Argyle Care Group Limited

Bentley Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bentley Care Home is registered to provide accommodation and support with nursing for up to 58 adults who require support with their mental and physical health. At the time of the inspection 36 people were living at the home.

The building is converted from three large Victorian houses and is divided into two units. People have their own bedroom and share bathroom and shower facilities. Each unit has sitting and dining facilities for people to share. Externally there is a small car park and gardens people can sit in.

We carried out an unannounced comprehensive inspection of the home in September and October 2015 and found breaches of legal requirements. As a result the home was rated inadequate and placed into special measures. We carried out a second unannounced comprehensive inspection of this service on 15 and 23 March 2016. At that inspection continuing breaches of legal requirements were found. This led to the home remaining in special measures. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bentley Care Home on our website at www.cqc.org.uk.

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

The service 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 of the date of the comprehensive inspection we carried out in March 2016.

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

The home had not had a manager who was registered with CQC since October 2015. 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.

Suitable systems were not in place to enable people in their bedrooms to summon help if needed. Clear care plans were not in place to support people who behaved in a way which could affect their safety or the safety of others. This left them open to potential abuse.

Some staff training had taken place however records of staff training were incomplete and inaccurate. No overall training plan was in place and we found that staff had not received the training, support and supervision needed to enable them to support people safely.

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

Improvements had been made to the safety of the environment. This included ensuring doors that should be locked remained locked and that people did not smoke within the home. Some changes had been made to the environment to address the overall appearance. However the overall appearance of the home remained shabby and the environment did not meet good practice guidance for supporting people living with dementia.

No systems were in place for formally communicating with people whose first language was not English. Action had commenced on findings representatives who could interpret for these people.
Care plans were generic and contained incomplete information about the care and support people required. Senior staff acknowledged this and said they had plans to make care plans more person centred.

A process had been recently introduced to investigate and record any concerns or complaints that people raised regarding the home.

A system for quality assurance had been introduced within the home. Although this had led to improvements to the safety of the environment, it was not yet robust enough to identify and implement improvements to the quality of the service people received. No formal system had been introduced to obtain the views of people living at the home.

The choice and quality of meals had improved and action was being taken to ensure meals met people's cultural and religious requirements.

People living at the home had been provided with a written guide to how the home operated.

Improvements had been made to the way people's medication was managed and it was now managed in a safe way.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all staff had received training in safeguarding adults.

Potential safeguarding concerns regarding individuals were not addressed within their care plans.

Action had been taken to make the environment safe.

Medication was managed safely.

Is the service effective?

Inadequate

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

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

Some changes had been made to the environment to address the overall shabby appearance. The environment did not meet good practice guidance for supporting people living with dementia.

People received meals that were of a good quality and action was being taken to ensure meals met people's cultural and religious beliefs.

Is the service caring?

Requires Improvement

No systems were in place for formally communicating with people whose first language was not English. Action had commenced on finding representatives who could communicate with these people.

Practices at the home were at times institutional.

No systems were in place for formally obtaining the views of people living at the home.

Is the service responsive?

Inadequate

Suitable systems were not in place to enable people to summon help if needed.

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

A system had been introduced to investigate and record any concerns or complaints that people raised regarding the home.

Is the service well-led?

Inadequate

The home did not have a registered manager in post.

A system for quality assurance had been introduced within the home. This had led to improvements to the safety of the environment. However it was not robust enough to identify and implement improvements to the quality of the service people received.

Bentley Care Home

Detailed findings

Background to this inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We undertook an unannounced focused inspection of Bentley Care Home on 5 July 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our March 2016 inspection had been made. The team inspected the service against five of the five questions we ask about services: is the service safe, is the service effective, is the service caring, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements and was in special measures. Two adult social care inspectors carried out this inspection.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider or their representative since our last inspection in March 2016.

During the inspection we spoke with ten of the people living at the home and spent time observing the day to day care people received. We also spoke with eight members of staff who held different roles within the home.

We toured the premises and looked at records relating to the safety of the building. We also looked at a range of records including audits, care plans, medication records and staff records.

Requires Improvement

Is the service safe?

Our findings

At our previous two inspections of the home in September 2015 and March 2016 we had found the home was not meeting regulations regarding keeping the people living there safe. We had found that staff had not had training in safeguarding adults. We also had concerns that where people who lived at the home acted in a way which was a risk to the safety of themselves and others, no written guidance was in place to show staff how to support the person and ensure everyone was safe.

At this inspection we asked for records of training in safeguarding adults and none were available. We saw a list of training on the wall which identified that nine out of 16 care staff had undertaken training in safeguarding adults. However we were unable to verify this.

We looked at the care notes for one person and saw that no plan was in place for dealing with and reporting any allegations the person made. A lack of clear guidelines for staff to follow meant that the person remained at risk of abuse occurring and it not being reported. It also meant that others may be at risk due to the lack of clear information and guidance on how to respond to potential allegations.

A care file for another person contained recent notes they had written asking for staff to contact the police. Staff told us that they had been working with other professionals to support this person and that the matter was historical. However no information on what if any action staff had taken or should take in response to these requests had been recorded. This meant that there was no evidence staff had responded to the person's request. There was no recorded evidence that the person's rights had been safeguarded.

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

At our last two inspections of the home in September 2015 and March 2016 we had concerns that the environment was not safe for the people living there. This was because we had found doors leading to potential hazards including basement areas, cleaning cupboards and electrical cupboards unlocked on several occasions. During this inspection we walked around the building and found all doors that should be locked were secure. A checklist located near each door demonstrated that staff had checked these periodically to ensure they were secured.

We had also identified concerns at the last inspection that people were smoking in the building and this posed a significant fire risk. At this inspection we saw no evidence that people had been smoking within the building. A new smoking shelter had been built in the garden and we saw that this was being used. We also saw that where needed staff were supervising people to ensure they smoked in a safe place and extinguished their cigarettes safely.

We saw a gap under a bedroom door that meant the door would not operate safely as a fire door. A representative for the provider advised us that they were aware of this, it was due to recent work in the

home and they intended to fix it quickly.

We looked at certificates and records relating to the safety of the building. Water temperatures had been checked throughout the building and the system had been recently checked for Legionella. Electrical safety testing had been completed on portable appliances and the fire alarm and emergency lighting had been regularly checked and documented. The electrical installation had been checked. The gas safety certificate had recently expired and we were informed that a copy of the new certificate would be forwarded to us. To date we have not received this.

A fire risk assessment had been completed by an outside contractor and an action plan produced from recommendations. The actions to be completed were on schedule.

This showed that the provider had taken appropriate action to meet the relevant regulations regarding ensuring that the premises were safe to use for their intended purpose and were used in a safe way.

At our previous two inspections of the home we had identified concerns with the safe management of medication. This was because medication stocks were not properly managed and medication administration was not properly recorded.

At this inspection we looked at how medication was managed including storage, recording and administration. We found that improvements had been made. The medication room was clean and tidy and we saw that a clear system was in place for ordering medication and checking stocks. We looked at a sample of records and saw that medication had been administered as prescribed. We checked a sample of stocks and found that this tallied with records. The home had completed recent audits of medication administration and storage. These had highlighted areas for improvement that we saw had been addressed.

This showed us that the provider had taken action to ensure medication was safely and properly managed.

Inadequate

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

At our inspection of the home in September 2015 we identified that no assessments had been undertaken to establish whether people would benefit from the safeguard of having a DoLS applied for. At our inspection in March 2016 we found that no assessments had been carried out to establish whether a DoLS application should be made for the person. We were told in March 2016 that three applications had been submitted and a further five had been granted. We found at that inspection that staff did not have up to date information on who had a DoLS in place and how to support people accordingly.

At this inspection we asked who had a DoLS in place and who had an outstanding DoLS application. No overall information could be located and nobody could tell us who if anybody had an outstanding application. We were told that one person had a DoLS in place. We looked at records for this person and saw that a DoLS had been applied for. We could not locate a copy of the agreed DoLS for this person. No care plan covering the DoLS was in place. This meant staff did not have guidance in place to support the person under their DoLS.

None of the care files we looked at had assessments to demonstrate that people had been assessed to establish whether they needed the protection of a DoLS. Following the inspection we spoke to the local authority who confirmed that apart from the one person already identified as having a DoLS in place no other applications had been submitted or were outstanding for people living at the home.

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

At our last two inspections of the home we identified that staff had not received appropriate support, training, and supervision to enable them to carry out the duties they were employed to perform. At this inspection we saw that staff had very recently been signed up to an on line training provider. We were told by the manager and provider's representative that this would enable staff to undertake a variety of training

and would enable the manager to monitor training staff had undertaken.

We asked to see records of staff supervisions and were told that none had taken place recently. Formal supervision provides a way for staff to discuss how they are performing in their role and any training or support needs they may have. We did see advertised a forthcoming staff meeting and spoke with a member of staff who told us they had attended a meeting approximately four weeks earlier.

We asked to see records of training and were told up to date records were not available due to internet issues. The provider's representative informed us that a training officer had been appointed to work at the home and would be monitoring staff training. A list on the office wall contained the names of staff along with a list of training. We compared this against a list of current staff working at the home and found it was not up to date. Training highlighted as undertaken by some, not all, staff included safeguarding, health and safety, mental capacity, moving and handling, dignity and fire safety. We were unable to verify if this training had taken place or the quality of the training as no records were available. We asked to see a training plan for the home and were informed that one was not yet in place.

This is a continuing breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that persons employed at the home had received appropriate support, training, and supervision to enable them to carry out the duties they were employed to perform.

We saw that some improvements had been made to the environment of the home. Work had commenced on replacing carpet in hallways with laminated flooring. We also saw that staff had begun supporting some of the people living there to personalise their bedrooms. The garden areas were free of rubbish and had been tended to providing pleasant areas for people to sit.

The overall environment remained shabby. Parts of the home felt very warm and we noted that some of the radiators were switched on. Some lounge chairs were in need of replacement, appearing uncomfortable with flat cushions and we observed that some had holes in them. As at previous inspections we found it difficult to find our way around the home easily, no pictures or signs were prominently available to help people living there find their way around or identify their bedroom or bathrooms easily.

A representative for the providers told us that they were aware of the need to upgrade the environment and intended to work their way through the home making improvements.

At our last inspection people living at the home had told us they missed having a choice of cooked breakfast daily. People who were Chinese had told us that they did not always get a meal they liked. At this inspection we saw that improvements had been made to the choice of meals provided.

People living at the home told us that they liked the meals provided. One person said the "Food has got better," another person us they "enjoy mealtimes." We observed part of the lunchtime meal in the house and the unit and saw that it looked appetising.

Meals for people on a soft diet had been piped onto the plate to make it look appealing. We spoke to the cook who told us he always served a soft diet separately when possible and showed us food moulds he had that could be used. This is important as it means people are presented with a meal that looks appetising and that they can still enjoy the different flavours.

Lunch consisted of homemade soup, sandwiches, salad, sausage rolls, quiches and fruit with corn beef hash

for people on a soft diet. Drinks were readily available and we observed staff providing the support people needed in a respectful manner.

Menus showed and the cook confirmed that Chinese meals were served every evening and that a choice of cooked breakfast was available daily. A member of staff told us that they were in the process of liaising with the meat supplier so that halal meat could be served.

Requires Improvement

Is the service caring?

Our findings

We asked people about the care they received at the home. One person told us, "They are very good to me." another person told us, "We are all cared for here." A third person said, "I'm ok, it's all right here."

At our last inspection of the home we had concerns regarding the culture in the home as we had found it institutionalised and potentially abusive. This was particularly around the way people were supported to smoke. At this inspection we saw that people who were able to manage their cigarettes safely were able to do so. Other people had their cigarettes managed by staff. After the lunchtime meal we saw staff appear with a plastic box containing packets of cigarettes. These were then handed to people who went out to the smoking shelter. Staff told us different people are supported with their smoking in different ways; some people are given an amount for the whole day, some on the hour and others when they asked.

We asked some of the people living at the home what they thought of this and they said that it was "okay." One person told us, "I have one smoke an hour, should be due one now. I wait in the shelter for it." We observed that this meant smoking in the home was much safer for everyone than previously. However we found this 'smoking round' still appeared institutional and advise that the provider works towards a more person centred approach in the future as people accept the fact that they cannot smoke indoors.

At the last inspection we identified that there were a number of people living at Bentley Care Home who were members of the local Chinese community, some of whom spoke little English. We did not see any evidence of formal attempts to communicate with people. None of the staff spoke the language people used and we did not see any formal arrangements for communication. We were also concerned about another person living in the home who did not speak English and was very isolated.

At this inspection a representative for the provider told us that they had made links with the local Chinese community and had arranged for representatives from the community to visit people. He also told us that they had made links with the local community for the person we had concerns about and they had visited. He told us that he had not made a record of these contacts within people's records. We were therefore unable to verify the information or assess whether it had had a positive impact on people's lives.

A representative of the provider had told us that information about the operating of the home had been made available to people living there via a copy of a 'service user guide' in all bedrooms. We looked for this document in nine bedrooms and found copies in three. One of the people without a copy told us that a copy had been given to them but they had hidden it. This indicated to us that a copy had been provided to people.

We asked for but were not provided with any information to demonstrate that the home consulted with the people living there about their care and the way the home operated.

Inadequate

Is the service responsive?

Our findings

We saw three people who were resting on their beds. None of these people had a call bell lead nearby. One person had a call bell lead but this was looped behind their bed, no lead was available in the other two rooms. One of the people told us they were pleased to see us as, "I want to go on my side." He had no means to summon help within his room. We informed senior staff on duty and were told by a nurse that they did not think any of these people could use a call bell. However no assessment of their ability to do so had been carried out and we did not see any alternative arrangements in place.

At our inspection of the home in March 2016 we found that information recorded in people's care plans was inadequate and did not ensure risks to the health and safety of service users had been adequately assessed and action had not been taken to mitigate known risks. At this inspection we found that information within care plans had not improved.

As at our previous inspection we found plans contained generic statements that did not apply to the person directly. For example we found a number of examples of a single plan referring to different genders throughout.

A mobilisation care plan stated, 'ensure use of correct mattress' it did not say what the correct mattress was. Another care plan stated the person had, 'high challenging behaviour' it did not state how they showed this behaviour or provide clear guidance for staff on how to support the person to manage their behaviour.

A third care plan contained no clear guidance on how to identify and support the person when they made serious allegations against others.

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

We also found examples whereby care plans for different people were word for word the same guidance and that this did not always match other information within the plan. We saw one plan for social activities that stated, 'promote auditable therapies including classical music' the plan then stated the person liked listening to Bob Marley and the Beatles. We also saw that the contents of this plan exactly matched another person's care plan; this indicated a lack of person centred care planning.

Some of the support guidelines for people placed restrictions on them. There was no evidence of mental capacity assessments or a best interest process to ensure the person had the capacity to consent to these guidelines and they were the least restrictive option available.

Recent care plan documents we looked at were not written with a person centred approach, some comments we found in the plans were inappropriate. For example one person's plan said if they got out of bed, 'return to bedroom and place in bed.' Another plan referred to the person as 'childlike'.

One recently written plan concentrated on the person's health care needs and a number of plans were in place to cover actual and potential health risks. However another part of the plan reflected that they had said they would like to visit a family member they were worried about. No evidence was in place that staff had discussed this further with them to help them achieve this goal.

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

We were informed by the manager and a representative for the provider that care plans had been written via a computer programme, due to issues with internet access they had not been able to update these but had handwritten more recent plans. Copies of the computer care plans had been printed out and were in people's care files. Both the manager and provider representative acknowledged that care plans were not adequate and stated they intended to work through them to ensure they contained person centred, accurate information.

At our last inspection in March 2016 we had concerns that complaints, including those made by people living at the home, had not been recorded and investigated. We found that improvements to the complaints system had commenced in recent weeks.

Information about how to raise a concern or complaint was displayed in the foyer of the home. This included a poster giving information on how to contact the provider or outside agencies. In addition a document tilted, 'A guide to our services' contained information on how to make complaints. Blank forms for people to complete to report a complaint were also located in the foyer.

We asked to see records of any complaints received by the home. We were shown a file that had been set up within the past couple of weeks by the newly appointed manager. This contained a record of one complaint made by a person living at the home. The records indicated that the manager had spoken with the person and taken action to investigate their concerns and respond back to them. No records of complaints between March 2016 and June 2016 had been recorded.
This showed us that the provider had begun to take action to ensure that an accessible effective system was in place for identifying and receiving complaints.

At our last inspection of the home in March 2016 people living there had raised concerns that there were very few activities taking place at the home. No activities took place during our inspection. We observed that people spent their time sitting around the lounge or their bedroom or in bed. The manager told us that no organised activities had taken place within the past two weeks that they were aware of. One of the people living there told us they used to be supported to go out but this has stopped. They said they used to go out for a pub lunch or to the cinema and they would like this to start again.

The lack of activities or therapeutic intervention for people meant that people lacked any stimulation or support with learning or maintaining lifestyle skills and in managing their mental health.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager. No registered manager had been in post at the home since October 2015, a period of nine months. During our inspection of the home in September 2015 we had significant concerns about the management and governance of the home. Following that inspection the provider employed a new manager to work at the home. Six months later at our March 2016 inspection they had not registered with CQC to be the registered manager. That manager subsequently left the home and a new manager had been in post for two weeks at the time of this inspection.

The manager told us that prior to our inspection the home had not had a reliable internet connection for the past two weeks. This had been due to bills not being paid. We were told that there had always been one working phone in the home and the ability to make outgoing calls had always been available. On the day of our inspection phone lines were working and we were informed the internet connection was due to be fixed within the next two days.

In September 2015 we found the systems and processes in place to manage the quality of the service to be inadequate. In March 2016 we again found these systems had not improved and remained inadequate.

At this inspection found that some improvements had been made. Checks had been carried out to ensure doors that should be locked to prevent access to hazards were regularly checked. The provider's representative was aware of a hazard with one fire door and action had commenced on meeting requirements in the fire risk assessment. We also saw that action had been taken to obtain Legionella tests and testing of small appliances.

Medication audits had been carried out and action taken on any areas for improvement identified.

However we found that systems for monitoring and improving the service were not yet robust enough to ensure the people living there received good quality, person centred support.
Although the new manager and provider's representative acknowledged that care plans were not of a good standard no clear plan was in place as to how this would be rectified within a reasonable timescale.

An action plan had been produced in June 2016 to address areas requiring improvement within the home. Although some of the actions on this plan, particularly relating to safety of the home, had been completed we did not consider the plan robust enough to enable some of the actions to be audited easily. For example the plan stated, 'regular audits will take place' but did not state what would be audited and by whom. The action plan also stated, 'applications for DoLS and update of DoLS will be monitored' although it stated who would do this the timescale given was 'ASAP' and it did not list how this would be done.

Systems to monitor staff support, supervising and training had not been implemented to a degree whereby meaningful information to plan future training could be obtained.

These were continuing 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.