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Bethany House

Inspection report

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Date of inspection visit:
17 October 2017
18 October 2017

Date of publication:
20 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 October 2017 and was unannounced on the first day and announced on the second day. At the last inspection on 21 and 22 April 2016, we found that the provider was 'good' under the key questions of safe, effective, caring and responsive and required improvement under the well-led.

Bethany House is registered to provide accommodation and residential care for up to 30 people, most of whom were living with dementia. At the time of our inspection 28 people were living at the home.

It is a legal requirement that the home has a registered manager in post. The registered manager is also the provider. 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.

At our last inspection in April 2016, improvements were required to the management of the service. At this recent inspection we found improvements had not been made and we identified further areas of concern.

Systems in place to monitor and improve the quality of the service were ineffective in ensuring people received a good and continually improving quality of service. The audits had not identified the issues we found and had not always been consistently applied to ensure where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

Where people lacked the mental capacity to make informed decisions about their care, it was not always clear how relatives, friends and relevant professionals were involved in best interest's decision making. Mental capacity assessments and best interest decisions were not always applied consistently to clearly show what decisions people were being supported or asked to make in relation to their care. Application to apply for a Dols for people who had mental capacity showed that the provider did not have effective systems to ensure staff understood the legislationso people's rights were protected. Some applications had been submitted to deprive people of their liberty, in their best interests; we found applications were not always submitted in a timely manner.

People were supported by suitably, recruited staff that had received training to identify signs of abuse to keep people safe. However, staff had not always followed safeguarding procedures when there had been verbal and physical altercations between people living at the home. Potential risks to people had been identified although staff practice did not always follow guidance put in place to minimise the risk of avoidable harm. People were supported by sufficient numbers of staff to receive their care and support. People were supported with their medicines, however, there was an improvement required with the administration of medicines.

Most people spoke positively about the choice of food available, although there was some inconsistency with staff not always ensuring people were given a choice of food available. People who were on food supplements received them, however, a number had consistently lost weight and referrals made to professionals were more reactionary as opposed to preventative. People were supported to access health care professionals, however this was not always consistent and some improvement was required. People's health care needs were assessed and reviewed but people were not always referred to professionals in a timely way when health needs changed. Relatives told us the management team were good at keeping them informed about their family member's care.

People and relatives told us that staff were kind, caring and friendly and treated people with respect, although there were occasions when people's privacy was not maintained. The atmosphere around the home was welcoming. People were relaxed and were supported by staff to maintain relationships that were important to people. There were activities that provided opportunities to optimise people's social and stimulation requirements although they were not always suitable for those living with dementia. People and most of their relatives told us they were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly.

People received care and support from staff that had received training but their working practices and knowledge demonstrated that the training provided was not always effective and required improvement. Staff received supervision and appraisals and they felt supported to carry out their roles.

We saw staff treated people as individuals, offering them choices whenever they engaged with people. Where people had the capacity to make their own decisions, staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review. If we have not taken immediate action to propose to cancel the provider's registration of the service, they 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 and a rating of inadequate remains for any key question or overall, we will take action in line with our enforcement procedures. This could be 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.

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

During this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People were not always safeguarded from the risk of harm because possible safeguarding issues had not been reported to the appropriate authorities.

The provider's recruitment processes had improved to ensure people were supported by appropriate staff.

Risks to people were assessed but care and support was not always effectively delivered to reduce the risk of avoidable harm.

People received support to take their medicines but the administration of medicines required some improvement.

People were supported by sufficient numbers of care staff to provide care and support to people.

Is the service effective?

Inadequate

The service was not consistently effective.

People received care and support from staff that were trained and knew people's needs.

Mental capacity assessments did not consistently identify what decisions people were being asked to make, or supported to make, in relation to their care.

Most people were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible. However, this was not a consistent approach to everyone and required improvement.

People were supported to receive food and drink and people received their fortified supplements, however referrals for people who had lost weight were reactionary as opposed to preventative.

People were seen by health and social care professionals.

However, referrals to professionals were not always made when necessary and required improvement.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not ensured that the service was always caring. They had not ensured that people were consistently kept safe.

Peoples' privacy was not always respected.

People' independence was promoted where possible.

People who were able made decisions about their care with support and guidance from staff and were supported to maintain contact with relatives and significant people in their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives were involved in planning and agreeing their care but the care delivered was not always person centred to meet people's individual needs.

People spent time completing social activities they enjoyed but the activities were not always suited for people living with dementia.

People and most of the relatives were confident that their concerns would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the service but they did not always ensure identified shortfalls were investigated thoroughly and appropriate action plans put in place to reduce risk of reoccurrences.

The provider had not informed CQC of notifiable incidents and accidents as required to by law.

Most people and relatives were happy with the service they received.

Bethany House

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.

This unannounced inspection took place on 17 October 2017 with a further announced visit on the 18 October 2017. The inspection team consisted of two inspectors and a specialist advisor on the first day and one inspector on the second day. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health needs.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also contacted the local authority for information they held about the service and reviewed the Healthwatch website, which provides information on care homes. This helped us to plan the inspection. We had received concerns from partner agencies that related to keeping people safe from the risk of avoidable harm. We looked into these concerns as part of our inspection.

We spoke with six people, six relatives, the registered manager/provider, the deputy manager and six staff members. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records in relation to seven people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included three staff recruitment files to

check suitable staff were recruited. The provider's training records were looked at to check staff were appropriately trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Inadequate

Is the service safe?

Our findings

At the last inspection in April 2016 we rated the provider as 'good' under the key question of 'Is the service safe?'. At this inspection we found that improvement was required. We had received information of concern regarding two separate incidents that prompted this inspection. We did not examine the circumstances of those concerns because there were on-going enquiries at the time of the inspection visit. However, the information shared with CQC indicated potential concerns about the management of risk in the service. This inspection examined those risks.

Three people and two relatives we spoke with gave us examples of incidents they had witnessed or been told about by staff that involved people living at the home hitting or pushing other people. One person explained, "[Person's name] has hit me." A relative told us, "We've been told [person's name] has pushed people over." Staff explained how they would try to intervene when people became anxious with one another. One staff member told us, "They [people living with dementia] can't help it, they don't know what they are doing, we have to try and keep everyone safe." We saw staff had received safeguarding training about how to keep people safe. We checked the accident and incident records and noted there were occasions where people had been involved in incidents that involved hitting, biting or pushing other people. Although staff had recorded these concerns within care records, they had not identified these as potential harm or abuse. On reviewing care records, we noted there were no behaviour management plans in place to support staff with guidance on how to mitigate the risk of reoccurrence. We also noted these incidents had not been reported as a safeguarding concern to the local authority or to CQC by the provider. The provider had apologised for the oversight and explained they had made judgements on whether incidents were a safeguarding matter or not. The provider accepted they should have notified the local authority and CQC. This meant the provider had not identified the cause or taken any action to protect people from further risk of avoidable harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

We saw that individual risk assessments were completed to assess people's risk of falls, developing sore skin, nutritional risk and moving and transferring. The assessments were, overall, updated and there was a brief record of the actions to be taken to reduce the risk of harm to people. One relative explained how well the home had managed their family member's sore skin when they were discharged from hospital. We saw people being moved safely, using a hoist and staff used appropriate moving and transferring techniques, that ensured those people were transferred safely. However, we also saw on four separate occasions, staff using an unsafe technique by supporting people under their arms without the use of lifting belts. The use of underarm lifting is not considered to be safe practice because it has the potential to cause bruising to arms and injure people. All the staff we spoke with and records we looked at, confirmed risk assessments were in place and staff had received training. Staff were also aware that under arm lifting could cause injury. This demonstrated to us that staff knew the correct procedures to move people safely but did not always practice this.

On day one of our visit, we observed a medicine round. We saw a staff member removed medicines from their containers and with their bare fingers, put the medicine into the person's mouth. We then saw the staff member, without sanitizing their hands, took medicine from its pack for another person, again with bare fingers and put it in that person's mouth. On the two occasions, we saw people were eating their meal so their mouth was already full with food and the staff member then encouraged the people to take a drink. This was not safe practice and does increase the risk of choking for residents with living with dementia who may have swallowing difficulties and co-ordination issues. It is recommended that people are discouraged from mixing food and drink together while feeding themselves. On this occasion the people were unharmed. At this point we intervened to reduce the risk of any further cross contamination and risk of harm. We saw staff, where appropriate, had received medication training. We were told the staff member had been nervous because of our presence. However, the staff member spoke with us and could not explain why they had administered medicines in that way.

This was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safe care and treatment.

We found areas of the home were not sufficiently clean. For example, an item of upholstered furniture in lounge B was stained and dirty with an unpleasant smell. Throughout our site visit we noted a strong smell of urine in lounge B, as well as a urine smell on floor 1A. One relative explained, "You can smell urine in that lounge, it's quite strong some days and you can smell it upstairs." We were told by that the odour upstairs was due to solutions the hair dresser used but there was no hairdressing taking place on the days we visited and the door to the hair dressing room was closed. Post inspection visit, the provider explained there was a schedule of maintenance programmes that included the cleaning of all floor areas at least twice a year. They continued to explain floors were also cleaned whenever necessary following accidents and therefore certain areas and rooms were 'thoroughly cleaned as often as once a week'. The provider also explained that furniture was scheduled for cleaning as part of a 'big cleaning process' for every area of the home. We noted from the information submitted to us by the provider (dated up to and including 07 November 2017) showed lounge A carpet was last cleaned on 06 July 2017 and lounge B on 20 October 2017 (one day after our visit). This information 8suggested the programme required a review because at the time of the inspection visit, the cleanliness in lounge B had required improvement.
We noted a downstairs corridor was cluttered with chairs and an emergency exit blocked by three wheelchairs. A hoist was also noted in the porch way blocking the exit. On checking some people's rooms, we found one emergency alarm was not working and in seven rooms the wall lights above people's beds were either not working or missing bulbs. We found the home environment, in places, required repair. For example, in lounge B two people told us they found the room to be draughty because improvements to the lounge had not been completed. The provider submitted to us following our visit their schedule for monitoring emergency alarms. We noted the alarms were checked every quarter with the last check being made on 06 September 2017. As we had found one alarm was not working, this would suggest a more regular check of people's emergency alarms was required. We discussed with the provider the blocking of an emergency fire exit. We were given assurances by the provider the equipment had now been removed. The provider explained that care staff should routinely check bedroom lights for bulbs that were missing or not working and notify the maintenance team to have the bulbs replaced. We found this had not happened with seven rooms identified with wall lights that required attention.

It was noted since the last inspection in April 2016, there had been a significant increase in the number of people living with dementia residing at the home. The home environment was not dementia friendly. There was no dementia friendly signage, for example, to signpost people to communal toilets or the garden area. The home was dark, particularly in the some of the corridors of the upper floors. Poor lighting can disorientate people and cause confusion. The radiators in the home did not have protective coverings on

them to protect people from the risk of burns. The provider told us the radiators were fixed at a temperature of 47 degrees and there had never been an incident of a person harming themselves on a radiator. However, someone living with dementia may not recognise the risk posed by radiators and could still cause injury to themselves, if they maintained constant contact with a radiator. This risk is increased if the person is also at risk of fragile skin that could tear or bruise easily.

This was a breach of Regulation 15 of the Health and Social Care Action 2008 (Regulated Activities) 2014. Premises and equipment.

People we spoke with told us they felt safe living at the home. One person said, "I feel very safe here." Another person explained, "We are safe because no-one can just walk in." Most of the relatives we spoke with told us they felt their loved ones were kept safe. One relative said, "I wouldn't leave my mother here if I didn't think she was safe." Another relative explained "I don't think the home is unsafe, I've never seen staff mistreat people in any way." A professional told us they had not seen any unsafe practice being carried out by staff. Staff we spoke with explained how they would report any suspicion of abuse and the signs they would look for that could indicate a person was being abused. One staff member said, "We get to know people and their ways so if a person was really down and this was unusual for them it could mean something was wrong." Another staff member told us, "We check for bruising and if we did find anything or saw anything then we'd report it to the senior and if they didn't do anything I'd tell CQC (Care Quality Commission)." Staff had reported incidents they witnessed or were involved in to the provider. However, we found the incidents were not reported to the local authority or CQC.

People and relatives we spoke with all told us they thought there were sufficient members of staff on duty to support people. One person told us "There is always someone around," However, staff we spoke with felt there was a need for additional staff to cover for unplanned absences. One staff member said, "Generally it's ok but it gets hard when people phone in sick, because the owner doesn't use agency staff, we have to come." Another staff member told us, "We have mentioned it to the deputy manager who said they are looking into it." Our observations on the days we were at the home showed, although the staff were extremely busy, there were sufficient staff on duty to attend to people's care and support needs.

Staff told us pre-employment checks were completed before they started to work at the home. We saw Disclosure and Barring Service (DBS) checks had been completed prior to their employment. The DBS check can help employers to make safer recruitment decisions and reduce the risk of employing unsuitable staff. However, it was noted that for staff who had been employed by the provider for over three years, this included the registered manager/provider, had not had their DBS reviewed. It is good practice to ensure all staff have their DBS checked approximately every three years to ensure people are protected from the risk of being supported by unsuitable staff.

During our visit we saw medicines were locked away in a secure facility. The temperature of the room was recorded and processes were in place for ordering and supply of medicines and we found that people's medicines were available. We saw that medication administration records (MAR) were completed correctly and audits conducted showed the amounts of medicine in stock balanced. We noted that protocols were not consistently in place to provide additional information for staff about medicines which were prescribed to be given only when required. However, staff we spoke with were aware of the signals and behaviours of people that could indicate they were in pain or required their as and when medicine.

Inadequate

Is the service effective?

Our findings

At our previous inspection in April 2016, we rated the provider as 'good' under the key question of 'Is the service effective?' At this inspection we found improvement was required.

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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked whether the provider was working within the principles of the MCA and found that improvement was required. People we spoke with told us staff asked for permission before carrying out any care or support. One person said, "Staff do ask me first before they do anything." One member of staff said, "Not everyone can tell you but I always ask people anyway or show them different choices, like what clothes they want to wear." However, we found some decisions were being made on behalf of people who staff or relatives said did not have mental capacity. For example, the information we had received suggested people subject to a restrictive practice. Although we did not investigate the actual events, we did review the provider's proceses. We found at least one person was being restricted to their bedroom, we were told was for their best interests, however, no best interests meetings had taken place with health and social care professionals to ensure this was indeed in the person's best interests.

We found the provider had not carried out assessments of people's capacity to make certain decisions and their care records did not reflect how decisions had been reached in their best interests. This showed the provider did not ensure staff worked within the principles of the MCA or had made sure staff had sufficient knowledge to make sure people received their care in accordance with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We had received information that suggested some people living at the home had been unlawfully deprived of their liberty. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Not all the staff we spoke with were able to explain why DoLS applied to some people or the implications of this on the way they provided care and support to people . Nor were they made aware when applications had been approved and whether the approvals were subject to any conditions. Therefore, the staff could not always be sure they were acting in a way that protected peoples rights. The deputy manager explained that DoLS applications had been submitted for everyone, including those who did have mental capacity, because the front door was locked. It was clear on speaking with the deputy manager and some of the staff that there was a lack of knowledge around the implementation of DoLS and how this could impact on people living at the home. An application to deprive someone of their liberty should only be made whjere people lack the capacity to consent to their care and treatment We saw that some applications had not been made to authorise restrictions on people's liberty in a timely way. We found three applications had been submitted

up to five months after the people had first arrived at Bethany House. This meant that these three people had potentially been deprived of their liberty without lawful authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

All the people we spoke with told us they were satisfied with the food they received. One person said, "The food is lovely, we get a choice and I get what I ask for, tonight I'm having porridge for tea." A relative told us, "[Person's name] has no complaints about the food, if they did, they'd tell me." We did hear staff tell people what their lunch was and at tea time we saw people were given a choice of two meals. However, the meal time experience required some improvement. For example, people that required plate guards had them added onto the plates while they were trying to eat. These should have been added onto the plates before being given to the people. Not all people were asked if they wanted clothes protectors but were politely told "Put this on." Condiments were not available on the tables for those who would like salt or pepper on their meals. We also noted that gravy was poured over dinners without asking people what their preferred choice was. We noted people were supported to move to the dining area up to 45 minutes before the meals were served. People had become restless and one person on four separate occasions tried to leave the dining area and was told repeatedly, albeit in a polite manner to, "Sit down, your dinner will be here soon." The tea time experience on the first day of our inspection was disorganised with a number of people trying to leave the tables and staff trying to encourage them to remain seated. Medication was being administered and people were pushing their medicine away with one person knocking their medicine to the floor. There was lots of noise which caused some people to become upset, while other people looked confused and unsure about what to do when their meal was placed in front of them. Staff did not always explain to people that the meal was their dinner and took time to place cutlery in people's hands to encourage them to eat. We did see one person being encouraged to eat, however, not everyone who required this encouragement received that support.

Our observations of people living at the home were that a majority of people were very slim or underweight. People's nutritional needs were assessed and there was information in people's care plans about their nutritional preferences. However, on reviewing people's records we noted that a number of people had lost weight since January 2017. We noted that overall the care plans identified a 'desired' weight range. However, no staff members were able to explain how this had been decided upon. Whilst the records we looked at stated that all of the people were either within their agreed weight or underweight (according to their care plans) there was no evidence of any personalised strategies to manage their weight or to either maintain or improve the situation. We noted, in particular, with six people's records there had been a consistent weight loss but referrals were only made to the GP when the person's weight had reduced their BMI to an 'at risk' level. The provider did not take a preventative approach to people's weight loss but a reactionary approach. We discussed with the deputy manager the matter of people's weight and the need to introduce food and fluid charts to monitor quantities eaten and drank, where appropriate. The deputy manager confirmed this would be looked. They continued to explain they would also request the provider purchased full fat milk in place of semi skimmed milk, which would assist with fortifying people's diets. We also discussed with the provider the need to be more proactive when managing people's weight. We explained to the provider that the purchase of full fat milk could help with adding calories to people's diets for those at high risk of losing weight. The provider told us they had purchased full fat milk in the past but people had complained. We tried to explain to the provider that it was their responsibility to ensure people's weights were monitored and maintained and this can be assisted, with fortified diets, for those at risk of losing weight. We did see there was additional support sought from dieticians and speech and language therapists (SALT) where people had difficulty swallowing their food.

Most people were not able to share their experiences of staff assisting them with their day to day health needs or helping them access healthcare professionals when required. But the people we spoke with told us they were seen by health care professionals, for example, the GP, tissue viability nurses, optician, podiatrist or dentist. Most of the relatives we spoke with had no concerns about their family member's health needs. One person said, "Fortunately, I don't need the doctor but if I do, they [staff] get them [GP] in." We saw from people's records that healthcare professionals had visited and one professional told us the staff followed any instructions they were given. However, records we looked at for two people had inaccurately recorded their weights, it appeared that the records were mixed up with each other. This had gone unnoticed and no action had been taken to account for the sudden loss of weight for the one resident. We also noted that some referrals had not been made for two residents. We noted that records for one person, at risk of sore skin, the risk assessment score had not been calculated correctly. Had it been, it should have triggered a referral to the GP because the person was at risk, but there was no evidence of this being done. We also noted that another person had sore skin for a period of three months but there was no evidence of a referral to health care professionals for review. On another person's plan it was noted between January 2017 and October 2017 the person had lost 7.2kg. There had been no pressure risk assessment since 22 December 2016 (March was incomplete) and their risk assessment score had also been calculated incorrectly lowering their score. There was no evidence in the care plan to correct the score that should have been higher, therefore identifying the person was at risk of developing sore and should have been referred to the GP.

Most of the people spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "The staff are very good and help you when you need it." A relative we spoke with said, "I can only speak as I find and I think the staff have the knowledge and skills to look after [person's name]." Staff we spoke with told us they had received training to support them in their role. One staff member said, "We've done quite a bit of training but most of it is watching DVDs, we complete a questionnaire at the end and the owner checks it." Another staff member told us, "We've completed training in moving and handling, I think that was early in the year." We saw new staff to the home had completed an induction that included working alongside more experienced staff before being 'signed off' by the provider. Staff had received training to NVQ Level 2 and Level 3. Staff did not complete the Care Certificate but told us they had completed training that reflected the Care Certificate standards. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. We discussed with the deputy manager the need to review the quality of training around the MCA and DoLS. We also discussed with the provider the need for identifying incidents as potential safeguarding and what could constitute potential abuse.
Staff we spoke with confirmed they had received supervision from the deputy manager and told us they felt supported by the deputy manager. One staff member said, "[Deputy manager's name] is a lovely person, you can call them anytime if you're worried about anything and they will always come into the home." This was confirmed by all the staff we spoke with.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in April 2016, we rated the provider as 'good' under the key question of 'Is the service caring?' At this inspection we found the service required improvement.

People we spoke with thought staff were caring. One person said, "Staff are kind." Relatives we spoke with told us, "They [staff] have the patience of saints," "Staff are kind and considerate, I wouldn't leave [person's name] here otherwise, and "The staff are pleasant and polite." Our observations of the staff showed them to be patient and polite. We saw some positive interactions with people, for example, we saw one staff member supporting a person to stand, talking kindly to them and offering encouragement. However, we did observe that at times staff missed opportunities to interact with people more. For example we observed staff supporting one person with their meal, and the staff member did not verbally interact with the person at all throughout their meal.

People we spoke with told us they were involved in decisions about their care and support needs. One person said, "The staff know what I want and how I like things to be done." Care plans we looked at included some information about people's previous lives, their likes and dislikes and their individual preferences. However, we could not see any evidence of how this information was being used to personalise support for people. For example, we noted one person was not offered meals that were culturally appropriate. It was explained to us that a staff member would sometimes bring food they had cooked into the home for the person. We discussed the person's cultural requirements with the deputy manager. They explained the family of the person had been made aware the provider did not provide culturally specific foods and that the person was 'happy' with the meals they received. This meant that some of the care and support being offered to people was not always person centred or based on people's individualised needs.

People we spoke with told us staff respected their privacy and dignity. One person told us, "The staff are very respectful." Staff addressed people by their preferred names but on two separate occasions we saw one staff member had entered a person's bed room without knocking or announcing they were coming in. Although the person did not appear to be upset that the staff member had just walked unannounced into their room, it did demonstrate that not all staff considered the privacy of people who preferred to remain in their rooms.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Our observations overall demonstrated that staff were friendly and they laughed with people and supported people to move around the home safely. Although this was not always carried out at a pace suitable to the person. For example, we saw staff walked slightly ahead of people which meant their arms were outstretched and at an angle in front of them which could lead to the person being rushed and become unsteady on their feet and fall.

Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell

by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. For example, one person could become upset when personal care was being given. Staff explained they would leave the person for a period of time and return later. If the person was still upset, a different staff member would attend to the person.

Everyone we spoke with told us there were no restrictions when visiting. A relative told us "I visit at different times." There were two lounge areas and a dining room for people to meet with their relatives in private. We found people living at the home were supported to maintain contact with family and friends close to them.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in April 2016, we rated the provider as 'good' under the key question of 'Is the service responsive?' At this inspection we found improvement was required.

People and relatives we spoke with explained how they were involved with the initial assessment of their family member's care and support needs. One person explained when asked if they were involved in the planning of their care, "The staff do ask me if I am happy with how things are done but I look at the care plan." A relative explained, "We needed to find another home for [person's name] so came to visit and explained [person's name] needs. I was so relieved when they [the deputy manager] said they would accept [person's name]." We saw that initial assessments were completed and located within the care plans. Although we could see care plans had been reviewed, there was no evidence to show how people or their family members had been involved in the review process. There was a small amount of personal life history information in the care plans and staff we spoke with were knowledgeable about people's needs and risks associated with their care. However, we noted the care plans were generalised and not always personalised to individual needs. For example, we found evidence of information being 'cut and pasted' from other care plans. Where care delivery had been recorded for the last three months, it was also noted the information was much the same in every person's record we looked at. There was a section for additional comments but few people's notes had anything written within them. Overall, there seemed to be limited personalisation within the care plans that took into account people's individual needs.

All the staff we spoke with told us that they received updates about changes in people's needs in handovers between staff at shift changes and would also read people's care plans. One staff member explained, "If you're unsure of anything you would read the person's care plan or ask [deputy manager's name]."

People we spoke with and most of their relatives told us they were satisfied with how people's needs were being met and had no complaints. One person told us, "I've got no complaints at all." Another person said, "You have to make the best of what you've got." A relative said, "I don't have any major concerns with the home other than the hygiene issue." Another relative told us, "I have had to raise a few things but [deputy manager's name] is quick to deal with anything their very approachable." We reviewed the complaints file and could not see any complaints recorded. However, this was not reflected in the conversations we had with some relatives. The deputy manager explained they had dealt with some issues but they had been resolved quickly. The deputy manager had reassured us they had dealt with any concerns. However, we could not see how the provider had monitored the concerns for trends to ensure the service could be improved upon and reduce the risk of any reoccurrences.

We noted since our last inspection in April 2016, there had been an increase in the number of people living with dementia. We found the provider had an 'activities co-ordinator' who also had other duties they were responsible for. We saw that some people were supported to participate in social activities of interest to them. People who chose to remain in their rooms told us they were happy to read their books and watch television. We were told by people and most of the relatives we spoke with, people had enough to keep them stimulated and prevent social isolation. During the two days we were on site, we noted there were

different activities for a small number of people. For example, playing bingo or drawing and painting. However, we could not see evidence of any person centred hobbies or activities suitable for people living with dementia taking place. A professional had shared their observation with us that people were not engaged in person centred hobbies or interests and felt the provider could do more for people living with dementia. We discussed our observations and feedback with the provider. It was explained how taking into account people's life histories could support a more focused and personalised approach by the provider to support people's individual needs. The provider said this was an area they would look into.

The home had a large, accessible garden to the rear of the property that people could access. Families used the garden to take their relatives out when they visited and if the weather was fine.

We asked staff how people's cultural and spiritual needs were being met. One staff member explained for people whose religion was important to them, the provider had arrangements in place for visitors to attend from local places of worship. One relative explained to us how important it was for their family member to continue with this practice. Staff we spoke with confirmed they had received training on respecting people's equality and diversity needs.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspections in February 2015 and April 2016, we rated the provider as 'requires improvement' under the key question of 'Is the service well-led?' At this inspection we found the service still required improvement.

Although we found the provider had systems in place to monitor the quality and safety of the service, they had not always been used effectively to implement or sustain improvements made where shortfalls had been identified. This was evident for some of the shortfalls we found during this inspection. The provider's systems to monitor accidents and incidents for themes and trends in order to mitigate the risk of any reoccurrence, required improvement. The provider's systems in place to evaluate staff knowledge on completion of some of their training required improvement. For example, the effectiveness of MCA and DoLS training to ensure staff knew how to ensure people's legal rights were been promoted. Systems were not in place to effectively record the amounts of fluid and food intake for people at risk of weight loss. The provider's policy stated hallways and passages were to be kept free of obstruction, however, spot checks of the environment had not identified a fire exit was blocked. The provider's policy stated staff should not wear jewellery. However, spot checks on staff members had not identified some staff were wearing large stoned rings and bracelets that could cause damage to people's skin if caught' as well as being an infection control risk.

We found care plans had not been consistently and accurately completed and on occasion had contained incorrect information about people. Potential risk had not been identified when records for people showed a sudden drop in weight and two care records had information that had not been calculated correctly. One of the records should have resulted in a referral to a health care professional. This meant the provider's audits had not recognised these shortfalls and required improvement.

This is the third time we have rated 'requires improvement' for the service under 'Well Led' and demonstrateds that the provider does not have effective systems and processes in place to drive improvemenst in the quality and safety of the service provided.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider had failed to inform us of a number of safeguarding incidents they were required to by law. There had also been a number of falls at the home which resulted in people being taken to hospital with serious injuries. The provider had a legal responsibility to ensure these significant events were notified to the CQC. They were not notified to us at the time the incidents occurred.

This was a breach of Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

People and most of the relatives we spoke with were complimentary about the quality of the service.

Generally, we found the atmosphere of the home to be calm and relaxed, with the one exception of the evening meal on the first day of our visit. Everyone knew who the deputy manager was and told us that they could speak with them whenever they wished and that they were visible around the home and approachable. One person told us, "[Deputy manager's name] is always here." One relative we spoke with told us, "I'm perfectly satisfied with what I have seen here, [person's name] is always clean and presentable, the staff pleasant and polite, I have no problems at all with the home." Another relative said, "I have no cause for concern, I do look around and feel the home is quite calm and I am reassured and encouraged by that." All the staff we spoke with told us they were happy working at Bethany House. One staff member told us, "It can be hard work, but I really enjoy working here, we all support each other and work well together." Another staff member said, "[Deputy manager's name] will listen to you, if you have any concerns, you can always go to them."

We saw the provider had received feedback from people who lived at the home, their relatives and healthcare professionals about the quality of the service. Some of the responses included: 'The home has a friendly atmosphere', 'The staff are always welcoming.' 'I feel that if I had concerns I would be listened to,' and 'I feel the overall experience to be a good and pleasant one.'

Staff members we spoke with told us the deputy manager was also approachable if they had concerns regarding the service and they would speak with them. The provider had a whistle-blowing policy in place and although staff knew who to contact, there were no contact details of relevant organisations on the policy. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from out last inspection is displayed within the home. We found the provider had displayed their rating. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. From discussions we had with people living at the home and family members, we found the provider was working in accordance with this regulation.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to inform The Care Quality Commission of a number of safeguarding incidents they were required to by law.

The enforcement action we took:

Issued a Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently carried out assessments of people's capacity to make certain decisions to reflect how decisions had been reached in their best interests. The provider did not ensure the service worked within the principles of the 2005 Mental Capacity Act.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Bethany House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that persons providing support to people worked in a safe way to protect them from risk of harm and the spread of infection.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at

Bethany House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not identified that certain incidents were potential abuse. This meant the provider had not taken appropriate action to protect people from further risk of avoidable harm. The provider had not ensured that people were not deprived of their liberty for the purpose of receiving care without lawful authority.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Bethany House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises was consistently maintained and standards hygiene were not always effective.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Bethany House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's processes had not improved sufficiently to ensure the service delivered to people was consistently safe and effective.

The enforcement action we took:

We have imposed a condition that the registered provider sends to the Commission a monthly report. The report should provide a summary of the quality assurance activities undertaken, the findings and any required actions to be taken including associated timeframes for completeness in order to demonstrate the service is able to meet the care needs and promote the safety and comfort of everyone living at Bethany House.