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? | Requires improvement |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This was an unannounced inspection carried out on 30 September 2015. We returned to the home on 15 October 2015, 16 October 2015 and 19 October 2015. These four visits formed part of this inspection. We began this inspection due to information we had received from a whistle blower and the local authority. Concerns we had received included the management style at the home and cleanliness of the building. We continued our inspection on 15 October 2015 due to concerns we had about the safety of the building. We returned on 16 and 19 October 2015 due to continuing concerns we had regarding the safety of the building.

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 47 people were living at the home and one person who lived there was in hospital.

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.

# Summary of findings

When we began our inspection on 30 September 2015 the home had a registered manager. 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. When we returned to the home on 15 October 2015 we were advised that the registered manager was no longer working at the home and had resigned. We were informed that a new manager had been appointed, we saw that they had commenced working at the home on 19 October 2015.

We last inspected Bentley Care Home in October 2013. At that inspection we looked at the support people had received with their care and welfare, whether they were safe, treated with respect and involved in their care. We also looked at the recruitment of staff and how the quality of the service was assessed by the provider. We found that the provider had met regulations in those areas.

**At this inspection we found a number of breaches relating to person centred care, dignity and respect, safe care and treatment including concerns regarding premises safety, receiving and acting on complaints, good governance and staffing.**

**You can see what action we told the provider to take at the back of the full version of this report.**

Parts of the premises were unsafe and potentially dangerous for people living and visiting the home. Fire escape routes were blocked, fire doors did not work and advice regarding fire safety was not acted upon in a timely manner. Unlocked doors led to steps and cupboards that were a hazard for people living at the home. Advice regarding these was not acted upon in a timely manner. The building was shabby overall, parts of the building were dirty, untidy and in need of cleaning and repair. The environment did not meet good practice guidance for supporting people living with dementia.

People's money was not managed safely and correctly.

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. Records relating to people living and working at the home were not kept securely. This meant they could be read and or accessed by people who did not have a right to the information.

People received support with their health care. However care plans were not updated accurately and contained guidance that if followed would pose a risk to people's health and safety.

Accurate information about how to raise a complaint was not available within the home.

People living at the home liked the staff team who supported them. Staff knew people well and spent time interacting with them. However notices and minutes of staff meetings showed that the registered manager had concerns that staff did not treat people with dignity and respect.

Quality assurance systems were not effective at identifying risks to people's health and safety. Nor where they effective at planning and improving the overall quality of the service.

Risks to people's health and safety were not acted upon in a timely manner.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting a proposal to vary the provider's registration to remove this location from the providers registration.

# Summary of findings

## 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.

Parts of the premises were unsafe and potentially dangerous for people living, working and visiting the home.

Fire escape routes were blocked, fire doors did not work and advice regarding fire safety was not acted upon in a timely manner.

Unlocked doors led to steps and cupboards that were a hazard for people living at the home. Advice regarding these was not acted upon in a timely manner.

The building was shabby overall, parts of the building were dirty, untidy and in need of cleaning and repair.

People's money was not managed safely and correctly.

**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.

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

People received support with their health care.

**Is the service caring?**

Requires improvement

The service was not always caring.

Notices and minutes of staff meetings showed that the registered manager had concerns that staff did not treat people with dignity and respect.

Meal times were 'task focused' and people did not always receive the emotional support they needed.

People living at the home liked the staff team who supported them. Staff knew people well and spent time interacting with them.

**Is the service responsive?**

Inadequate

The service was not responsive.

Care plans were not updated accurately and contained guidance that if followed would pose a risk to people's health and safety.

# Summary of findings

Accurate information about how to raise a complaint was not available within the home.

**Is the service well-led?**

**Inadequate**

The service was not well led.

Notices and minutes of meetings from the registered manager to staff were unprofessional and inappropriately worded.

The registered manager did not have the skills to lead the staff team to provide a safe, quality led service.

Quality assurance systems were not effective at identifying risks to people's health and safety.

Quality assurance systems were not effective at planning and leading improvements to the quality of the service provided.

Risks to people's health and safety were not acted upon in a timely manner.

# 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The first day of the inspection was carried out by a team of four inspectors. The team included a lead Adult Social Care (ASC) inspector, two ASC inspectors and a specialist advisor (SPA). The SPA was a Nurse with expertise in managing care services for older people and people living with dementia. The following three days of the inspection were 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 October 2013. We also spoke with Healthwatch England and with a Local Authority who commissioned services for people living at Bentley Care Home.

During the inspection visit of 30 September 2015 we spoke individually with three of the people living at the home and held meetings attended by 11 other people living there. We spoke with a relative of one of the people living there and with two visiting health care professionals. We also spoke with 12 members of staff who held different roles at the home, this included the registered manager. At the end of the first day we provided initial feedback to the provider and two of his representatives.

We spent time observing the general support provided to people and looked at a range of records including 10 care plans, weight records for ten people, 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.

We used the Short Observation Framework Tool (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

During the subsequent three visits we made to the home as part of this inspection we met with a further three members of staff including the newly appointed manager. On 15 and 16 October 2015 we contacted Merseyside Fire Service who visited the home and provided advice on immediate risks relating to the fire safety of the building.

Inadequate

# Is the service safe?

## Our findings

People living at the home told us that they felt safe living there. They said if they had concerns they would report them to staff.

Staff we spoke to told us they knew how to report any safeguarding concerns they had and knew who to report these to. They also told us that if they felt appropriate action had not been taken they knew how to contact external agencies to report their concerns. One member of staff told us, "I would see the manager if I thought someone was not safe here." A second member of staff told us, "I would not hesitate to whistle blow if I thought something was wrong. I would report it straightaway."

In the entrance hall we saw two different versions of the whistle blowing policy. Whistle-blowing protects staff who report something they think is wrong in the work place. One policy was dated 2007 and one dated 2015. This could prove confusing for any staff wishing to access the information.

Training records for staff showed they had last received training in safeguarding adults in 2012. Eight care staff, a senior member of staff and 12 staff with roles other than care had no training date recorded; this indicated to us that they had not undertaken the training. This means that staff may not have the knowledge needed to recognise potential abuse and how to act upon their concerns.

We looked at a sample of how people's personal money was managed by the home. A representative for the provider told us that people's money was held centrally by the organisation in a named account. However no records of this were held at the home. They told us that each week head office sent £30 to the home for the people they acted as appointee for, unless they were advised this was not needed. Again no records of this were available for us to view in the home.

One person's money envelope stated that they had £1340 in the home; however their envelope contained only £10.03. We saw no records to indicate where the rest of the money belonging to this person was. A record stated this person had spent over £500 on clothes, bedding and blinds. Blinds are part of the fixtures and fittings of a home and we would not expect to see them being paid for by the person living there. Records showed that the provider acted as appointee for this person, however we saw no record of how the decision was made that it was in the person's interests to spend their money in this way.

A second person's money envelope stated they owed another person living at the home £73. The first of these was dated 'July 2015'. We saw no record of whether the person had been consulted regarding lending another person money. The provider was appointee for both of these people's benefits. However no record of why the decision had been taken that it was in the person's interests to lend money could be found. No auditing of monies held at the home for people appeared to have taken place. Receipts were not numbered and there was no clear system in place that we could follow to check whether people's money was accurate.

We discussed this with the provider and recommended that they report these issues to the local safeguarding team for investigation under safeguarding adult's procedures. We checked with the local authority that this referral had been made.

**These were 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.**

We toured the building and noted that overall it looked shabby with a smell of stale urine present in areas of the main house. We also found several areas that were unsafe.

On 30 September 2015 we saw a door in the unit on the ground floor was labelled, 'fire door keep locked'. We found this unlocked and saw it led to wooden steps down to the basement. We also saw a second unlocked door leading to a basement area. We informed the provider that these could prove to be a hazard for people who were unsteady on their feet or who are living with dementia and may become confused as to where they were.

On 6 October 2015 one of the people living at the home opened this door and fell down the stairs to the basement causing injuries that required an ambulance to be called.

On 15 October 2015 we visited the home and found that this door had been fitted with a mortise lock to prevent people using it. We also checked a further two doors leading to different areas of the basement. We saw that

these had keypads fitted and were locked. We tested both doors and were informed that the door leading to the 'handyman's room' got stuck on the carpet and needed to be pulled closed. We were informed that this had formed part of an action plan given to the home by the fire service. This showed us that relevant staff and the provider were aware of this issue. On 16 October 2015 we checked all three doors again. We found that the door leading to the handyman's room had not closed properly. This meant the stairs leading down to the room were accessible to people living at the home and could present a risk to their safety.

On 30 September 2015 we noted that the lifts which led to all floors including the basement area did not have a safety device fitted. This means people were able to access areas in which they would be unsafe without a member of staff supporting them. We informed the provider of this issue.

We opened two external fire doors and saw that the exit routes were blocked with outdoor furniture. We followed one route and found that it led to an overgrown garden which was a trip hazard. The garden led to a pair of gates that were padlocked. In the event of a fire this could prevent people leaving safely. The other route was through an unmarked garden; again gates to the side of this garden were padlocked. The garden could be further followed to reach open gates however, there did not appear to be adequate lighting along this route. The latest fire risk assessment we could find was dated 2013. This means that it was out of date and therefore may not provide safe advice. We saw that the gates remained padlocked on 15, 16 and 19 October and we were informed that the keys had been lost.

We referred our initial concerns about fire safety to Merseyside Fire Service who visited the home.

On 15 October 2015 we saw that 15 people living at the home were watching a film in the basement cinema room. The internal door leading from the unit down the stairs to this room was locked externally to prevent further accidents. We saw that the fire door leading from the basement had a sign on it saying it did not work. We were informed that it was awaiting repair. The only way out of this area was via the lift. A lift cannot be used in the event of a fire; this meant that people would be potentially trapped in this area of the home. Some of the people living at the home were able to access the lift independently and the lift led to this basement area which was a fire risk. We advised the provider that this was unsafe and asked that an immediate plan be put into place to keep people safe overnight and that the cellar must not be used until a safe means of fire escape was accessible.

On 15 October 2015 we saw that the laundry room in the basement had several doors wedged open, this included doors leading to a gas metre that had a sticker on advising it should be kept shut. The door to the laundry room itself was propped open with laundry baskets, and the dryer was in use. Propping doors open means that in the event of a fire it will spread through a building far quicker than it should.

We informed the fire service of our concerns and they visited the home the same day to carry out checks.

On 16 October 2015 we walked around the building and again found fire safety concerns. A fire door on the top floor of the house had been wedged open with a towel, a second fire door in this area was caught open by the carpet and a third fire door did not appear to close correctly. We also saw that an external fire exit door from the house leading outside did not appear to open. We asked for the fire alarm to be set off. We saw that the external fire door from the house to the garden did not open; a fire door on the top floor of the house did not close when the alarm sounded and a second fire door was unable to close due to being wedged open with a towel.

We contacted Merseyside Fire Service who visited the home again and provided instructions as to the work that needed to be undertaken to keep people safe. Merseyside Fire Service stayed in the building with CQC inspectors until remedial repairs to the fire doors had been completed to assure ourselves that people living in the home would be able to evacuate safely in the event of a fire.

On 30 September 2015 we saw that a small kitchen in the basement had been used recently as it contained used cups and bowls. This room had cobwebs hanging from a fan, peeling paint and black marks on the walls indicating mould. It therefore presented an infection risk to anyone using it to prepare food or drink. When we toured the building on 15 October 2015 we saw that this kitchen was still in use and that the issues we had noted on 30 September 2015 and shared with the provider had not been addressed.

On 30 September 2015 the bar room in the basement was being used by people living at the home and their visitors

as part of a celebration. This room had 2 half empty cans of alcohol and 12 used or partly full glasses, which appeared to have contained alcohol. As the room could be accessed by people living at the home this could present a risk to them. We were informed by staff that these were from a 'social' held at the home the previous Friday evening. We also noted that the floor and bar area felt sticky and bins were full in this room.

On 30 September 2015 we saw a door in the unit with a sticker on it stating it should be kept locked. We found this unlocked and saw it led to a cupboard containing hot pipes and an emersion heater. We informed the provider at the end of the day that this could present a hazard to the people living at the home. On 15 October 2015 we saw that a second cupboard containing an emersion heater and hot pipes was also located on the unit. We found both doors unlocked despite a sticker on each door clearly stating 'keep locked'. We informed the provider of these findings at the end of the day. On 16 October 2015 we again looked at these two cupboards and found them unlocked. The doors were locked by the afternoon of 16 October 2015.

Concerns had been raised with us prior to our inspection regarding mice in the building. Records of a staff meeting showed that an issue with mice had been discussed in April 2015. Records showed that the provider had appointed a pest control service who were visited the home regularly. We saw that pest control had visited on September 24, 25, 28 and 29. The last recorded signs of mice being on the 25 September 2015. We saw overgrown gardens with rubbish including an old mattress stored outside and we observed gutters overgrown with weeds and windows and doors left open. On 15 October 2015 we saw a squirrel and birds eating in the garden. We found empty nut shells on the lawn and were told by a member of staff that one of the people living at the home fed the squirrels. These may be contributing to the on-going issues with mice in the home.

We visited a 'cinema' room which activity staff were creating. This contained chairs which had been ripped and which activity staff were attempting to repair for use in this room. As this may mean they would not meet fire safety standards this could place people at risk.

**These examples were significant 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 systems in place for supporting people with their medication. We found that medication was stored safely in a room with a controlled temperature. A photograph of the person was available with their medication chart, this helps to reduce the risk of people receiving the wrong medication.

We saw that one person had an 'as required' medication prescribed for them. No guidance as to when or why this medication should be given was recorded. This may means that without clear guidance the person may be given or not given their medication incorrectly.

Records showed that one person had 28 tablets of Diazepam 5 mg to use 'as required'. We found two boxes of 28 tablets totalling 56 for this person. This meant that there was no clear audit trail of medications in the home. If medication was to go missing this would not be noted due to incorrect recording of quantities.

**These were 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.**

People living at the home told us that they felt there were generally enough staff to meet their needs and provide the support they needed. One person told us, "There are plenty of staff." However another person said, "We could do with an extra one at night" (on the unit).

Staff we spoke with told us that there were usually enough staff on duty to meet the needs of people living at the home.

At the time of the inspection there were two registered nurses working at the home. Both were agency nurses who had worked there regularly. The provider explained that they were having difficulty recruiting registered nurses but tried to use regular agency staff who knew people's needs.

Throughout the day we observed that there were sufficient staff available to meet people's needs. We looked at a sample of staff rotas and saw that staffing levels had been maintained.

Inadequate

# Is the service safe?

We looked at recruitment processes in the home and at three staff files. Two of the files contained all of the required checks including references and a Disclosure and Barring Service (DBS) check. The third file had a DBS but no references. Although the member of staff had previously worked at the home obtaining references for them would ensure that they remained suitable to work with people who may be vulnerable.

Where a DBS check noted a caution or conviction we saw that these had been investigated to check they did not impact on the person's suitability to work at the home.

Inadequate

# Is the service effective?

## Our findings

One of the people living at the home told us, "Food is good. I have three cooked meals a day." Another person told us, "I think the food is all right but could do with a bit more choice sometimes."

People told us that they had received the support they needed with their health care. One person explained staff had called an ambulance for them when they had been unwell.

A relative told us staff kept an eye on their relative, ensuring they ate their meals and providing support to them to do so.

Staff we spoke with told us that they had received the training they believed they needed in order to support the people living at the home. We spoke with a senior member of staff who displayed a good understanding of the types of dementia people could have, she also explained that she used the internet to research this further.

We looked at training records for staff and saw that relevant staff had undertaken training in food hygiene. We also saw that a variety of training had taken place in 2015. This included, risk assessment, moving and handling, fire, infection control and hand washing. Staff had also undertaken training in areas relating to people living at the home, this included supporting people living with dementia and understanding the Mental Capacity Act 2005.

We saw that 11 staff had no date recorded for induction training at the home. A induction to the home is an important part of employing and training new staff, it helps to ensure they are familiar with the building, fire routes, the people living there and the ethos of the home.

No training for agency staff who worked regularly at the home had been recorded. It is important that agency staff receive basic training at the home including fire procedures and an induction so they are aware of actions to take in an emergency. It is also important that the home are aware of the training agency staff have received elsewhere so that they can make an assessment of their competence to meet the needs of people living at the home.

We asked to see records of supervision and appraisal for staff however these were not available. Formal supervision provides staff with a forum to discuss their training needs and any concerns or issues with their work. We saw minutes of two staff meetings held in April 2015. However these contained only information and instructions given to staff by the manager. There was no indication that staff had been able to raise any issues that they may have or that they had been able to discuss these openly.

The fact that we saw fire doors propped open, staff supporting people in a basement with no working fire exit and a door leading to basement stairs left accessible to people showed us that staff had not received appropriate training, supervision and support to enable them to carry out their duties safely.

**These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured persons employed at the home had received appropriate support, training, and supervision to carry out the duties they were employed to perform.**

A notice displayed on the office wall in the unit regarding one of the people living there stated, '(Name) is to be given ONE can of cider per day after tea. 6 pm. Should (they) participate in helping in the dining room (they) are to receive another can of cider.' This was signed by the registered manager. We spoke with the person who told us, "I would like to have more .. but I am not allowed." We looked at their care plan and saw no evidence that they lacked the capacity to make this decision for themselves. Their plan stated they were to have 'two cans of cider daily after evening meal' the person had signed their agreement to this. However this contradicted the notice on the office wall and the wishes the person expressed to us. This therefore means that the person's rights to make decisions for themselves had not been upheld.

We did not see any assessments of people's capacity to make important decisions for themselves. Nor did we see that where a person lacked capacity to make a decision that a 'best interest' meeting had been held for them. For example where the provider acted as appointee for people's money we saw no evidence that a 'best interest meeting' had been held to make decisions about how to spend the persons' money whilst ensuring it was in that individuals best interests.

We found that six people living at Bentley Care Home had a Deprivation of Liberty Safeguard in place. A recent legal ruling stated that if a person, lacks capacity, is unable to leave unsupervised and is under constant supervision' then

a DoLS should be considered. As many of the people living at Bentley Care Home are living with dementia then it is possible that more than the six people identified would benefit from this protection. We did not see any assessment within peoples care files to establish whether a DoLS would benefit them.

**These were 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.**

A member of staff who worked at the home regularly commented, "Their food is gorgeous, especially the homemade soup."

We observed the lunchtime meal in both the house and the unit. We saw that people were offered a choice of meals and that staff provided support to people who needed it. Throughout the day we saw that people were offered drinks and snacks regularly. We saw that a list was available in the kitchen of people who were on special diets, and the cooks for the day were aware of this. We saw that staff followed a care plan for one person whose plan said they should be offered fruit following their meal.

We looked at stocks of food in the kitchen and saw that sufficient food was available including fruit and vegetables.

We looked at weight records for one lady who we observed did not eat their lunch time meal. In June, July, August and September the record recorded, 'unable to weigh due to challenging behaviour'. Two other people had weight records that stated staff were unable to weigh them. A member of staff explained this was because they could no longer sit on the scales. We saw no evidence that any other system had been put into place for monitoring the person's weight, such as taking measurements of their upper arm. This means that people could be gaining or losing weight and it may not be noted and acted upon.

We saw that people had access to external health professionals including, district nurses, community matron, physiotherapy and dietician. In discussions with staff they were able to explain people's health care needs to us and explain how these were met. A visiting health professional told us, "They are very good communicator's here. Get in touch very quickly."

A senior member of staff explained that nobody living at the home currently had pressure sores. However they had a good knowledge of their role in providing pressure care and were able to explain the procedure they followed to minimise the risk of these developing.

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. A lift was available to take people between floors. However we saw little evidence that the building had been adapted to meet the needs of people living with dementia. 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 easily. Similarly some handrails had been painted red to help people find them easily, however others had not.

Requires improvement

# Is the service caring?

## Our findings

People living at the home were complimentary about the care staff provided for them. Their comments included, "Staff are great, kindness, what you show to them and they'll show it to you." "They are good to me," and, "The staff have a tough job here but I think they all do a great job. I am happy to be here."

One of the people living at the home told us, "No one tells me what time to get up or go to bed. I choose for myself." Another person explained, "We decide everyday stuff."

We saw that staff spent time sitting with people in the lounge and interacting with them. In discussion with staff they displayed an understanding of people's different needs and how to meet these in the way the person preferred.

We observed the lunchtime meal in the house and found that it was task focused and lacked atmosphere. Two people tried to stand up and were instructed, "Sit down, not had dinner yet." A third person was crying, staff did not appear to find this unusual and responded with, "I'm just doing drinks then I'll come and sit with you," or "When I've finished this I'll come." After some time a carer did sit with the person and unsuccessfully tried to encourage them to eat.

Notices displayed around the home indicated to us that the registered manager had on-going concerns regarding the care provided by staff. This included one notice dated July 2014 but still displayed in the staff room stating, 'If residents are denied attention disciplinary action for neglect will be taken.' Similarly minutes of a staff meeting dated 10 April 2015 stated, 'Staff will not tell residents to get back to bed they are not children.'

Minutes of a night staff meeting dated 10 April 2015 stated, 'if residents are awake in the morning prior to day staff commencement, they are to be washed and dressed and provided with a hot drink and not be left.'

The fact that a manager believes staff may not give people the attention they need, order them back to bed and not give them a hot drink when they wake indicates that people living at the home may not be receiving the care they are entitled to in a dignified manner.

We asked to see a copy of a 'service user guide' or information provided to people living at the home. However this was not provided to us. We did see loose leafed pages in one person's bedroom. This contained information regarding funding and advocacy services who could support people living at the home. However they referred to an advocacy agency as Careware. The agency is actually called Care aware; this misspelling could make it difficult for people to gain the information if needed.

A number of people were living at Bentley Care Home who were members of the local Chinese community, some of whom spoke little English. Although we saw that the home met people's meal requirements 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.

**These were 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.**

Nobody living at Bentley Care Home was receiving end of life care at the time of our inspection.

Inadequate

# Is the service responsive?

## Our findings

One of the people living at the home told us, "If I had anything to complain about I would tell the manager or see one of the staff." Another person told us, "Most of the staff are very patient with everyone and seem to know what we all need. They are good with us."

A relative of one of the people living at the home told us they would feel confident to approach the manager with any complaints they may have.

We looked at a care plan for one person who was frail due to their age. We found that care plans had been written for them in January 2014 and these had not been updated since although the person's needs had changed. None of the six care plans we looked at in the house had been updated since July 2015. This means that any changes to the person's health, welfare or choices may not have been noted and therefore acted upon.

We saw that one person had a risk assessment in place stating, 'nil by mouth due to chocking/aspiration'. They had been provided with alternative methods of nutrition in February 2015. However a care plan was in place for them that had been evaluated in July 2015 which stated, 'ensure 3 nutritious meals a day' and, 'good oral fluid intake'. If staff followed this written advice the persons health would be placed at risk.

Care plans contained a number of abbreviations that may not be easily understood to the person reading them. These included, 'NIC to administer anticonvulsant therapy as PX'd', and 'administer any Px oral aperients'. The use of these abbreviations means that not everyone reading the care plan may understand the care the person requires and how to deliver that care.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that an up to date plan of care was maintained for people living in the home.

One of the people living at the home told us, "We don't do anything to be honest. Just do our own thing. Some people go out. Some stay in and that's it." Another person told us "I would like to go out more."

Two activities coordinators are employed to work at Bentley Care Home, each working 30 hours per week. On the day of our inspection they were covering the cook's duties in the kitchen and were therefore not providing support with activities or occupation for the people living there.

We were told that activities included a weekly 'social' held in the home, films in the home, pub lunches and entertainers. As well as these 'events' we were also told activities included games and quizzes. A pastor visited to give communion to those who wanted to receive it and a hairdresser visited regularly.

No organised activities were taking place in the home on the first day of our inspection. We saw that the activities staff had created a 'bar' room downstairs and were in the process of creating a 'cinema room'. However the decorating of these rooms by the activity staff will have taken time away from direct contact with the people living there. No records were maintained of activities provided either on a daily basis or for individuals, therefore it was not possible for us to assess whether people were getting the support they needed with activities and occupying their time.

A visiting professional told us that they had issued several invitations to people living at the home to attend a local reminisce club or luncheon club but they had not been supported to attend for some time. These clubs were held for people from the local Chinese community and attendance may have been particularly beneficial for people living at Bentley Care Home who were from the Chinese community and whose first language was not English.

We did not see a copy of the complaints procedure displayed within the home. This meant that for people living there and visitors it may be difficult for them to access the information needed if they wished to raise a concern or complaint.

The complaints procedure we saw in the procedure file stated, 'please do not hesitate to contact me personally should this procedure not resolve any problems.' it did not given any name or number to indicate who this referred to. The procedure also referred to, the ' Commission for Social Care Inspection'. This is a previous regulatory body that ceased to exist in 2009.

A current complaints file was empty indicating no complaints had been received or recorded. We found an old complaints file with the last recorded complaints being

Inadequate

# Is the service responsive?

one in 2011 and one in 2012. It is unusual for a service to receive no complaints for almost three years; complaints often act as a way to plan improvements to a service and increase people's satisfaction with the service they are receiving.

**These were 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.**

Inadequate

# Is the service well-led?

## Our findings

We asked people living at the home if they felt it was well managed. One person described the registered manager as, "fantastic" whilst another person said the registered manager was, "A bit strict."

We asked people if there was a forum for them to share their views of the home such as a house meeting. People told us there was not, with one person saying, "We should be able to say things."

A member of staff who worked at the home regularly told us, "The home atmosphere has improved greatly." Another member of staff told us, "I know I could talk to the manager at any time because she is that sort of person, she listens".

However we had concerns about the culture of the home and how it was managed.

We saw a number of examples of inappropriate language used when addressing staff. These were both in minutes of staff meetings and displayed around the home. Minutes of a staff meeting dated April 2015 stated, ' There will be some of you that are pleased (staff name) is leaving as you do not have a good word to say about her and call her lazy.' They also stated ' What I will say is for those of you who take a wage out of the Bentley and continue to put us down, bringing down the morale of our staff, I think it would be better for all concerned including the residents if you found a job elsewhere as the Bentley has outgrown you.' it is not appropriate for a manager to describe an ex member of staff in this manner. Nor it is appropriate for a manager to speak to staff in this manner.

Minutes of the meeting also stated, 'it has also been said that staff are not listened to, but my door is always open. No one has knocked on my door or rang me'. An undated notice in the staff room, signed by the registered manager stated, 'CQC stipulate that all carers are to be enrolled for level 2 NVQ in care. Without this qualification carers will not be permitted to work within the care industry.' It is not true that the Care Quality Commission (CQC) stipulate this training nor is it the role of CQC to 'permit' people to work as carers.

The tone of messages and minutes of meetings was defensive, dictatorial and unprofessional and would not encourage an open and transparent atmosphere with the home. It is a matter of concern that a registered manager relies on notices to manage a staff team and attempt to improve practices within the home. A registered manager should be able to motivate staff, lead by example and encourage a professional attitude throughout the home.

The breaches of regulations we found on 30 September 2015 indicated to us that the registered manager did not have the skills needed to properly perform her role.

Minutes of the night staff meeting dated 10 April 2015 stated that staff paid a voluntary £5 per month. They stated that this has been used amongst other things to pay for dining furniture, blinds for the home and paint for the unit. Minutes of a day staff meeting held on 10 April 2015 reiterated that this was a voluntary contribution for which staff got meals and drinks through the day. They stated that a member of the public who used their car park had also been asked to contribute to this fund. Paint, furniture and blinds are part of the fixtures and fittings of a care home and a provider should not rely on a staff fund to pay for these.

We looked at a report titled 'report of registered providers visit to care home' this was dated 16 September 2015. The report stated that the auditor was unable to get into the office and therefore could not check paperwork including manager's audits. The report also stated that the auditor had spoken with one of the people living at the home and with two members of staff. This is a low number of people to speak with as gathering people's views is an important part of assessing the quality of a service and planning future improvements. As part of the inspection we asked to see minutes of any meetings held with people living at the home and their relatives. None were provided. We also asked to see copies of any surveys carried out. Again none were produced.

In the staff meeting file we found minutes of a meeting the registered manager held with a member of staff regarding their absence from work. This showed us that laws governing confidentiality had not been followed. In the office on the unit we saw a notice relating to a particular service user and their alcohol intake. We also saw a second notice relating to a person's visitors. A member of staff confirmed that the office was used by visitors; it is also likely that it would be used by members of staff who did not need access to this information. It is therefore a breach of people's right to confidentiality to display this information on a notice board.

Inadequate

# Is the service well-led?

At the end of the first day of the inspection we informed the provider and two of his representatives that we had received no information during the inspection regarding gas, electrical and lift certificates. We also explained we had not received any information about surveys, staff supervision or meetings with people living at the home. We provided an email address where these could be sent following the inspection. This information was not received

No effective quality assurance systems were in place at the home to identify risks to the people living there or to identify and plan improvements to the service. We saw no evidence that issues we noted with the unsafe environment, fire risks, lack of capacity assessments, tone of messages to staff and the way people's money was managed had been identified and therefore addressed.

On 30 September 2015 we informed the provider of risks we had identified at the home. These included unlocked doors opening to basement steps. Six days later a person living at the home fell down these steps as the door had remained unlocked. 16 days later we again found a door leading to the basement unlocked.

**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.**

On 7 October 2015 a representative of the provider sent us a copy of a document titled, 'Bentley programme of repairs'. This document contained two completed columns. One titled location the other issue. The document did not identify which areas of work were a risk, for example one indicated flooring needed replacing and another duvet covers purchased these may both be needed however we would expect to see them prioritised in terms of the risk and impact for people living there.

When we returned to the home on 15 October 2015, we were informed that the manager had resigned and had left the service. The deputy manager had also resigned and was working their notice period but was due to leave in a short time. We shared our concerns with the provider regarding this situation and our concerns regarding the issues we had found with the safety of the premises. The provider informed us that they were going on holiday the next day and the new manager was starting work the following week and would be inducted by the company accountant as the company secretary was also on holiday. We expressed our significant concerns that there was not adequate management oversight in the home.

We met the new manager of the home on 19 October 2015 and raised concerns with the company accountant regarding the recruitment procedures that had been followed for the new manager and asked them to take steps to ensure that appropriate references were urgently sought.

During and following this inspection we shared our findings with the local authority commissioning and safeguarding teams and the health authority.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>**Systems and processes were not established and did not operate effectively to prevent abuse of service users.**<br><br>Regulation 13 (2) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**Care and treatment of service users did not meet their needs and reflected their preferences.**<br>Regulation 9 (1) (b) (c) |

**The enforcement action we took:**
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>**Service users were not treated with dignity and respect.**<br>Regulation 10 (1) |

**The enforcement action we took:**
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>**An accessible, effective system was not established and operating effectively for identifying and receiving complaints.**<br>Regulation 16 (2) |

This section is primarily information for the provider

# Enforcement actions

**The enforcement action we took:**
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Systems and processes did not operate effectively to assess, monitor and improve the quality and safety of the service provided and to monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk.<br>Regulation 17 (1) (2) (a) (b) |

**The enforcement action we took:**
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Persons employed at the home had not received appropriate support, training, and supervision to enable them to carry out the duties they were employed to perform.<br>Regulation 18 (2) (a) |

**The enforcement action we took:**
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'.

This section is primarily information for the provider

# Enforcement actions

We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**The premises were not safe to be used for their intended purpose and were not used in a safe way.**<br><br>Regulation 12 (2)(d) |

**The enforcement action we took:**

We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Accommodation for people who require nursing or personal care'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Treatment of disease, disorder or injury'.
We commenced enforcement action to cancel the provider's registration at this location for the regulated activity 'Diagnostic and screening procedures'.