Prasur Investments Limited

Bentley Care Home

Inspection report

2 Bentley Road
Liverpool
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Tel: 01517273003

Date of inspection visit:
10 April 2017
11 April 2017
13 April 2017
03 May 2017
08 May 2017

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01 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Bentley Care Home on 10, 11 and 13 April, and also 03 and 08 May 2017.

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

The home had a manager who was in the process of applying to be the 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.

At this inspection we found serious breaches of Regulations 9, 10, 11, 12, 13, 14, 16, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were assessed by CQC as extreme, as the seriousness of the concerns placed a significant risk on the lives, health and well-being of the people living in the home.

The premises were unsafe and poorly maintained. The kitchen had been closed by the Environmental Health Department as it was unsafe and the home had a serious rodent problem that was not being managed appropriately. The food preparation areas were unsuitable and placed people at risk from food poisoning. People were found to be smoking in the building which was unsafe and against the home's policies and no action had been taken to address this.

Medicines were not safely managed which placed people's health at risk and staffing levels were insufficient to meet people's needs.

The Mental Capacity Act 2005 was not adhered to in the home. Staff did not have the knowledge and skills to support people or follow legal processes to make sure decisions were in people's best interests.

There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led. The manager and provider were unable to demonstrate the skills, knowledge or ability to make the urgent changes that were required to make the service safe during the time period of a month in which the inspection took place.

On 09 May 2017 CQC used its urgent powers to keep people safe.

The provider has 28 days to appeal against this action to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. Once this period has passed, the action will be reported upon.

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

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

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

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The premises were dangerous and had been poorly maintained. The kitchen had been closed as it was unsafe and the home had a serious rodent problem that was not being sufficiently managed.

The home did not have adequate arrangements in place for the proper and safe management of medicines.

The home did not have sufficient staff on duty to meet people's needs safely and the provider had not taken reasonable steps to ensure that staff were safely recruited to work in the home.

Is the service effective?

Inadequate

The service was not effective.

The provider did not have suitable arrangements in place for people to consent to their care and there were not always legal processes in place when people could not give consent.

Staff had not received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

Is the service caring?

Inadequate

The service was not caring.

People were not supported to maintain their personal care in a dignified way that supported their well-being.

People were left for long periods of time without the care and support that they needed.

Is the service responsive?

Inadequate

The service was not responsive.

People living in the home were not receiving care that met their

individual needs. The care plans and risk assessments did not adequately describe people's needs.

There was no effective system in place for identifying, receiving, recording, handling and responding to people's complaints.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

The records relating to people's care were very poor making it impossible to see if the home and the equipment in it were safe and if the people in the home were having their needs met.

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.

This inspection took place on 10, 11, 13 April and 03 and 08 May 2017 and was unannounced.
This inspection was carried out by two Adult Social Care (ASC) inspectors on 10, 11, 13 April 2017. On 13 April they were also accompanied by a specialist advisor (SPA) who was specialist in the use of medicines. An ASC inspection manager and an ASC inspector attended on 03 and 08 May 2017.

We carried out this inspection because concerns were raised by stakeholders in relation to safeguarding investigations at the home.

We spoke with 11 people who used the service, and with eight visiting relatives. We also spoke with the provider, the manager, the deputy manager, the care taker, the administrator, and four care staff and two domestic staff and the cook and kitchen assistant and the activities coordinator.

We looked at six care files which included the daily records, five staff recruitment files and other records relating to staff training and supervision. We also looked at other records and documentation in the home relating to the safety of the premises.

We observed people and staff throughout the inspection and saw how people were being cared for.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe and they told us that they did feel safe in the home. Most of the relatives we spoke with told us that they thought that the home was safe but that more staff were needed.

On 10, 11and 13 April 2017, we looked at the safety of the premises and found a number of concerns. The electrics in the home were potentially unsafe. The maintenance person told us that only half of the building had a valid electrical safety certificate and we saw records to confirm this. We were also informed that staff were receiving static shocks from door keypads and when some lights were turned off this triggered some of the nurse call bells being set off.

We also found that the emergency lighting system was not working safely and was faulty. This has been the case for some time and repairs had not been made. This meant that it could be difficult to evacuate people in an emergency such as a fire, especially at night.

We also looked at equipment checks and these were out of date so it was unknown if these items were safe to use. This included hoists which meant that service users could potentially be at risk. The call bell system was inadequate as many call bells did not work. This meant that people who lived in the home would not be able to call on staff to help them if needed. There was one call bell that we saw had been cut off at the wire. We were told by a member of staff that this had been cut by staff to stop a person calling for help as they were prone to doing so and irritating the staff.

Throughout the inspection people who lived in the home were found to be smoking in their bedrooms and the provider and manager admitted that they knew this to be the case but had not taken action to deal with this issue. This meant that everyone was at potential risk from a fire.

We looked at medicines administration and found that this was unsafe as people who lived in the home were not always receiving their medicines when required. In one case a person was not given their prescribed pain relief for a whole month. The medicines room was cluttered and unhygienic and too hot to ensure safe storage of medicines at required temperatures.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The premises were dangerous and were not safe for people to use.

Following the April 2017 inspection dates, CQC used its urgent powers keep people safe.

The provider has 28 days to appeal against this action to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. Once this period has passed, the action will be reported upon.

On 03 May 2017, Inspectors returned to the home to check that work had commenced to make improvements to the issues that had been found. We saw that the provider and the manager had made

some progress with making improvements. However, we had serious concerns about the standards of cleanliness and hygiene in the home. We liaised with the local authority and an urgent visit was requested by the environmental health department. Environmental health officers attended the home on 04 May 2017 and raised serious concerns about rodent activity in the kitchen and dining room of the home and also poor cleanliness and poor hygiene standards they observed at the home.

Environmental health officers liaised with the provider and the provider entered into a voluntary agreement to close the home's kitchen until improvements could be made. The local authority also arranged for the Council's pest control department to come into the home and deal with the rodent problems.

CQC returned to the home on 08 May 2017 and found serious concerns that impacted on the lives, health and safety of the people who lived in the home.

The kitchen was still closed. We inspected the kitchen and found it to be extremely dirty and unhygienic with ground in dirt and grease on a number of appliances. The floors were also covered in ground in dirt and we found mouse droppings. This was four days after the kitchen had been closed for cleaning. We found dead flies in a potato peeler and grease and grime on a trolley that was currently being used to transport people's food.

As the kitchen was not in use we looked at the room where food was currently being prepared for people who lived in the home. There was no separate sink for anyone to wash their hands as there was only one sink in the room. This sink was dirty and contained bits of food that had not been cleaned away after use. The microwaves used to heat food were dirty as there was split food inside them that had not been cleaned. There was no fridge to store food in the vicinity. The nearest fridge was down a flight of stairs and through two doors. We observed cooked meats that were left on the side for over two hours and were not refrigerated on a warm day. The meat was then used in sandwiches for people's lunches. In addition to the identified risks posed by the rodent infestation at the home, the way people's food was being prepared created a high risk of contamination and growth of harmful bacteria. This placed the people living there at high risk of developing food poisoning. This posed an immediate and potentially life-threatening risk to some of the older and frail people who were cared for at the home.

On 09 May 2017, the provider took the decision to reopen the kitchen which was in conflict with the voluntary agreement that had been entered into with environmental health. Environmental health officers inspected the home and issued a formal closure notice of the kitchen by serving an urgent hygiene prohibition notice.

This was a serious breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The premises were dangerous and were not safe for people to use.

On 09 May 2017 CQC used its urgent powers to keep people safe.

The provider has 28 days to appeal against this action to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. Once this period has passed, the action will be reported upon.

During the inspection we looked at the staffing levels and found that there were insufficient staff and those staff had been ineffectively deployed to meet the needs of the people living in the home. We were told and this was confirmed by the manager and the provider that the night staff were sleeping on duty and were not

meeting the needs of the people who lived in the home at night. This placed people's safety during the night at serious risk.

We also saw that one unit in the home was only staffed by two staff members who were unable to safely meet people's needs due to the high dependency of the people living in the unit. We saw people waiting for care and asking for assistance and not receiving any.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient staff to safely meet the needs of people living in the home.

We looked at the arrangements in place to safeguard people from harm and abuse and found that they were not effective in meeting people's needs. During the inspection we referred a number of people to the local authority safeguarding unit for investigation based on situations we observed and staff conduct when supporting people living in the home.

We discussed safeguarding concerns with the provider and found that they did not understand their responsibilities in relation to reporting concerns to the appropriate authorities. For example there was an incident where a person who lived in the home had sustained an injury and the provider had not reported this issue as they thought it was another professional's responsibility. The provider was also not aware that they had an obligation to report such incidents to the CQC.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient arrangements in place to safeguard vulnerable adults living in the home.

We looked at the recruitment records for staff working at the home. We found some concerns with the processes that had been followed. The records were incomplete in some cases. We found application forms that were vague with gaps in staff's work histories which had not been explored. There were not always two references for staff employed and sometimes these had not been provided by recent employers.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment processes were not robust to ensure that fit and proper persons were employed to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

We asked people who lived in the home if they liked the food. Comments were mixed. Some people responded positively and said that the food was good and they enjoyed it. One person said, "Sometimes the food is good, and sometimes not."

We spoke to the cook who had worked at the home for two months. The cook was not qualified as a cook or in basic food hygiene awareness. The cook could not tell us about any of the special dietary needs of people living in the home. We were aware that there were people who needed a diabetic diet and people who needed soft diets for different reasons. This was a considerable concern as we could not be assured that people were receiving a safe and adequate diet suitable for their needs. We also saw that a soft diet consisted of soup and sandwiches blended together. This looked very unappetising and did not constitute a well-balanced diet.

During the inspection we also became aware of a person who received nutrition differently. We found that this person was not receiving adequate hydration or nutrition and was not being supported safely in accordance with their risk assessment relating to their dietary needs.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The RM / Provider had no systems in place to ensure that people had access to a safe and adequate diet that met their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the home was not operating within the legal requirements of the Mental Capacity Act. For example some people's DoLS had lapsed and had not been reapplied for. This meant that people may have been detained unlawfully in the home. We also found that very few of the people in the home had consented to their care and that their consent had not been explored with them.

We found information in people's files relating to their end of life wishes was photocopied from their previous place of residence which was not valid or lawful. We also found conflicting information in people's care files relating to their ability to consent to care and treatment.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

We looked at the arrangements for supporting staff and found that staff were not supported or trained to an acceptable standard to be able to meet people's needs safely. We saw that most staff training was delivered using elearning. We saw that staff were not trained in supporting people with mental health support needs and there were lots of people in the home living with these support needs. Many staff told us that they would like to undertake such training but none had been made available. We also saw that there was no induction training available for new staff.

Staff did not receive supervision or appraisals to develop their skills or support them in the jobs. We discussed this with the provider and they told us they knew that staff were not being supported adequately.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure that staff were suitably competent and skilled for their roles.

Inadequate

Is the service caring?

Our findings

Most people we spoke with were very positive about the staff and the care that they provided. One person said, "The staff are lovely here". Another person told us that the staff were very helpful.

We saw that the staff had warm positive relationships with people and obviously knew people and how to communicate with them well. However we observed a number of issues that caused us considerable concern as to how people were being cared for.

We observed one person repeatedly asking staff for a cigarette. They were told by a staff member, 'in a minute' and 'come back in a bit'. They also asked a staff member who was assisting another person. The staff member said, 'I can't help I'm busy, ask another member of staff'. This was said in a curt and impatient tone.

We saw that one person should have been receiving 15 minute observations from staff in order to maintain their safety. We observed this person for a number of time periods and did not see any interactions with staff. This meant that this person was potentially at risk as they were not receiving the care that their care plan stated that they needed.

We saw another person had broken glasses and they were having to hold their glasses on their head so they could see properly. This was very undignified and irritating for the person and we could see their discomfort.

During the first three inspection days (which spanned a four day period as we inspected on 10, 11 and 13 April 2017) we observed a number of people were dressed in the same clothes every day and each day their appearance was becoming more unkempt. Their clothes were dirty and stained and we did not consider this to be acceptable for them.

A number of people who lived in the home raised concerns to us around the lack of choices they could make in relation to going in and out of the building, having cigarettes and personal monies. These issues did not correlate with the people's care plans and it was impossible to see how the provider considered people's independence and choices, how these were respected or even taken into account.

On the first day of the inspection we found an old wardrobe that had been left on a landing in the care home. It was full of clothes, a suitcase and some personal belongings. We asked who it belonged to and a staff member told us it was a person who had lived at the home previously and had died "a year or two ago". We found this to be uncaring and disrespectful.

These examples are a breach of Regulation 10 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect and were not always able to make choices.

Inadequate

Is the service responsive?

Our findings

We asked people if they had been involved in planning their care. Most people told us they had not. One person said they have not seen their care plan. We asked about complaints and some people told us that they had made lots of complaints but that they had not been responded to. One person told us, "I've made complaints about things going missing out of my room; books and DVDs and I've asked for a lock on my door and a key. I asked [staff member] and she ignored me so I asked [staff member] and she said it was nothing to do with her."

We spoke with a number of relatives who told us they had made various complaints. We checked the complaints logs and saw that there was no record of the complaints and whether they had been responded to. Relatives told us they had received no response.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was not an effective complaints procedure in place to record and respond to people's complaints.

We viewed the care files and found there was no evidence of a person centred approach. Much of the documentation was generic and although there was a summary in the front of most people's files, this did not match the care that people were receiving. There were some reviews documented but there was no record that the person, their relative, or any other professional involved in their care, had been involved and these reviews had taken place a long time ago and were out of date.

We had concerns about all of the six care files that we looked at. Information was scant and did not provide any guidance for staff regarding how the person wished to be cared for. For example we saw that a number of people had health concerns and there were no care plans in place to tell staff how to support the people safely.

Care records were also maintained on computers and were not accessed by the care staff. Many of the care staff told us that they were not computer literate. We had concerns that people were being cared for by staff who had no access or understanding of their documented care needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people living in the home were not receiving person centred care.

We asked about how people spent their time and saw that a variety of activities were offered by the activities worker and this was as varied as possible with limited resources. We saw that a monthly newsletter was produced to show people who lived in the home what was planned for the following month. We saw that outside entertainers occasionally came into the home to provide a different activity and some people told us that they enjoyed these. We were however concerned about a number of people in the home who appeared to have very little or no stimulus and they appeared to be low in mood and socially isolated.

Inadequate

Is the service well-led?

Our findings

The manager had only recently started working at the home and was trying to support us with the inspection and provide the information that was required in a home that they were not that familiar with. They had made an application to CQC to become the registered manager but informed us that they were withdrawing their application.

There were no effective systems of monitoring or quality assurance of the care provided in the home. Most of the home's policies we viewed were not followed in the service. Many of the policies contained out of date information and they were not fit for purpose. Staff were not familiar with the policies so they did not use them. For example, the home had a clear smoking policy but this was not adhered to, putting everyone who lived in the home at risk of significant harm from a fire.

We looked at some audits that had been completed but they either did not identify any of the issues that we found in the home or did not take action in response to the issues found. For example, we looked at an infection control audit that had been completed in the home. The audit was not signed so we did not know who had completed it. The audit identified a 'fail' in infection control in March 2017 yet no action had been taken to improve the standards of cleanliness in the home.

We also looked at a quarterly health and safety audit that had been completed in March 2017. All of the answers to the questions were ticked 'yes' with no recognition of any of the glaring problems that were present in the home, which had been there for some time. These included the broken nurse call bells, the broken emergency lighting, the poor record keeping and the lack of oversight with regards to staffing levels, support and training.

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Records relating to people's care were very poor and had not been appropriately checked, updated or monitored. The care plans did not reflect the care that people required or received?.

We shared our concerns with the provider and they were not able explain why there were so many issues of concern in the home that had not been dealt with other than to say that they had plans to improve things. The future plans were not presented in any written format to demonstrate to us that the plans were serious and in progress.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

During the period of a month in which the inspection took place we raised our concerns with the provider and requested that urgent action was taken to mitigate the immediate and extreme concerns. The manager submitted an action plan that told us that emergency work had been undertaken. On 03 May 2017 we returned to the home and found that some action had been taken but we identified further concerns with the cleanliness of the home and we alerted the local authority and environmental health. We again returned to the home on 08 May 2017 and found that sufficient and timely action had not been taken and we found

continued and serious risks to people's lives, health and well-being.