Mrs M Plumb and Miss K Bolt-Lawrence

Enbridge House Care Home

Inspection report

Church Road
Woolton Hill
Newbury
Berkshire
RG20 9XQ

Tel: 01635254888
Website: www.enbridgehouse.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Enbridge House Care Home is a residential care home providing personal care for up to 17 people aged 65 and over. The service was supporting 14 people at the time of the inspection. The care home accommodates people in one adapted building, across three floors.

People's experience of using this service and what we found
People were not safe in the service. There were serious concerns about the care of people's skin in the service. The provider had not involved external healthcare professionals appropriately to support people safely. There were health and safety risks in the service. The provider lacked understanding of safeguarding processes. Medicines were poorly managed, and the service did not learn from incidents.

There were serious failings to assess and meet people's health needs, including where people had lost weight. The service was not up to date with best practice.

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. The provider had not sought appropriate authorisation to restrict people's freedom.

The provider told us they tried to protect people from COVID-19 by keeping professionals out of the service. This had created a closed culture where people were put at risk and people's health needs were not met. The provider had failed to maintain oversight of the service and had not identified the concerns identified in the inspection. They were providing treatment that had not been agreed with healthcare professionals and were making decisions without appropriate consultation with the GP or community nurses.

Though we observed some caring interactions from staff, the closed culture within the home and lack of support for people's health needs did not demonstrate a caring culture. People were not appropriately involved in decisions about their care.

Care records were not person-centred or appropriately detailed and sometimes were out of date. There was a lack of meaningful activities taking place in the service. Decisions around end of life care planning were not appropriately documented.

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 13 April 2019).

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Enbridge House on our website at www.cqc.org.uk.

Why we inspected
The inspection was prompted due to concerns received about wounds, moving and handling, the management of the service and that people's needs were not being met. A decision was made for us to inspect and examine those risks.

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 have found evidence that the provider needs to make improvements.

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

The provider was working with external agencies to make improvements and reduce the risks identified in the inspection.

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 service users from risk of abuse, meeting nutritional needs, good governance, staff training, recruitment, notification of incidents and display of the Commission's rating 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 requested and received an action plan from the provider following the inspection to understand what they will do to improve the quality and safety of the service. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details in our well-led findings below.

Inadequate

Enbridge House 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 two inspectors and a medicines inspector.

Service and service type
This is a care home service without nursing.

Enbridge House 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 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 five people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, care manager, senior care workers, care workers and the chef. We observed people and staff in communal areas of the home to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and seven people's medication records. We looked at three staff files in relation to recruitment and reviewed staff supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested an action plan urgently to address the serious concerns we found in the service. The first action plan received was poor and we asked the provider to submit another one which was received and contained more detailed information.

We requested further documentation and 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.

Assessing risk, safety monitoring and management

- Skin and wound care was poorly and inappropriately managed. For example, one person had 12 wounds. We saw records that suggested some wounds were approximately a year old and the community nurses confirmed this in their assessment of people's wounds. People should have been referred to the community nurses for treatment, but the service had been inappropriately treating the wounds. One staff member told us, "I do agree with you. There's things that should have gone out of the building to the district nurses" and "It wasn't getting any better, I noticed [person] had a red mark on her foot months ago". The GP had not been informed of wounds or pressure ulcers until a safeguarding was raised by a healthcare professional.
- There was a lack of appropriate equipment in place to reduce the risk of harm. For example, appropriate chairs and mattresses.
- Concerns about risks were not handed over among the staff team. Wounds were poorly recorded and body maps not always completed. Some of the wounds staff were unable to explain.
- Health and safety was poorly managed in the service. Hot water tanks were not locked and secure. Hot water tanks pose a risk of scalding if people can access them. We found a window on the first floor that was not restricted and presented a risk of injury.
- The provider was not managing fire risks appropriately. For example, they were not carrying out fire drills as detailed in their fire risk assessment. The registered manager informed us there were no personal emergency evacuation procedures (PEEPs) in place. This meant in the event of a fire, there was no readily available information to support the fire service or staff in how to evacuate people safely according to their individual needs.
- We reviewed the provider's legionella risk assessment. It was dated 2011 and had not been completed by a suitably competent person. We asked the provider for more information about their management of legionella risk, but it was not received.
- Records and risk assessments were either not in place or did not support safe care. For example, a person who was very low in weight did not have a robust risk assessment regarding eating and drinking.
- One person in the service was at risk of choking. They were given a pureed diet but the provider had not referred the person to speech and language therapy. Although the person did not come to harm, this meant the causes of their risk of choking were not professionally assessed and an appropriate diet not professionally advised. Staff preparing food had not had training in specific diets for people at risk of choking and were not following up to date guidance.
- Bedrails were in place with no risk assessments. For example, one person's leg became trapped in bed rails and they sustained an injury. No risk assessment had been completed.

The failure to assess and mitigate the risks to the health and safety of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback, the provider took immediate action to address the health and safety concerns found. The provider received support from the community nursing team to manage people's wounds and put appropriate equipment in place. An external team provided skin care training to staff on 19 July 2021 and another session was planned to take place. A speech and language therapist attended the home and provided training on 22 July 2021 in how to support people with choking risks safely.

Systems and processes to safeguard people from the risk of abuse

- The provider and registered manager had a poor understanding of safeguarding processes. They did not understand that certain types of wounds could be a sign of neglect and required reporting to the local authority and the Commission. This meant information about people's wounds had not been notified to the local authority and this had exposed people to harm.
- Staff we spoke with had a basic understanding of safeguarding but most had not received training and had not recognised concerns about the care being provided. The culture of the home was closed and staff accepted the concerns in the home as normal. Where concerns were raised, they had not been acted on.

The failure to protect people from neglect as a form of abuse 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 provider informed us all staff had completed safeguarding training following the second day of the inspection. The provider agreed their knowledge of safeguarding needed improvement.

Staffing and recruitment

- The provider did not have an effective system in place to ensure staff were safe to work with people who received care. Three staff members had started work before their Disclosure and Barring Service (DBS) check had come through, one person three months before. The DBS check is important as it gives providers information about any previous cautions or convictions a prospective employee may have, enabling them to make safer recruitment decisions.
- It was not clear if references had come through before people started work and one person's reference was dated after they had started work. The provider told us this was because they knew the staff member personally and didn't have any concerns. The three staff did not have complete employment histories, reasons for leaving previous employment or health risk assessments. These failures in the recruitment process meant the provider could not be assured staff had been recruited safely.

The failure to carry out appropriate employment checks as detailed in Schedule 3 was a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were not assured about the staffing levels in the service. The provider, registered manager and care manager were regularly providing care or covering care shifts. The provider was also covering shifts for the cook. This meant they were providing care instead of maintaining appropriate oversight of the service.
- There were three staff members rostered to support with mealtimes. Although the management of the service sometimes helped with mealtimes there were several people who preferred to eat in their rooms, people who needed encouragement or prompting to eat and three people who needed full support to eat. The provider was unable to show us evidence that this was a sufficient number of staff to support people to eat, particularly people who were malnourished. We also observed an external healthcare professional helping support people to eat.
- One relative told us the staff were always busy.

Using medicines safely

● We observed staff supporting people with their medicines. The staff were constantly interrupted when they were giving medicines to people. The staff left medicines with people to take themselves unsupervised without appropriate risk assessment. The staff also signed for medicines on the medicine administration records (MAR) before giving them. MARs must be signed after the person has been seen to take their medicines.

● We found medicines in one person's room from the previous day as they had not taken them. However, the staff had signed the MAR to record these medicines as being administered. This meant the MARs were not an accurate record of medicines administered to people living at the home.

● Processes for storage of medicines were not appropriate or secure, for example, some medicines were kept in people's rooms and next to food in the fridge.

● Records were not maintained accurately for the administration of controlled drugs. There was not always a second staff signature to show the medicine administration had been witnessed.

● All the MARs at the home were handwritten by the staff. However, these had not been checked and signed by the staff who wrote them or a second member of staff to identify errors.

● Some people were prescribed medicines to be taken on a 'when required' basis but there were no protocols in place to guide staff on how to administer these medicines.

● The staff received training for handling medicines. However, the provider had not carried out regular competency assessments to ensure staff administered and handled medicines safely.

● The provider's medicines management policy was not up to date with best practice guidance.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We identified concerns around food hygiene in the service. Due to concerns also raised by the local authority Environmental Health attended the service on 20 July 2021. They informed us there were major concerns about the food hygiene practices in the service and they issued the provider with immediate actions to make the food hygiene practices safe.

● We identified concerns about the infection prevention and control in the wider service for example, the management of personal protective equipment and areas where the home was cluttered or in a poor state of repair and presented a risk of cross infection. We received feedback from an infection prevention and control (IPC) specialist nurse with multiple areas of concern about IPC practices.

The failure to assess and mitigate the risk of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they took immediate action to complete urgent actions raised by Environmental Health. The provider immediately started improving the condition of the building internally. An external professional provided training in IPC for staff.

● Visiting was taking place in the service. One relative told us they were unsure what the rules for visiting the service were.

Learning lessons when things go wrong

● The service was not documenting all incidents. We were informed of a serious medication incident that had not been recorded or investigated. Pressure ulcers were not documented as incidents or investigated. This meant the provider and registered manager did not have oversight of the amount of pressure ulcers in

the service.

● There were examples of the provider not learning from previous incidents. Staff told us about incidents where people had either fallen out or nearly fallen out of wheelchairs due to footplates not being used or causing a hazard to the person. We saw people being moved in wheelchairs without footplates and without the person's feet being closely monitored. This demonstrated the provider and staff had not learnt and had not sought appropriate advice from the relevant healthcare professionals. Wheelchairs were in a poor condition and people were not in an appropriately sized wheelchairs to support their posture. The provider purchased new wheelchairs and referrals were made to physiotherapists and occupational therapists for assessment.

● The provider ordered a new accident book to facilitate better documentation around accidents and incidents.

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 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 people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- Some people had sustained significant unintentional weight loss. This had not been appropriately identified or managed by the provider. Seven people were at high risk of malnutrition and should have been referred to the dietician. One person had lost 26kgs in 15 months and their weight should have triggered a dietician referral in May 2020. Where people had lost weight or were low in weight, it was unclear what action had been taken. In relation to weight loss, the registered manager told us, "To be honest, we had appreciated that things are not as tight as they should be." External healthcare professionals told us the service lacked understanding in how to monitor and act on weight loss.
- There was a lack of recognition from staff that people were low in weight and losing weight consistently. This was seen as an inevitable part of ageing alongside pressure ulcers. There was a lack of understanding the two concerns are linked to each other as malnutrition increases the risk of skin breakdown.
- Daily records did not demonstrate any concerns being raised about weight loss even if a person was noted to be 'eating very little'. The nutritional risk assessments were poor or not in place. People's weight was not monitored regularly enough. There was no clear guidance in the kitchen to show people at risk and their specific needs.
- Although the provider told us high calorie foods were offered to people regularly there was no documented evidence this had taken place or been monitored for those at risk of malnourishment.

The failure to meet the nutritional needs of people in the service was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to make urgent dietician referrals for people and these were completed. Staff were re-trained in nutrition and hydration. The provider introduced a daily nutrition and hydration form to monitor people's intake to be reviewed in conjunction with the dieticians. The provider made information available to staff on how to escalate concerns about eating and drinking to outside professionals.

Staff support: induction, training, skills and experience

- It was unclear from records that staff had been appropriately trained. We reviewed paper training records at the service and training records from an online provider, but the provider was not able to clearly evidence what training staff had received. After the inspection, the registered manager sent us a training matrix but was still unable to evidence whether staff had suitable training.
- Fewer than half the staff had safeguarding training at the start of the inspection. Neither the provider, registered manager or care manager had safeguarding training and had very little training overall. The staff

member who had been treating wounds did not have any recent training in wound management. Very few staff had training in food hygiene. Given the concerns found in the inspection, this placed people at significant risk of harm as staff were not suitably trained to carry out their duties and this had an impact on people.

The failure to ensure staff received appropriate training was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager asked staff to complete a number of training updates during the inspection and told us they would put in place a better system to have oversight of the training staff received.

● Staff told us they felt well supported by the registered manager and provider. Supervision sessions did take place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider was not following up to date guidance across the service. We asked the registered manager if any areas of the care provided had been updated in line with up best practice and they were unable to give us an example.
● People's needs and choices were not sufficiently assessed. The service made assumptions about how people would want their health and care needs to be managed. This led to a lack of professional input to support people's health and wellbeing.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider told us they had stopped external healthcare professionals from entering the home at the beginning of the pandemic and this had only resumed at the end of June 2021, except the GP who had visited on a few occasions. This had placed people at risk of harm and people had experienced poor health outcomes.
● The GP reported some clinical concerns had been raised by the home, but the home had kept no records of this. The provider told us they had stopped recording communication with external healthcare professionals in July 2020, but it was unclear why. Therefore, there was no evidence the service had sought advice from external healthcare professionals since that time. We received feedback from external professionals that they had not heard from the service for many months.
● The service had not explored other reasons for people losing weight. For example, two people in the service had ill-fitting dentures and the service had not discussed this with the person or referred to an appropriate healthcare professional, for example a dentist. For one of these people, there was no record of the dentures being ill-fitting in their notes at all. The GP informed us they had challenged the approach of people being given pureed food due to dentures, but dentistry input had still not been sought. No one in the service had received an oral health assessment, as recommended in best practice guidance.
● Some people in the service were low in mood but there was no evidence this had been followed up appropriately. For one person, staff had recorded, 'she doesn't want to be here anymore'. There was no evidence advice had been sought or support given to the person. The GPs were involved in the prescription of antidepressants for some people, but this was the only evidence of intervention for low mood we found. The GP informed us that antidepressants could have a negative effect on appetite, but no other interventions were tried to support people. The provider had not supported people's wellbeing or recognised the impact this could have on their nutrition.
● A staff member confirmed external support was available during the pandemic, but the home wanted to

keep visiting professionals to a minimum. They confirmed that as a residential home, they understood they should not assess pressure ulcers and should call community nurses in, but they had still decided not to. The GP was the only visiting professional to have accessed the home since the start of the pandemic.

The failure to make referrals to appropriate healthcare professionals and do all that is practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following input from the Commission and other agencies, numerous healthcare referrals were made for people. This was indicative of the gap in healthcare provision before the inspection. The provider and registered manager acknowledged they should have involved professionals sooner and accepted support from all agencies involved. Concerns about ill-fitting dentures were also handed over to the GP for follow up.

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- There were people living at Enbridge House who had restrictions on their freedom. Most people needed staff supervision and were not free to leave the service as this would endanger their safety. There were also pieces of equipment which restricted people such as bed rails to restrict movement in bed and sensor mats to alert staff when the person moved position. The service had not sought the legal authority to maintain these restrictions over people. This was a breach of people's human rights. No person should have a restriction on their liberty without lawful authority.
- Staff we spoke with demonstrated an understanding of mental capacity and supporting people to make their own decisions as much as possible but there were no capacity assessments in place. This meant the service was regularly making decisions without considering if people needed support to make decisions.
- Where people did have bed rails in place, there had not been any mental capacity assessment or risk assessment in place. This is important due to the risk of injury posed by bed rails.
- Five people were being given a pureed diet but there was no evidence people's consent had been sought or best interests decision considered with appropriate professionals. Pureed food could present an unnecessary reduction in quality of life and it was unclear if this had been considered.

The failure to ensure people were not deprived of their liberty for the purpose of receiving care without lawful authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback from the commission and local authority that these authorisations needed to be made, the provider made the applications. The provider accepted they lacked understanding of mental capacity and the records required but assured us they would undertake additional training to improve their understanding. The provider also received support from an external team in how to complete bed rails risk assessments appropriately.

Adapting service, design, decoration to meet people's needs

- The provider informed us they were planning to make changes to the interior of the building. It was unclear how much people would be involved in the decisions about the changes to the environment.
- The building was cluttered and there was no particular signage or decoration to support people with dementia to orientate themselves in the building. We noted two areas in the building where the lighting was poor which would not support people with dementia to move through the building comfortably or safely.

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 were not always well-supported, cared for or treated with dignity and respect.

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

- We received positive feedback from external professionals about the staff being caring and relatives told us Enbridge House was a nice home. However, there was a closed culture within the home where people were not supported to access healthcare appropriately leading to poor outcomes.
- We observed some nice interaction from staff during the inspection. However, some staff members described people who needed support to eat as "feeds" and care records were not always caring, for example, describing people as 'needy'.
- Where people were low in mood, there was a lack of evidence that this was followed up and people's wellbeing supported.
- The service had celebrated people's birthdays with them and records showed people had enjoyed presents and cake.

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

- We asked the provider to send us evidence of seeking and acting on people's feedback. We did not receive this so could not be assured that people were supported to express their views about the service provided. People had not been consulted about healthcare referrals and there were examples where appropriate consent had not been sought from people. We were not assured that people were involved in decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- Staff told us they supported people to make their own decisions as much as possible, particularly around day to day decisions. One staff member told us a positive example of supporting a person with dementia with dignity.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records were not person centred, lacked detail and were often out of date. They were also not always appropriately dated and timed, making it difficult to establish which records were the most recent. The records did not give a clear understanding of the person and their individual needs. Daily records were task focused and did not demonstrate a person centred approach or that people were able to access meaningful activities.
- We received feedback from the local authority and external agencies that the care records they reviewed lacked appropriate detail and needed improvement.

The failure to maintain accurate, complete and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider continued to receive support from external teams to improve the quality of records in the service. They were moving records to an electronic system and reported this would improve the records substantially. We received feedback from the local authority that records were improving as the inspection progressed.

- Rooms were well personalised with people's personal belongings, such as books and photographs.
- The registered manager told us no one in the service had specific needs around protected characteristics such as religion or sexual orientation but that any such needs would be accommodated. They reported in the past they had accommodated religious services in the home.

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.

- The registered manager was not aware of the AIS but reported they would support anyone if they required information in a different format.

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

- Staff told us people were supported to do things they enjoyed for example, watching television or doing jigsaw puzzles. However, the service was not providing any meaningful person-centred activities where they

had sought the person's input on what they would enjoy. People appeared lacking in energy and withdrawn in the service. The registered manager told us, "A general feeling of flatness would be fair to say."

● Although staff told us they supported people emotionally during the pandemic because people could not see their relatives, it was unclear how they did this. The provider confirmed no activities had taken place during the pandemic because people that used to come to the service to provide activities had not been able to. The service had not tried to do meaningful activities in house.

Improving care quality in response to complaints or concerns

● The provider told us they had not received any complaints since the last inspection. We asked the provider and registered manager how they would handle complaints, but they did not provide this information.

End of life care and support

● End of life care planning was not always clearly recorded and did not always show how staff could support people. There was a lack of evidence that all appropriate action had been taken to ensure people were comfortable and had all of their health and wellbeing needs met at the end of their life. There was a lack of evidence that appropriate professionals such as GPs had been involved in decisions about advanced decisions or end of life planning.

● The provider told us they communicated with families regularly when people were approaching the end of their lives.

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

● There had been serious failings in the governance of the service that led to a closed and complacent culture within the home. The registered manager told us, "I think we became totally insular for this isolation time" and "because we all know each other, it allows for complacency". The attitude within the service was that pressure ulcers and weight loss were an inevitable part of aging. This was inappropriate and not evidence based.

● People had been in the service for some time and their needs had changed. The provider had not recognised this and attempted to manage without appropriate support from external agencies. The registered manager told us, "Over the last 18 months, I hold my hands up. We didn't use our outside resources as much as we should." One healthcare professional told us the home's strategy for COVID-19 had been misguided. It had been a disproportionate response which placed people at risk of harm and led to poor health outcomes for people.

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

● Enbridge House is registered as a care home that can only provide support for personal care needs. People living in the home need external healthcare support and advice for all medical needs. At the time of the inspection the provider confirmed that a member of staff had been providing care and support to meet medical needs. Whilst this member of staff was a registered nurse, this was outside of the provider's registration. The provider had made the decision to carrying out nursing care when they were not legally registered to do so.

● The provider reported some of these tasks, for example blood tests and injections, had been delegated to them by the community nurses and GP. However, there was a lack of appropriate competency assessment and oversight of the community nurses and GP for this to be safe or in line with guidance. It is the provider's responsibility to ensure they are only carrying out regulated activity they are registered to provide.

It is an offence under Section 10 of the Health and Social Care Act 2008 to carry out a regulated activity without being registered.

We advised the provider of this and they agreed to immediately stop providing this care.

● The provider and registered manager had failed to monitor the service appropriately and there were

widespread issues across all areas of the home. This demonstrated a poor understanding of regulation and their legal responsibilities as registered persons.
● The provider did not have an effective system in place to monitor the quality of the service. The provider had carried out audits of the building and medicines, both of which had failed to identify and address the issues found. They had not carried out any other audits of the care provided and therefore had not identified concerns. Records were hard to find and analyse and many that we requested were not received or received in a format we could not open. This was indicative of a poor governance system. Policies and procedures were outdated and the provider had not kept the service up to date with best practice.
● The registered manager was not available for the majority of the inspection and systems and processes did not ensure the service ran effectively in their absence. The provider did not know where information was and did not understand elements of the care being provided. The provider acknowledged the records in the service were poor and told us, ""I hold my hands up, the records are [very poor]".

The failure to have systems and processes in place 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.

● Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. The provider and registered manager had failed to notify the Commission of the safeguarding concerns that had been raised about the care provided and the serious pressure ulcers in the service. The provider's policies did not note the requirement to notify the Commission of certain incidents.

The failure to notify the Commission of all relevant incidents that affect the health, safety and welfare of people who use services was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We spoke to the registered manager and provided clarification on the type of incidents required to be notified to CQC to improve their understanding. Following our feedback, the provider completed necessary notifications.

The service was not displaying its Care Quality Commission rating from the last inspection in the service or on their website.

The failure to display their previous rating was a breach of Regulation 20A Requirement as to display of performance assessments 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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was able to tell us what the duty of candour was. We asked the provider and registered manager to provide evidence they had met the duty of candour in relation to incidents in the service, but this was not received. We received feedback from some relatives that they were not always communicated with or kept up to date regarding people's health needs.

Continuous learning and improving care
● The culture of the service was not one of continuous learning. The lack of auditing in the service demonstrated a lack of understanding of the importance of identifying improvements in care.
● The service had failed to learn from previous incidents.

● The provider was unclear how to complete an action plan and sought support from external agencies. The provider had recognised the need to move to electronic records but had not identified the other concerns found in the inspection.

Working in partnership with others

● The service had close relationships with local healthcare professionals and teams. Despite this, a closed and complacent culture had developed where the service was working alone. This placed people at risk of harm and people experienced poor outcomes.

● The provider was working with the local authority and external teams to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay of incidents specified in the carrying on of a regulated activity. Regulation 18 (1) (2)

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 operate effective recruitment procedures to ensure the safe recruitment of staff. The provider failed to have information available in relation to each person employed as detailed in Schedule 3. Regulation 19 (2) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the rating of its performance by the Commission on their website and on the premises they were providing regulated activity. Regulation 20(A) (2) (3)

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 received appropriate training to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)