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This briefing provides direct evidence of unsafe care in care settings during the first wave of the pandemic because of poor regard for, and breach of, regulatory standards in England. Our research suggests that failures in regulatory compliance contributed significantly to the impacts of the pandemic on the care sector, including care workers and people who use care and support services.

During the first wave, care workers were England's eyes and ears in care settings; the first-hand witnesses to what took place. This is especially significant because visitors were barred from care homes between March and late July 2020 and routine inspections of care settings by the Care Quality Commission (CQC) were suspended. However, the Committees' Inquiry has not heard directly from care workers. Our evidence fills part of that gap, by sharing data we gathered from 102 care workers in England, working for over 50 different registered providers during the first wave of the coronavirus pandemic.¹

The data is based on interviews and survey responses and is drawn from a larger, ongoing, Wellcome Trust-funded study: [Social Care Regulation at Work](#), based at [Kent Law School](#).² That study explores the regulation of registered care providers and the scope for care standards law to positively influence care workers' conditions and terms of employment. This briefing, however, is based on information shared with us by care workers, about conditions of care and support during the first wave of the pandemic. It focuses on what that information reveals about potential failures to comply with fundamental standards set out in law to ensure safe care.

The fundamental standards, which apply to all registered adult social care providers in England, principally derive from the [Health and Social Care Act 2008 \(Registered Providers\) Regulations 2014](#), (referred to throughout this briefing as the 2014 Regulations). These regulations make manifest the *legal duty* of the Secretary of State for Health and Social Care, introduced by the Health and Social Care (Safety and Quality) Act 2015,³ to ensure that the regulated activities of registered care providers do not cause or contribute, either directly or indirectly, to harm that is avoidable. Consequently, it is the responsibility of the Secretary of State to regulate to ensure that care and support services are safe for those who use them. The fact of over 19,000 deaths from Covid-19 in care homes between March-June 2020 provides horrific evidence that care was not safe. We report here on broad, systemic, organisational failures to meet the fundamental standards laid down by regulations.⁴ The 'fundamental standards' are 'a clear baseline below which care must not fall'.⁵ Our evidence demonstrates that care did fall below those standards. Failures of regulation and regulatory systems suggest that harms inflicted on users of care and support services, including the deaths of many care home residents, could have been avoided.

¹ The gender and workplace demographics of the sample are broadly reflective of the adult social care sector in England; the vast majority are women working for private sector providers. BAME workers are under-represented.

² Data collection is continuing from our surveys and interviews with care home managers, inspectors of social care providers, and hands-on care workers in England, Scotland and Wales. Figures included in this report were correct *at the time of writing*, 30 Nov 2020.

³ Amending section 20, Health and Social Care Act 2008 (health and adult social care services: regulation of registered activities).

⁴ The data is anonymised to protect participants, employing organisations and users of care and support services.

⁵ Explanatory memo and CQC guidance.

We are gravely concerned by evidence from care workers that conditions and practices of care fell significantly below legal requirements. The primary function of care standards regulation is to ensure that service provision meets the minimum thresholds of safe care. The imperative that care is safe is set out as a fundamental standard at Regulation 12 of the 2014 Regulations. There is explicit reference at Regulation 12(h) to the legal requirement to prevent, detect and control the spread of infections.

In this briefing we detail:

- **Unsafe care because of dangerously low staffing levels**, in contravention of Regulation 18 of the 2014 Regulations and Care Quality Commission (Registration) Regulations 2009 Regulation 18(2)(g).
- **Unsafe care due to neglect of individuals and failure to treat people with dignity and respect**, in contravention of Regulation 9, Regulation 10 and Regulation 12, Regulation 13 and Regulation 15(2) of the 2014 Regulations.
- **Unsafe care because care workers were not adequately trained or supervised to care for people safely in the context of the pandemic**, in contravention of Regulation 18(2) and Regulation 12 of the 2014 Regulations.

1. Unsafe care because of dangerously low staffing levels.

Compliance with regulation required additional care staff to be deployed in care settings during the pandemic. Demands on the care workforce increased at the same time as the needs of users of care and support increased. Indeed, when asked if coronavirus had changed the way they work, 86% of our respondents confirmed they were working differently because of the pandemic. However, in clear breach of the regulatory protections, they told us there were fewer staff deployed. A large majority of respondents to our questions about staffing levels said their workplace was understaffed (58%). The risks of avoidable harm, especially in care homes, are self-evident.

Having sufficient staff is a legal requirement that effectively underpins compliance with all fourteen of the fundamental care standards. Registered care providers must ensure (Regulation 18):

‘sufficient numbers of suitably qualified, competent, skilled and experienced persons [are] deployed in order to meet all the requirements of [the fundamental care standards].’

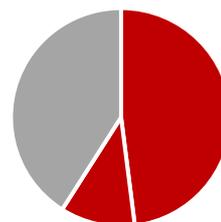
“This is a massive home and there has been [...] six carers for three floors. Like dangerously understaffed”

There is not a fixed numerical ratio of staff to residents in care homes that is set out in law. Rather, the law requires providers to take a ‘systematic approach’ to determine staff numbers and skill requirements. They must review staffing levels and skills continuously, in order to adapt and respond to changing needs and circumstances.⁶ The regulatory requirement to adapt was vitally important and should have ensured an adequate staffing response to the changed circumstances of the pandemic.

Skills for Care publishes guidance to assist providers to know how to staff services safely.⁷ It requires providers to go beyond thinking about ‘care tasks’, to ensure time is made available for staff to check ‘cleanliness’; to satisfy the individual needs and wishes of users of services; to complete documents; to ensure effective handovers; to talk to relatives and healthcare professionals; time for supervision; and time for staff personal development.

The CQC (Registration) Regulations 2009 require that providers report to CQC without delay if, ‘an insufficient number of suitably qualified, skilled and experienced persons being employed’ prevents,

Do you feel your place of work is understaffed?



- Yes - and it was also understaffed before coronavirus
- Yes - but we were not understaffed before coronavirus
- No - we are not understaffed

Prior to the pandemic, care work was typified by low wages, insecure work and zero-hour contracts. Weekly working patterns would fluctuate and only a minority worked regular shift patterns. The sector was carrying 122,000 care worker vacancies going into the pandemic.

⁶ CQC Guidance for Providers on Meeting the Regulations (2015)

⁷ [Skills for Care Guide to Safe Staffing \(2018\)](#)

or appears to be likely to threaten to prevent, the providers' ability 'to carry on regulated activities safely and in accordance with regulations'.⁸

The needs of care home residents increased considerably during the pandemic and it was harder to meet those needs because of requirements such as social distancing, increased need for cleaning, greater need for social contact and companionship; especially since family and friends were no longer visiting. Hence, compliance with fundamental standards necessitated more staff than usual to be deployed in care homes during the pandemic.

However, our research indicates the opposite – during the first wave of the pandemic, staffing levels fell below those required in law and there were fewer staff deployed than prior to the pandemic. In our interviews, care workers described how understaffing created levels of risk that they found deeply concerning. For example, one care worker described staffing levels as 'dangerous' in the large residential care home where she worked. She told us that when she took a one resident to use the toilet, she would leave a whole floor of residents unattended. She said she was left to make 'serious decisions of weighing up risk', of neglect, in a 'situation where you know ultimately you could lose your job'. Another care worker explained, 'I am not getting any sort of positivity coming out of what I am doing. It's quite damaging for your mental health, I think. There are some days when I have come home, and I have cried'.

“I am contracted at 39 hours [...] Sometimes I do 90 a week”

Regulation 15(2), in relation to premises and equipment, requires appropriate standards of hygiene to be maintained. However, we were told of many breaches of hygiene, infection control and safety requirements. Care workers did not always have enough time to wash their hands regularly. Working in conditions of understaffing meant they could be too hurried to meet basic safety requirements that they change their personal protective equipment (PPE) while on shift. As one participant explained, this was not through 'not caring about infection control or being dirty, it's because you've literally got so much to do'.

During the pandemic, individual workloads soared in many care settings. One care worker told us: 'throughout Covid. [...] my workload went up through the roof [...] I am contracted at 39 hours and I do 65 [...] sometimes I do 90 a week'. Long working hours create unsafe working conditions in which mistakes become highly likely and working in a hurry creates conditions for inadvertent abuse. Indeed, around half of the respondents to our questions about working time felt they had insufficient time to always provide good quality care (49%). A third of our respondents felt unable to raise concerns about low staffing levels with their supervisor. This too represents a breach of fundamental care standards. Guidance to Regulation 12 and the general duties imposed by Regulation 18(2) of the 2014 Regulations require that workers receive the supervision they need. Our findings of a widespread inability of care workers to raise concerns about understaffing, and its consequent dangers, suggest serious risks to the safeguarding of vulnerable adults and failures in respect of Regulation 20 of the 2014 Regulations. These require a 'culture of openness and transparency' and set out responsibilities to ensure staff can speak freely and candidly about concerns.

2. Unsafe care due to neglect of individuals and failures to treat people with dignity and respect.

⁸ Regulation 18(2)(g)(i)

Regulation 15(2) requires the maintenance of hygiene standards appropriate for the purposes for which premises and equipment are being used. However, in our research we found evidence of

“All cleaning [...] has gone out the window”

clear and routine breaches of regulatory requirements, for example failure to observe hand washing requirements due to time pressures and inadequate cleaning of shared spaces. Undoubtedly, keeping spaces clean was

an enormous challenge, as one care worker explained:

You have got people that are spitting all over the place or throwing stuff [...] they are extremely unpredictable. You will get people that throw their spit. You will get people that throw faecal matter. You will get people that throw pads at you [...] You will get people coughing without covering their mouth because they have all got really bad [...] respiratory hygiene.

This speaks to the need for the deployment of a higher than usual number of staff during the pandemic if regulatory requirements for safe care were to be met. However, we found that cleaning regimes were a casualty of the pandemic in some care settings. One care worker told us that initially, ‘there was also a lot of cleaning going on, door handles [...] wiping rails down and things like that’, but this good practice was not maintained and, ‘all cleaning as I just mentioned [...] have gone out the window.[...] It doesn't happen anymore’. Another care worker explained that there simply were no new rules in place about cleaning during the first wave.

Repeatedly, care workers drew our attention to the difficulties of ensuring Covid-safety in care settings where people using care and support services expressed behaviours of distress, or did not want to be distant from others, or found it difficult to understand or remember the rules. In the absence of legally compliant staffing levels, it is not hard to see why care workers struggled to meet requirements to clean *and* care simultaneously.

However, in the context of the risk of exposure to a highly contagious and potentially fatal virus, failure to maintain hygiene raises issues of neglect as well as safeguarding. Regulation 13 of the 2014 Regulations requires that users of care and support are protected from abuse and improper treatment, and definitions of abuse include neglect. A breach of this requirement is a criminal offence if it results in avoidable harm or significant risk of harm to a person using the service.

“They will often be in their rooms for hours on end have no one in their room for longer than ten minutes”

Potential safeguarding problems were also evident in comments by care workers about widespread risks of neglect, isolation and loneliness. Care workers expressed concern about residents being confined to rooms and their struggles to provide meaningful human contact. One said, ‘it might only be fifteen minutes, but it's better than nothing’. We heard

of residents being confined to their rooms for 24-hours a day with only a handful of ten-minute visits from care workers. This level of isolation suggests residents were not treated with dignity and respect, as is required by Regulation 10 of the 2014 Regulations. It also prevents the effective delivery of person-centred care, as required by Regulation 9 of the 2014 Regulations. Person-centred care meets the individual needs of users of services and respects their wishes and preferences. In our research we found that disruption to usual patterns of work meant care workers were less familiar with the individual care needs of service users and several said they were unaware

of care plans. In such circumstances, the delivery of person-centred care is put under considerable strain.

Regulation 12(2)(e) of the 2014 Regulations is about the safety of equipment. CQC Guidance sets out expectations that equipment is 'available in sufficient quantities'. The regulations are clear that

“We were told that we didn't need to use masks and that I think that was because they couldn't get hold of them at that time”

providers retain legal responsibility under Regulation 12 when they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. They must therefore make sure that the regulatory requirements about equipment are adhered to, as responsibility for any shortfall rests with them. Staff should have the necessary training

and skills for the safe use of equipment.

In light of the fundamental standards set out at Regulation 12, it is highly concerning that several care workers reported confusion about the use of Personal Protective Equipment (PPE). In the context of the pandemic, the consequences of this confusion were potentially fatal. Some care workers noted their surprise at being told it wasn't necessary to wear PPE at work and that this was a matter of personal discretion. Concerns about increased transmission risk because PPE was not used, or was unavailable, are compounded by reports from care workers in our research that their concerns about spreading the virus were dismissed by supervisors. One care worker said managers were so desperate for staff that they 'force you to come in even when you feel [ill]'. If users of care and support were exposed to coronavirus by workers who were inadequately protected, it suggests breaches of many of the fundamental standards.

3. Unsafe care because care workers were not trained in how to care for people safely in the context of the pandemic and did not receive adequate managerial supervision.

Regulation 18(2) imposes a general duty on service providers to ensure that workers receive support, training, professional development, supervision, and appraisals necessary for them to carry out their responsibilities. CQC guidance expects staff to be provided with any additional training necessary to carry out their duties and meet the needs of users of care and support. Regulation 12 requires providers to ensure that care workers ‘have the qualifications, competence, skills and experience’ to provide safe care.

Concerns about poor quality and inadequate training in the care sector are longstanding. However, the challenges presented by the pandemic were new. In our survey questions about the impact of the coronavirus on caring practices, 86% of respondents confirmed that the pandemic had changed the way they work. In the context of clear, life-threatening dangers to many users of care and support, it was exceptionally important for care workers to receive appropriate training. However, in our survey, the numbers of care workers reporting they had not received Covid-specific training were alarmingly high.

“I have never received training in the twenty years I have been a care worker”

31%

No infection control training

When asked about training, a third of respondents (31%) said they received no infection control training and were consequently lacking information about how to reduce virus transmission. Of those who had received infection control training, concerns were expressed that training was not communicated well or was of poor quality. For example, one worker said her employer called it ‘training’ when instruction posters were put up on the walls for staff to read. Another said that training could only be accessed by an e-learning platform, but that she had not been told about it and was unaware of its existence.

The vast majority (67%) of care workers reported that they were unaware of how to care for a person who tested positive to Covid-19.

Training deficits were cumulative and the responses of 22% to questions about training indicated they had received no training at all in any aspect of care provision or PPE use during the first wave of the pandemic.

35%

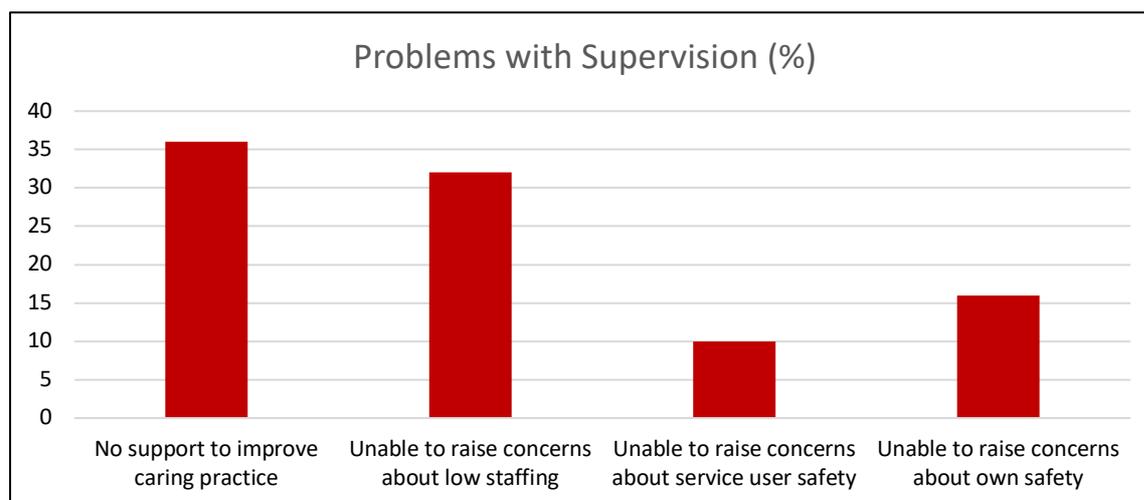
No PPE training

CQC Guidance in respect of Regulation 12 and Regulation 15 of the 2014 Regulations requires service providers to have up-to-date training plans for the safe operation of premises and equipment. It is deeply concerning that, when asked about training, over one third of care workers (35%) reported they had received no training in the use of PPE designed to prevent virus transmission. Training and clarity in the use of PPE are key to the prevention of coronavirus infection.⁹ The impact on social care of the lack of availability of PPE during the first wave was

compounded by the lack of training of care workers.

⁹ see <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0239024>

Our data also raises concerns about a reduction in supervision and supervisor presence in some care settings since the pandemic began.



In our survey, 36% of respondents did not feel their supervisor supported them to improve their care practice; 32% did not feel able to raise concerns about low staffing levels; 10% of participants did not feel able to raise concerns about the safety of the people they care for; and 16% did not feel able to raise concerns about their own safety.

In the absence of effective supervision, workplace pressures on care workers were exacerbated. A care worker told us she was ‘often making decisions regarding vulnerable peoples [sic] health without a lot of support’. Others noted how their supervisor ‘seldom visits during covid’ or was ‘not seen often’, and calls for help were ‘often ignored’. In interviews, many care workers noted a lack of supervisor engagement during the pandemic and explained that this caused a lack of direction because, as one care worker said, ‘there is not naturally someone there being like, “you do this, and you do that” ... [so] you just kind of have to hope you have got a good team’. In light of the understaffing issues we have already discussed, hoping for ‘a good team’ to ensure safe care is an alarming suggestion.

Data from care workers provided some explanation for the lack of managerial supervision. In some care settings, managers ceased being present in offices or care homes because they were able to work from home in a way that care workers could not. In others, managers were simply too busy or too stressed to make time for supervision during the pandemic. While staff shortages made supervision even more important for workers who were struggling to cope with unprecedented challenges, managers were also

“Never enough time”
“Often ignored”

working long hours and had little time to spare.

Conclusion

Regulation 12 of the 2014 Regulations requires that care ‘must be provided in a safe way for service users’. Accordingly, registered providers must:

- (a) assess the risks to the health and safety of service users of receiving the care or treatment;
- (b) do all that is reasonably practicable to mitigate any such risks;
- (c) ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

- (d) ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
- (e) ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;
- (f) where equipment or medicines are supplied by the service provider, ensure that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;
- (g)[...]
- (h) assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated;

The related CQC guidance emphasises that registered providers ‘must be able to demonstrate they have done everything reasonably practicable to provide safe care’.

In this briefing, we have reported our findings of dangerously low staffing levels in some care settings in England during the first wave of the pandemic. In our survey of care workers, 58% of respondents from England said their workplace was understaffed. We have detailed our concerns about breaches of regulatory standards in the context of the pandemic, in which more staff than usual were required to ensure the delivery of safe care.

Our research found evidence of inadequate cleaning and it suggests that cleaning became a casualty of the pandemic in some care settings in England because of staff shortage. We have reported that residents were left unattended because of staff shortages, and residents were isolated by confinement to their rooms for periods of 24-hours in which some had only 10-minute episodes of contact with a care worker as their only opportunity for human interaction. In some cases, staffing shortages in England were so severe that care workers reported to us that they had insufficient time to wash their hands to reduce the risk of infection spread. We found examples of care workers in England for whom full-time hours of work had more than doubled from 39 to 90 hours a week.

One third of respondents in England told us that they felt unable to voice their concerns about low staffing levels with their supervisor. Changes to staffing rotas and routines meant some staff were less aware of individual care needs or the care plans of individuals. Some said they were unable to change their PPE as required, because the time pressures upon them were so great. Despite PPE being vital for the provision of safe care, some care workers in England were told it was unnecessary and a matter of personal discretion as to whether it was used. Over one third of the respondents to our survey who were care workers from England, reported they had received no training in how to use PPE. Care workers from England reported to us that they had been forced to come to work when ill. One third of respondents from England in our survey reported they had received no infection control training and two-thirds were unaware how to care for a person who tested positive for coronavirus. We have reported on a considerable absence of supervision, which left care workers without direction and support while making decisions in unprecedented situations.

Throughout this briefing, we have identified how the evidence we have collected from care workers in England points to breaches of fundamental standards, set out in regulations that are supposed to ensure safe care. Our research suggests that failures in regulatory compliance contributed significantly to the impacts of the pandemic on the care sector, including care workers and people who use care and support services.

We are gravely concerned by evidence from care workers that conditions and practices of care fell significantly below the regulatory baseline of the fundamental standards. The primary function of care standards regulation is to ensure that service provision meets the minimum thresholds of safe

care. However, care workers have reported to us many examples of unsafe care during the first wave of the pandemic.

This briefing highlights that staffing levels were dangerously low, individual users of care and support were neglected, and that care was unsafe because care workers were not adequately trained or supervised. Our linking of this evidence to failures in regulation and regulatory systems suggests that harms inflicted on users of care and support services, including the deaths of many care home residents, could have been avoided. We conclude that the lack of regard for the status and importance of fundamental standards in the national response to the pandemic is a key lesson from the first wave.

Nov 2020