Argyle Care Group Limited

Bentley Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bentley Care Home is registered to provide accommodation and support for up to 58 adults who require support with their mental and physical health. At the time of the inspection 43 people were living at the home.

The building is converted from three large Victorian houses divided into two units. These are known as 'the house' and 'the unit'. People have their own bedroom and share bathroom and shower facilities. Each unit has sitting and dining facilities for people to share.

Bentley appointed a manager in October 2015. At the time of this inspection the manager had registered with the Care Quality Commission to become the registered manager of the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected Bentley Care Home in September and October 2015. At that time we found a number of breaches of regulations relating to person centred care, dignity and respect, safe care and treatment, receiving and acting on complaints, good governance and staffing.

At this inspection we found that significant improvements had not been made. We found that continuing breaches remained in areas relating to person centred care, dignity and respect, safe care and treatment, safety, receiving and acting on complaints, good governance and staffing.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not

enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

People living at the home had varied experiences of the care and support provided to them. Some people felt safe living there, others did not. The home had taken no action to formally communicate with or obtain the views of people whose first language was not English. This left people feeling isolated and unable to make their concerns heard or to contribute to discussions regarding their care.

Staff had not received training in safeguarding adults for some time and did not always recognise and therefore taken action on potential incidents of abuse.

Action had not been taken to ensure the building was always safe for people living there. This included leaving doors unlocked that led to dangerous areas of the home. Robust action had not been taken to prevent people who were unsafe smoking within the building from doing so. This increased the risk of fire within the home.
People's medication was not managed safely and effectively. Guidance for staff was not clear and could lead to mistakes with medication occurring.

The environment did not meet good practice guidance for supporting people living with dementia.

Staff had not received the training, support and supervision needed to enable them to support people safely.

The care and treatment people received did not always reflect their needs and preferences. No system was in place for obtaining people's views of their care and treatment.

People's legal rights were not always protected. People were not supported to make important decisions or to ensure important decisions were made in their best interests.

People generally received support with their health care. However care plans were generic and did not provide clear advice for staff to follow to support people safely and well.

People living at the home had concerns and complaints but these had not been recorded or acted upon.

No effective system was in place for monitoring and planning improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had not received recent training in safeguarding adults and did not always recognise potential safeguarding concerns.

Action was not taken to ensure doors leading to unsafe parts of the premises were secured. This presented a risk to people living at the home. Robust action was not taken to minimise fire risks within the home including people smoking unsupervised.

Medication was not managed safely and was not audited correctly to minimise the risks of errors occurring.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training, support and supervision needed to enable them to support people safely.

The care and treatment people received did not always reflect their needs and preferences. People's legal rights were not always protected.

The environment did not meet good practice guidance for supporting people living with dementia.

Some people did not always get offered the meals they preferred that would meet their cultural needs.

People generally received support with their health care.

Is the service caring?

Inadequate

The service was not always caring.

People had mixed experiences of the care and support that they had received.

No systems were in place for formally communicating with people whose first language was not English. This meant people

could not contribute to discussions about their care or raise a concern.

The culture of the home was at time institutional and potentially abusive.

Is the service responsive?

Inadequate

The service was not responsive

Care plans were generic and contained inaccurate information about the care and support people required.

Peoples concerns and complaints had not always been listened to and acted upon. Complaints from people living at the home had not been recognised, investigated and recorded.

Is the service well-led?

Inadequate

The service was not well led.

The home did not have a registered manager in post.

Quality assurance systems remained ineffective at identifying areas of concern within the home and implementing improvements to the safety and quality of the service people received.

Bentley Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out this inspection at this time as the home were in special measures and had been rated inadequate and we needed to check whether improvements had been made to the quality and safety of the service and whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The first day of the inspection was carried out by a team of four people. The team included an Adult Social Care (ASC) manager and an ASC inspector. In addition a specialist advisor (SPA) and expert by experience were also part of the team. The SPA was a nurse with experience of services for older people and people who require support with their mental health. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who attended this inspection was bilingual and therefore able to speak to people who lived at the home whose first language was not English. The second day of the inspection was carried out by an ASC inspection manager and an ASC inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the manager since our last inspection in September and October 2016.
During the inspection we spoke individually with eight of the people living at the home and one of their relatives. We also spoke with eight members of staff who held different roles within the home.

We spent time observing the general support provided to people and looked at a range of records including care records, staff records including training and recruitment, medication records, and records relating to health and safety. We spent some time touring the premises and looking at safety aspects of the building.

Inadequate

Is the service safe?

Our findings

We asked some of the people living at the home if they felt it was a safe place to live and found their responses varied. One person told us, "Very safe, staff are very reassuring." Another person said, "My room cannot be locked. It's broken. I reported it long time ago. Not safe because anyone can enter my room." Other responses we received included, "Yes, I've got my own room and key," and "safe or not? I can't go anywhere. I have no choice. Does it matter?"

At our last inspection we had concerns about arrangements for safeguarding people who lived in the home. Staff had not undertaken training in safeguarding adults for a number of years and had limited understanding of what actions to take if they had concerns about people. At this inspection we found that staff had still not received this training. During the inspection we identified a number of people who were not being cared for safely. We asked the manager to refer these people to the local safeguarding authority for investigation under safeguarding adult's procedures. The manager provided evidence to confirm that they had done this following the inspection.

We saw records for one person who had a history of making serious allegations against others. When we read their care records we saw that no care plan was in place for dealing with and reporting any allegations the person made. A lack of clear guidelines for staff to follow means that the person is at risk of abuse occurring and it not being reported. It also means that others may be at risk due to the lack of clear information and guidance to support the person.

At our previous inspection of the home we had found that no clear system was in place for ensuring people's money was safely managed. At this inspection we saw that a system had been put into place to record money people had spent. We checked a sample of these and found that the amount of money the home held for the person tallied with records. However we also saw that only the manager dealt with this and no auditing system was in use. This meant people's money was still not being managed as safely as it should be.

These were continued breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that systems and processes operated effectively to protect people from potential abuse.

At our previous inspection we had concerns regarding the safety of the building; we had found cellar doors unlocked and a person had subsequently fallen down the cellar steps and hurt themselves. We had also found unsafe fire doors and unlocked electrical cupboards. On the first day of this inspection we found an unlocked cellar door, an unlocked electrical cupboard and an unlocked sluice room that contained cleaning products that could be hazardous to health despite a sign on the door that stated 'keep locked'.

We also found that people were smoking in the building putting themselves and others at significant risk from harm. We saw bedrooms with multiple burn marks on the floor, cigarette butts and ash on the furniture and floor and a strong smell of cigarette smoke. We raised immediate concerns with the provider and

requested that they take action with immediate effect to ensure that people did not smoke in the building. We also referred our concern to Merseyside Fire Service who visited the service the following day and gave the provider a list of immediate action to take to make the service safe.

We returned to the service on the second day of inspection to check that appropriate action had been taken. We saw that all people who lived in the home had been informed that they could not smoke in the building. However as many of the people living at the home have memory loss or need support due to their mental health it is unlikely that they would retain, understand or comply with this request without support from staff.

The provider and manager had sent us evidence to demonstrate that staff were checking the people who smoked at 15 minute intervals to ensure that they did not smoke in the building. However, we saw a bedroom door propped open with a bin containing three cigarette butts and ash. We asked the manager and the provider how this had occurred if people were checked every fifteen minutes and no satisfactory response was given.

Electrical appliance checks were overdue and the maintenance person estimated that they still had 70% of appliances to check. We asked to see records of legionella tests that should be carried out regularly to ensure that the water is safe. A competent person, who understands the water systems and any equipment associated with it, should assess the risks of hot and cold water systems, and advise on whether adequate measures are in place to control the risk of exposure to legionella bacteria. The maintenance person did not demonstrate adequate understanding of the risks and they told us that the test for legionella had been carried out once in the last seven months.

These examples were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that the premises were safe to use for their intended purpose and were used in a safe way.

We looked at the building and equipment checks and saw that the lifts and mobility equipment had been checked regularly and that the main electrical and gas certificates were up to date.
On the second day of the inspection we found that the cellar door lock had been replaced and the electrical cupboards and sluice rooms were all locked.

At our last inspection we had concerns about the management of people's medication. At this inspection we found that no improvements had been made. Medicine stocks were not properly recorded so it was impossible to see if they were correct. They were not booked in and out of the building correctly. We saw that only one medication audit had been carried out since our last inspection and this only looked at two people's medicines. We also saw that staff had not received adequate training in medication administration.

There had also been a recent serious safeguarding referral as a person living in the home had been given an overdose of their medicine. On the second day of the inspection we found a tablet on the dining room floor.

One person had prescribed creams and their Medication Administration Record (MAR) stated 'apply four times daily.' We saw that on two days these had been signed for as being applied less than four times each day. We asked to see records of where the creams should be applied and we were told body maps were used to guide staff, however these could not be found.

Another person's MAR stated 'take half a tablet … tablet already halved by pharmacy.' We saw that tablets had not been halved and although a member of staff told us the dose had been increased by the persons GP

we saw no written evidence of this. This confusion around what dose of medication the person was prescribed could lead to them getting the incorrect medication.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured medication was safely and properly managed.

The people living at the home told us they did not think there had been sufficient staff available to meet their needs. One of the people who lived in the house said, "No, I have to push myself (wheelchair) downstairs for meals slowly as it's too long a wait for staff to take me downstairs. Waited a long time for assistance after I pulled the cord."

People who lived on the unit told us that there had been times when only one member of staff was working on the unit in an afternoon to support them. Their comments included, "Previously, we had two staff. Now only one staff on duty like now for 21 people," and "I think not enough staff during the day time. There have been times we only have one person on duty."

A member of staff said that they did not think there had been sufficient staff working on the unit, they told us, "There isn't much time for therapeutic intervention."

We looked at the rotas and saw that staffing levels were generally maintained in the home. However, we did have concerns that there were a lot of agency staff used to meet the staffing levels and these staff did not always know the people who lived in the home.

We looked at two recruitment files for staff who had commenced work since the previous inspection. We saw that these staff had been recruited safely and adequate checks had been carried out prior to them starting work.

Inadequate

Is the service effective?

Our findings

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 be 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. We found that they were not.

At our last inspection of the home we had identified that no assessments had been undertaken to establish whether people would benefit from the safeguard of having a DoLS applied for. At this inspection we saw no assessments had been carried out to establish whether a DoLS application should be made for the person. A board in the office identified that eight people had a DOLS in place. However when we queried this we were told that three applications had been submitted and a further five had been granted. We looked at a care plan for one person who we were told had a DOLS in place and saw that this had expired. A second person's care plan stated that they had a DoLS in place. In fact we found that this had expired. This meant that staff did not have up to date information on who had a DoLS in place and how to support people accordingly.

These were continued breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the care and treatment of service users met their needs and reflected their preferences

One of the people living at the home told us that they had previously had the option to have a cooked breakfast everyday but this had stopped and was now only available at weekends, they were unhappy about this decision. We confirmed this with a member of staff. The people living at the home who were Chinese told us that they only got Chinese food twice a week and would like more Chinese meals to be provided. They told us that they bought food themselves or had it supplied by friends. One person said that they had the same meal every day for lunch for the past six months. We spoke to staff who confirmed that Chinese meals were provided twice a week, other than that the person had been offered packet noodles with additions from the main menu.

We observed the lunch time meal in both the house and unit. We saw that when people required support with their meal this was offered by staff in a dignified manner. We also saw that staff took time to persuade people to eat a snack if they did not want their main meal.

A relative of one of the people living at Bentley Care Home told us, "(My relative) is well looked after. Hearing

aid, teeth, any problems they have him in hospital."

Records showed that people had access to other health professionals including a dietician, GP, geriatrician and community nurse. However records regarding people's health care were mixed. We saw that one person had not been weighed for some time and staff had not explored other ways to monitor their weight such as taking regular arm measurements. We also saw one person whose record indicated they had a pressure sore. We saw no care plan for this and asked for it to be referred for investigation under safeguarding adult's procedures. The manager later informed us that the person did not have a pressure sore any more. This lack of clarity in records makes it difficult for staff who may be unfamiliar with people to provide the care they may need.

Everyone living at Bentley Care Home had their own bedrooms and we saw that some of these had been personalised to meet the person's choices. However we also saw that some bedrooms had not been personalised and appeared very stark.

At our last inspection of the home we had seen little evidence that the building had been adapted to meet the needs of people living with dementia. During this inspection we found that no additional adaptations had been made. As at the last inspection we found it difficult to find our way around the home easily, no pictures or signs were prominently available to help people living there find their way around or identify their bedroom or bathrooms easily.

Ramps were in place to help people access outdoor spaces and two passenger lifts were available to help people access all floors of the home

Inadequate

Is the service caring?

Our findings

The people we spoke with who lived at the home had mixed views as to how caring they had found the staff team. Their comments ranged from, "Don't like them. They are not very caring. They don't come into my room to say hello and ask me how I am," and "Previously, staff entered my room by unlocking my door without knocking to check if I was ok or not. Not happy with that, so I complained. They woke me up from my sleep."

Other people living at Bentley Care Home reported a more positive experience telling us, "Very, very nice. They asked: Are you alright?" and "Staff are very good. I give them 20 out of 10."
We spoke with a relative of one person who had lived at the home for some time, they told us, "Staff are marvellous. I have never found anything wrong with the place."

We spoke with one person who had a notice in their bedroom stating the name of their keyworker. However when we asked the person about their keyworker they did not know what the role of a keyworker was and told us the member of staff named on the notice had left.

Some of the people we spoke with knew about their care plans and said they had been consulted about their care. Other people said they had not. One person explained that they spoke little English and the home had never used an interpreter therefore they had no idea about their care plan.

At the last inspection we identified that there were a number of people were living at Bentley Care Home who were members of the local Chinese community, some of whom spoke little English. We did not see any evidence of formal attempts to communicate with people. None of the staff spoke the language people used and we did not see any formal arrangements for communication, for example by the use of a regular advocacy service, organised meetings for people or the use of pictures to help people explain how they were feeling. We were supported at this inspection by a Chinese speaking expert by experience who was able to communicate with these people and they shared a number of concerns about the care that they were receiving.

We were also concerned about another person living in the home who did not speak English and was very isolated. We were told by the provider that they did have one staff member who spoke this person's language. This staff member was not on duty during our inspection and we saw that the person sat alone starring at a wall for hours on end with no stimulation and no one to talk to.

We observed interactions in the home that gave us concerns that the culture in the home was very institutionalised and potentially abusive. On the second day of our inspection, a staff member entered the dining room and called people by name and shouted "Cigarette" and "Smoke time". The staff member was standing with a number of loose cigarettes in their hand and then led people in a group outside to smoke. This was undignified for the people involved and did not offer them individualised, person centred care. We shared our concerns with the manager who agreed with us that this was not acceptable practice.

We also observed a person who required help with their personal care to preserve their dignity and they were present in a communal part of the home where other people could see them. We prompted the staff on two occasions within fifteen minutes to ask them to give this person the support that they needed.

These were continued breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that service users were treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

The majority of people living at the home who we spoke with told us that they knew how to make a complaint. Their comments included, "Not really. I don't have anything to complain. I don't want to get into trouble." "I've been alright. No, I wouldn't complain because I've got nothing to complain about, " and Yes, I know who to speak to."

The home had changed their care plan format and a member of staff explained that the intention was for all care plans to be on computer with staff provided with an electronic pad so they could access plans. However at the time of the inspection we were told that only senior staff had access to the care plans. This meant care staff could not easily access the guidance they may require to support people.

We found care plans generic in format and that they did not reflect the needs of the person they referred to. For example we looked at one plan for a person who did not speak English. Their communication plan made no reference to this fact. They also had a care plan in place to support them with their mobility. This made no reference to the fact that they needed staff to use a hoist to move them safely.

We saw several care plans written for a male service user that referred to 'her' throughout. This indicated to us that plans had been written generically and not in a person centred way.
We saw two care plans for people to support them with their sexuality. Both said, 'Likes to express their sexuality through clothing.' We were unsure what this meant and the care plans lacked guidance for staff to follow.

A care plan was in place for another person for supporting them with angina. We were concerned as this referred to using their 'emergency medication' and we saw that this had not been prescribed. The manager later informed us that the person had no history of angina and the plan had been removed from their care file. Having a care plan in place that refers to an incorrect medical diagnosis could have a serious impact on the person's health and wellbeing.

A care plan for another person stated that they displayed, 'some incidents of challenging behaviour.' The action for staff to follow was recorded as, 'observe and document'. This did not provide sufficient guidance for staff to follow to identify and support the person with any challenging behaviour they displayed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure risks to the health and safety of service users had been adequately assessed and action had not been taken to mitigate risks.

At our last inspection we had concerns that the complaints procedure was not up to date and contained the wrong contact details. At this inspection we saw that the complaints procedure had been updated and was displayed in the reception area of the home. This stated that people could complain directly to the Care Quality Commission if the concern related directly to an adult protection issue. This is inaccurate, safeguarding or protecting adults concerns should be reported to the local authority. Whilst CQC welcome

any information about the care services we regulate we cannot directly investigate an individual complaint.

We were told that no formal complaints had been received since the last inspection. The last record of a complaint being received by the home was in 2012. However people we spoke to who lived at the home told us that they had raised concerns that had not been dealt with. This indicated to us that the complaints procedure at the home was not effective.

One person told us that they had complained about their meals but no action had been taken. Another person told us that they had complained about not having a lock on their bedroom door and asked us to speak with staff about this as nothing had been done. We asked a member of staff who said the decision had previously been taken not to replace the lock as the person has lost their key three times. However when we relayed this to the person they had never been given this information.

A third person also told us they had complained repeatedly about the temperature in their bedroom. .A member of staff told us they had checked the room temperature and found it, "fine." However the person told us they had been sleeping in the lounge as their room was too hot. No record of any of these concerns or complaints was available in the home.

These are continuing breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that an accessible ,effective system was in place for identifying and receiving complaints.

The home employs two activities coordinators to support people with their occupation. However a member of staff told us, I've only seen dominoes and board games once since I've been here". On the afternoon of the first day of our inspection we saw activity staff informing people that there was a quiz and a film taking place and encouraging them to attend. The people we spoke with told us that they would like more support with activities and occupation. Their comments included:
"No, never take me out. I would like to go to the Park." "I like to listen to music on the radio. Staff don't help me with this because I have my own radio." "I like to paint. No, they don't take an interest in what I do." "Yes, video of the actor that I like in my room." "Previously, we had painting, beading and craft activities which I enjoyed. All these stopped," and "No, they just leave me to do it."

Inadequate

Is the service well-led?

Our findings

We asked six of the people living at Bentley Care Home if they had ever been asked their opinion of the home. Five people told us that they had not with one person saying, "No, I can't tell them what to do. I am quite happy here." Another person told us, "Sometimes they do."

During our last inspection we had significant concerns about the management and governance of the home. The new manager commenced working at the home during our last inspection. Six months later they have not yet registered with CQC to be the registered manager.

We looked at the systems and processes in place to manage the quality of the service and found that they had not improved and were still inadequate. Only one medication audit had been completed and it failed to identify any issues. The health and safety audit had failed to identify any concerns and the safeguarding audit was not completed but had "Non-compliant" written across the front of it.

There were no systems in place to monitor the safety of the building or the equipment in it adequately and safely.

There were no meaningful care plan audits as the current audits had failed to recognise the incorrect contents in the care files.

There were no systems to monitor staff support and supervision or training by the manager so staff were not given the support they needed to do their jobs safely.

We saw a board in the manager's office that contained the names of all of the people living at the home. In addition it contained information as to whether they had a Deprivation of Liberty Safeguard in place, whether a Do Not attempt resuscitation agreement was in place for them and a record of their NHS number and date of birth. Senior staff confirmed that this office was used to talk to visitors. This meant that people's private information was not being securely maintained.
The training manager, office manager and company accountant all raised concerns about the manager's lack of engagement with them in order to make improvements in the home. We discussed all these concerns with the provider following the inspection and that as the registered provider they had failed to monitor the manager's practice in the home.

These were breaches of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that systems and processes at the home operated effectively to assess, monitor and improve the quality of the service provided. The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk.