People did not always receive their medicines safely and as prescribed. We found medicine stock was not appropriately managed and was not always available which resulted in some people not being administered their medicines as prescribed.
- Staff did not always record the time when they administered people's medicines. This meant they did not know when the last dose was administered which placed people at risk of their next dose of medicine being administered too soon.
- Protocols to administer 'as and when required' medicines were not always in place or detailed which meant staff did not have appropriate guidance to help them determine when someone needed their medicine or be able to assess if the medicine had been effective.
- Handwritten medicine records were not always countersigned by another member of staff. This meant information had not been checked to ensure it was accurate and matched the prescriber's instructions, which placed people at risk of their medicines being administered incorrectly.

People were placed at risk of harm by the continued failure to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people's health, safety and wellbeing were not always identified, assessed, or effectively managed.
- Risks associated with people's behavioural needs were not managed. For example, we observed a person displaying challenging behaviours towards others. However, staff did not manage their periods of agitation and did not offer reassurance to the person or others who may have been affected. Referrals had not been made to relevant professionals and their care plan and risk assessments lacked guidance for staff on how to manage behaviours of agitation and distress. Behaviour records were not always completed following

periods of agitation or aggression.
● Moving and handling equipment was not always safe to use. We found defects had been found on a hoist in May 2023 during its 6 monthly servicing. However, the issues had not been resolved and staff were seen using the hoist to transfer a person during the inspection.
● Fire doors were not effectively monitored and maintained to ensure they provided a suitable barrier in the event of a fire. We found several doors with large gaps underneath which may have reduced their effectiveness in the event of a fire.
● Strategies to safeguard people from the risk of abuse were not appropriately implemented. We found outcomes from a strategy meeting had not been fully considered as rotas were not reviewed and records did not show care was delivered in line with this safeguarding plan.

People were placed at risk of avoidable harm by the failure to identify, assess and manage risks. This was a breach of Regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Referrals had been made to the local authority safeguarding team. However, we found other incidents which may have met the threshold for a safeguarding referral and there was no evidence advice had been sought from the local authority safeguarding team.

We recommend the provider reviews their safeguarding systems and associated records to ensure advice and guidance is sought from the local authority safeguarding team with regards to accidents and incidents which may indicate a safeguarding referral is required.

Preventing and controlling infection
● Not all areas of the service were clean. We found the communal lounge and several bedrooms had unpleasant odours.
● Some areas of flooring could not be effectively cleaned as they were damaged or poorly fitted.
● There were a large number of flies in the service which landed on people and their food and staff did not take appropriate action to address the issue.

People were placed at risk of harm as risks regarding infection prevention and control had not been identified and addressed. This was a breach of Regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely. We found 2 members of staff were employed at the service. However, the provider had not ensured they had received assurances about staff's conduct from their previous employers before allowing them to work independently at the service.
● The provider had not followed their recruitment policy and had failed to assess the risks of staff working at the service without all required employment checks being in place.

People were placed at risk of harm as recruitment of staff was not safe and staffing levels did not support staff to maintain people's safety and meet their needs in a timely manner. This was a breach of Regulation 19 (2) (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels did not always meet people's needs. For example, we observed staff were constantly busy which meant people had to wait for support and their needs were not always met in a timely manner.

● The provider told us staffing levels were safe. However, we saw multiple occasions when the communal lounge was not staffed. This meant people who required supervision due to the risk of falling or demonstrating behaviours that may challenge did not receive the supervision they needed to maintain their safety. Some people's relatives told us they had concerns about staffing levels. For example, a relative said, "I have concerns over the residents in the lounge as there are only a few staff around and if someone falls, they are unsupervised and it's a concern." Staff told us they needed more staff on shift to keep people safe.

People were placed at risk of harm as sufficient numbers of staff were not deployed to meet people's care needs and maintain their safety. This was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider and registered manager were unable to learn lessons when things went wrong as accident and incident reports were not always completed by staff or were not completed in a timely manner. This meant they could not effectively monitor accidents and incidents to learn from them and reduce the risk of them happening again.

People were placed at risk of harm by the failure to ensure complete and contemporaneous records were maintained in relation to accidents and incidents. This was a breach of Regulation 17 (2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were supported by staff who had not completed the required training for their role. For example, 3 staff told us they had not completed all training, this included 1 member of staff who told us they had worked at the service for over a year and had not completed any training during that time.
- The provider and registered manager could not effectively monitor staff training as not all staff employed by the provider were on the training matrix.
- Staff dressed people's wounds despite not completing training or being deemed competent for this task. Records showed a member of staff had dressed a person's legs after they had removed their dressings. However, there was no care plan in place to support staff with this task and the training matrix did not show any staff had received training in the dressing of wounds.
- The provider and registered manager could not ensure staff received appropriate supervision for their roles and they could not effectively monitor staff conduct and skills. We found the provider's supervision matrix was not up to date as all staff employed at the service were not recorded on it.

People were placed at risk of harm by the failure to ensure staff had the training and skills required for their roles. This was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider and registered manager had failed to ensure the MCA was effectively applied to ensure consent was gained and care was delivered in the least restrictive way. People's capacity to make specific decisions around support and restrictions had not been assessed to ensure people could consent.
● Where people were unable to make decisions, there was no evidence to show decisions made were in people's best interests and they were the least restrictive option.

The failure to effectively apply the MCA meant people's care was not always provided with the relevant consent and the use of restrictions had not been appropriately explored. This was a breach of Regulation 11 (1) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS had been applied for and authorisations granted, and a system was in place to help with monitoring and meeting DoLS conditions.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to maintain their nutritional and hydration needs.
● People were not always offered alternative meal options, a choice of drinks or the option to eat at a dining table. We saw people were not always offered a choice of meals or drinks, and were not informed of what was being served. People were also all served the same meal and people were not offered the opportunity to have their meal at the dining table. A relative told us, "[Person's name] is not bothered about food they just eat what's put in front of them. I don't think they give [Person's name] a choice, it's the same for everyone."
● People were not always referred for professional support when there were concerns. For example, on 2 occasions we saw 1 person coughing when eating. Staff had not identified this person was at risk of aspiration when eating and a referral to the relevant medical professional had not been made.
● Where people had been referred for professional support, advice and guidance was not always followed. For example, 1 person required thickened fluids to manage their risk of aspirating when drinking. However, we found not all staff were providing this in all drinks, which placed the person at significant risk of aspiration.

People were placed at risk of care being delivered which did not meet their needs and was not in line with their personal preferences as people were not provided with appropriate support and choices around their care. This was a breach of Regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were assessed prior to using the service and care plans were created. However, these were not regularly reviewed and updated which meant they contained conflicting information about people's needs and the support they required.
● Areas of the service were not used effectively to help meet people's needs. For example, dining areas were not used at mealtimes and there was a lack of communal areas that people could access if they needed a quieter space but didn't want to spend time in their bedrooms.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to manage risks to the health, safety and welfare of people. This was a breach of Regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● The provider and registered manager continued to fail to fully understand their responsibilities to deliver a safe, well led service. Issues found at the last inspection had not been addressed and significant shortfalls were found during this inspection.
● Quality assurance systems were not operated effectively to identify quality and safety shortfalls. For example, fire doors were monitored for defects and some shortfalls had been found through the provider's audits. However, they had not been operated effectively as they had not found shortfalls with 3 fire doors which we found during the inspection. We requested another, thorough audit be completed, and a total of 15 fire doors were found to have defects which compromised fire safety.
● Audits had failed to identify shortfalls we found in relation to the safe administration of people's medicines.
● Quality assurance systems and processes were not regularly reviewed and updated to ensure they remained effective at identifying shortfalls. We raised shortfalls with the registered manager and the nominated individual during the inspection, but found the information was not used to improve audits and audits did not follow best practice guidance.
● Quality assurance systems failed to identify shortfalls in the delivery of people's care, and they failed to identify risks to people's safety and wellbeing and were not being effectively managed.
● Records of people's care and treatment were not up to date and accurate. We found incidents were not recorded and records did not match information we had been given by the registered manager.
● There was a lack of oversight of accidents and incidents which meant risks to people's safety and wellbeing had not been appropriately reviewed, assessed, and learned from to reduce the risk of them happening again.

The failure to ensure systems and processes were established and operated effectively to manage risks to the health, safety and welfare of people placed people at risk of avoidable harm and of receiving poor quality care and had failed to ensure complete and accurate records of people's care and treatment were kept. This was and continued breach of Regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we recommended the provider reviewed and analysed questionnaire responses and take action to implement people's and staff's views. The provider had not made improvements.

● Feedback was not sought from people who used the service, staff, and other visitors to the service, such as visiting professionals. This meant the provider and registered manager were unable to identify how people wanted the service to be improved and were unable to improve the safety and the quality of the service.

The failure to encourage feedback about the quality of care from service users, their relatives and other relevant bodies placed people at risk of receiving a poor-quality service. This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not offered choice and control of their day-to-day life. This included meals options, drinks, and mealtimes. For example, we raised with a member of staff that a fly had landed on a person's meal. They took the meal away from the person and brought them out a pudding. However, they had not checked if they wanted a fresh meal providing, if they had in fact finished their meal, if they were ready for their pudding or offer them a choice of puddings.
● People appeared unkempt, and care had not been delivered in line with their preferences. For example, a relative told us their loved one liked to be clean shaven, and this was recorded in their care plan. However, on both days of the inspection we saw them with long stubble and their relative told us their loved one was not always clean shaven and, "[Person's name] has some stubble."
● Records showed people were not always supported to bath or shower. We checked bath and shower temperature records which showed for 1 week only 5 people had been supported to bath or shower, despite 19 people using the service.

The failure to ensure care met people's needs and the failure to provide person-centred care and support placed people at risk of harm and at risk of their care needs not being met in line with their personal preferences and requirements and which compromised their personal hygiene and dignity. This was a continued breach of regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Notifications had been submitted to the local authority safeguarding team and to CQC when things went wrong. Though we found there was a delay in submitting 1 safeguarding referral and some incidents had not been discussed with safeguarding which may have required a safeguarding referral to be made.

Working in partnership with others

- The local authority was supporting the provider to identify shortfalls and with creating action plans to address the issues within set timeframes.
- Referrals were not always made to relevant professionals and the provider had not ensured guidance was always followed.

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 The provider failed to ensure care met people's needs and failed to provide person-centred care and support. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to effectively apply the MCA which meant people's care was not always provided with the relevant consent and the use of restrictions had not been appropriately explored. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure the safe recruitment of staff and staffing levels did not support staff to maintain people's safety and meet their needs in a timely manner. Regulation 19 (2)(a)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure staff had the training and skills required for their roles. Regulation 18 (1)(2)(a)