Mrs Victoria Lavender-Mew

Bedwardine House Residential Care Home

Inspection report

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Tel: 01905425101

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bedwardine House is a care home providing accommodation and personal care for up to 25 older people. The care home is an adapted building over two floors. At the time of the inspection 14 people were living at the home.

People's experience of using this service and what we found
Systems, processes and reviews to assess the quality and safety of the service provided to people continued to be either not in place or ineffective in recognising shortfalls identified during the inspection.

Improvements in the storage of certain medicines had taken place since our previous inspection. Further medicines management shortfalls were identified as requiring improvement.

Improvements had taken place regarding the safe recruitment of staff since the previous inspection.

Government guidelines regarding infection control were not always followed and recorded as required. Staff were seen to be wearing Personal Protective Equipment (PPE) and relatives spoke highly of how the COVID-19 pandemic had been managed including enabling people to maintain contact with their family.

The information within care plans and risk assessments had improved since our previous inspection to ensure staff were able to provide consistent care and support.

Management and staff were aware of their responsibility to report all allegations or suspicions of abusive practice within the home as a means of keeping people safe from harm.

The provider, business manager and deputy manager acknowledged our feedback and gave further reassurances of their plans to make the necessary improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update:
The last rating for this service was requires improvement (published 04 February 2020). There were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when they would improve. At this inspection we found improvement had been made and the provider was no longer in breach of three regulations. Enough improvement had not been made and the provider was still in breach of one regulation. The service remains rated requires improvement. This service has been rated requires improvement for two consecutive inspections.

Why we inspected
This inspection was prompted in part due to concerns regarding the management of the home during the COVID-19 pandemic and the deployment of staff. This followed notification from the provider of the

outbreak.

In addition, the inspection was prompted following notification of a specific incident resulting in the death of a person following a fall from a height. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

As a result, we undertook a focused inspection to review the key questions of safe 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.

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 have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bedwardine House Residential Care Home 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 monitor the service and 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 a breach in relation to good governance regarding the management of the home.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bedwardine House Residential 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
This inspection was carried out by one inspector.

Service and service type
Bedwardine House Residential 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.

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 and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return 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 this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, business manager, deputy manager, two care workers and one cook.

We reviewed a range of records. This included two people's care records and multiple medication records. Additional we looked at a variety of records relating to the management of the service, including policies and procedures.

We carried out short observations taking into account the need for social distancing during the COVID-19 pandemic to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found and viewed documents sent to us as requested. We spoke with three family members to seek their experience of the home and the management of the pandemic.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- At the previous inspection we highlighted areas which needed improvement regarding people's medicines. At this inspection we saw areas whereby improvement had taken place however further improvement is required.
- The provider was unable to evidence the safe return of controlled medicines (medicines requiring additional recording to ensure they are stored and maintained safely) to the pharmacy. This was because the records did not evidence the amount received by the pharmacist.
- Although we were assured people had received their medicines safety and as prescribed the provider was not always able to fully evidence this. For one person we could not be establish whether there had been an administration error or a recording error.

Preventing and controlling infection

- The recording of people's daily temperatures in line with government guidance within the document 'Admission and care of residents in a care home during Covid-19' was either not in place or insufficiently maintained. This meant the provider was unable to evidence they were taking proactive action to people encountering someone showing a symptom of COVID-19. Following the inspection, the deputy manager confirmed they introduced a system to ensure these are recorded as required.
- Although the provider was not recording staff and visitors' temperatures, we were assured by relatives who had visited they had their temperature taken prior to entering the home and were required to take a rapid COVID-19 test and wear full personal protective equipment (PPE).
- We were assured additional cleaning practices were in place as a result of COVID-19 however there was no evidence of these having taken place. We found the environment to be clean in the areas we viewed.
- We were assured that the provider was using PPE effectively and safely. Staff members were seen to be wearing face masks throughout the day in order to protect people living at the home and themselves in line with government guidelines. People confirmed staff always wore a mask while assisting them with any personal care.
- Staff had received training on the putting on and removing of PPE and were to commence refresher training on the computer at the time of the inspection.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● Accidents were recorded following the incidents. However, there was a lack of oversight of accidents and incident to mitigate the risk of reoccurrence. The deputy manager undertook to introduce a system whereby they would evidence and record regularly an oversight of any incidents.

Staffing and recruitment

At our last inspection the provider had failed to mitigate risks to the health and safety of people because people were not protected against the risk of unsafe recruitment. This constituted a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (2008) Regulated Activities (2014).

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Prior to new members of staff starting work for the provider checks, including one to the DBS (Disclosure and Barring Service), were undertaken. The DBS is a national service who keep records of criminal convictions.

● People living at the home believed there were enough staff on duty to be able to have their needs met. One person described the staff as, "Super". Staff told us there were sufficient numbers on duty to be able to meet the needs of people.

Systems and processes to safeguard people from the risk of abuse

● Staff members were aware of their responsibility to report any concerns they had regarding potential abuse.

● People told us they felt safe living at the home and were aware they could speak with staff members in the event of them having any concerns or worries regarding their care. One person stated, "I am safe here".

Assessing risk, safety monitoring and management

● The provider had introduced an electronic system for recording care interventions as well as care plans and risk assessments. We saw an improvement in the record keeping since the previous inspection as a result of the newly implemented systems.

● Identified risks regarding people's care were assessed and regularly reviewed in order to ensure safe systems were in place. Risks included people's mobility, skin care and dietary recorded as well as individual likes and dislikes.

● Care plans were seen to be individual and person centred, these covered areas such as how people's care and support was affected due to the COVID-19 pandemic. Areas such as how people's privacy and dignity were recorded. Staff displayed an awareness of how they needed to support people.

● One person told us they were, "Happy with the care" they were receiving.

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 requires improvement. At this inspection this key question has remained the same. 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.

At our last inspection we found that systems had not been established to monitor the risks to people's health and safety. This was a breach of regulation 17 (Good Governance) 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. This is the second consecutive inspection where the effectiveness of the provider's systems to monitor the quality of the services has been a cause for concern.

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

- The provider had not undertaken sufficient and effective oversight of the service provided. Systems to monitor the safety and wellbeing of people were either limited or insufficient.
- The provider did not, have systems in place to monitor, review and analyse accidents and incidents. This meant the provider was unable to demonstrate they had considered any trends or themes regarding incidents within the home to reduce the likelihood of these reoccurring.
- The provider confirmed they had not undertaken any audits in relation to the management of people's medicines. This meant opportunities to highlight shortfalls were missed placing people at potential risk.
- Although staff confirmed they had their temperature taken upon arriving for their shift these were not recorded during the COVID-19 pandemic. This meant the provider was unable to evidence they had taken due diligence. Government guidelines state it is the employer's responsibility to ensure staff work safely. Following our inspection, the deputy manager confirmed they had introduced a system whereby they were recording these temperatures.
- The recording as per government guidelines of people's temperatures twice daily was sporadic and disjointed. The provider had not as part of their monitoring of the service highlighted this as a concern and in need of improvement to show they were actively protecting people from the spread of COVID-19. Following our inspection, the deputy manager confirmed they had introduced a system whereby they were recording these temperatures.
- Systems in place to monitor hot water temperatures were in place. However, these only monitored extremities within the water system and not all hot water taps to ensure the water was delivered at a safe temperature in line with health and safety guidelines. Although no one had been scaled this was a potential risk which was not identified due to the lack of systems in place.
- The provider was unable to locate records regarding checks undertaken to assure themselves people were

living in a safe environment. This meant they were unable to be assured these had recently taken place and of any actions which were required had taken place.

Systems were either not in place or robust enough to demonstrate systems were in place to ensure people were safe and their wellbeing managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and deputy manager were open and transparent with us and assured us further improvements would be made within the home. The provider and business manager spoke highly of the work undertaken by the deputy manager especially during the COVID-19 pandemic and recent outbreak.
● Following our inspection, the deputy manager confirmed they would introduce a system whereby they would review accidents and incidents to identify any trends in order to mitigate risks. We will assess the impact of these changes at our next inspection.
● The deputy manager had undertaken checks during the night to ensure staff were wearing personal protective equipment (PPE) as required.
● The provider was aware some training such as practical fire training had not taken place due to the need to have collective staff together. They were seeking alternative ways of providing this training in a COVID-19 secure way.
● The previous rating given by the CQC was displayed as required.

At our last inspection we found the provider had failed to notify the Care Quality Commission [CQC] of important events as required by the legislation. This was a breach of regulation 18 (Notification of other incidents) of the Registration Regulations 2009.

The provider was no longer in breach of regulation 18 of the Registration Regulations.
● Since our previous inspection the provider and deputy manager have submitted notifications as required following certain events which have occurred within the home. The provider and deputy manager have demonstrated an awareness of the requirement to inform CQC of certain events and incidents.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People told us they were well cared for. People had an understanding or awareness of recent or current restrictions such as social distancing, remaining in their own space and the limitations regarding visitors.
● Staff were seen to support people and provide individual care whereby people were empowered to make decisions such as where they spent their time.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● Relatives told us they had been kept informed throughout the COVID-19 pandemic regarding their family member and how they believed the provider had managed the situation well. This had included enabling visits to see loved ones and using technology effectively to keep in touch.
● Staff members told us they felt supported by the management. Staff told us they liked the work they were doing.
Working in partnership with others
● The provider and deputy manager worked with healthcare and social care professionals including during a recent outbreak of COVID-19.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective governance systems in place to assess and monitor the quality of the service to identify shortfalls and ensure compliance with regulations. Regulation 17 (1) (2) (a),(b),(c)

The enforcement action we took:

Warning Notice