J A Rodrigues

# Bethany House

## Inspection report

434-440 Slade Road
Erdington
Birmingham
West Midlands
B23 7LB

Tel: 01213507944

Date of inspection visit:
11 August 2021
12 August 2021

Date of publication:
10 February 2022

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Bethany House is a residential care home providing personal care and accommodation for up to 30 people. The service was supporting eight people at the time of the inspection.

People's experience of using this service and what we found
People were not supported in a safe way or protected from potential harm. Infection prevention and control (IPC) practices, medicines management and staff recruitment were not safe. Risks to people were not assessed or mitigated.
The providers systems failed to identify that care and support was not provided in a safe way. Check list audits did not identify shortfalls in IPC, medication services, staff recruitment or assessment and mitigation of risk.

The provider took immediate action to protect people from harm, when information of concern was shared with them.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 31 March 2021) and there were breaches of regulation. At this inspection enough improvement had not been made or sustained, and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at IPC measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches at this inspection in relation to, safe care and treatment, staffing and recruitment, staff training and skills, dignity and respect, and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can read the report from our last focused inspection, by selecting the 'all reports' link for Bethany House on our website at www.cqc.org.uk.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not caring.<br>Details are in our caring findings below. | **Inadequate** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-Led findings below. | **Inadequate** |

# Bethany House

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention (IPC) measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection site visit was carried out by an inspector and an assistant inspector.

Service and service type
Bethany House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider was also registered with the Care Quality Commission as the registered manager. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 11 August 2021 and ended on 26 August 2021. We visited the service on 11 and 12 August 2021.

What we did before the inspection
We reviewed information we had received about the service, since the last inspection. We sought feedback from the local authority who work with the service. The provider was not asked to complete a provider

information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with four people who used the service and six people's main carers, about their experience of the care provided. We spoke with eleven members of staff including the provider, the manager, the deputy manager, senior care workers, care workers, maintenance staff and office workers.

We reviewed a range of documents and records including the care records of four people and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service including policies and procedures.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Preventing and controlling infection; Assessing risk, Safety monitoring and management; Using medicines safely; Learning lessons when things go wrong.

At our last inspection we found people were at risk of preventable harm. The provider and staff demonstrated poor and inconsistent use of personal protective equipment (PPE). The provider failed to robustly assess the risks relating to the health safety and welfare of people. Medicines were not safely administered. Where things had gone wrong the provider did not analyse information or take preventative action. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements have not been made and the provider was still in breach of Regulation 12.

● The provider did not have effective systems, policies or procedures to safeguard people from the risk of abuse.
● People, staff and visitors were not effectively prevented from catching and spreading infections.
PPE was not used in a safe and effective manner. The provider and staff were seen repeatedly pulling masks under their noses. Inspectors brought this to the attention of the provider and staff and then noted further repeated instances. This demonstrated a culture of noncompliance in IPC.
● Staff did not follow the providers COVID-19 visiting arrangements. One visitor was not asked to wait the recommended time period before entering the home, following their COVID-19 test. This visitor was not offered a mask or asked to wear one and did not wear a mask for the duration of their visit. Other visitors were escorted to the exit through the dining room, near people eating their lunch. One relative said, "I haven't been told about changes to visiting. I haven't had an update on restrictions". This meant people were placed at unnecessary risk of harm from infections.
● People did not have personalised COVID-19 risk assessments in place. This meant people's risk of contracting COVID-19 may not be effectively managed or mitigated.
● Skin conditions were not safely treated or managed. Risk assessments for skin conditions were not in place. Body maps were not reviewed. The deputy manager stated, "It would be discussed between staff, I know it is not documented but the district nurse would be called". This meant people were at unnecessary risk of harm from skin conditions.
●Topical creams were not always safely stored or used. Topical creams had been purchased by the provider and stored in the first aid box. These topical creams did not have an opening or use by date, were not recorded on any Medication Administration Record (MAR) and were for multiple people's use. This placed people at risk of harm from cross contamination.

● One person developed red skin. The provider purchased topical cream which staff applied. The skin condition was not risk assessed, clinical advice was not sought, and body maps were not in place. The failure to obtain a diagnosis and prescribed cream, placed the person at unnecessary risk of harm.
● The medication room was not safely secured. Inspectors found the door open, the medication fridge was not locked, and a medication cupboard was open. The senior care worker on duty told inspectors, "The keys are in a cupboard by the door at night and the senior carer has them in the day". This meant that medications were not securely stored.
●There were no clear instructions recorded for as required (PRN) medication. Medication records did not record why PRN had been administered or the outcome of the administration. The deputy manager said, "We do not do this, we will start to do it". This meant that the effectiveness of the medication could not be reviewed.
● The medication policy did not include homely remedies. The provider was purchasing homely remedies for people to use. The GP had not been consulted about suitable homely remedies for people taking prescribed medication. This meant that people were at unnecessary risk of harm, from the potential for medication contraindications.
● Lessons had not been learned regarding IPC and administration of medication. Issues identified at this inspection were also identified at the last inspection.

Systems were either not in place or robust enough to demonstrate safe care and treatment. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment processes were not in place. The provider did not ensure people employed were of good character, safe to work with vulnerable people and had the necessary competence and skills to undertake their role. This placed people at risk of harm.
●The provider failed to obtain a current or up to date Disclosure and Barring Service (DBS) certificate for all staff. Where DBS information was available, the provider consistently failed to carry out a risk assessment of the information identified on DBS records, placing people at extreme risk of harm.
● Recruitment files were not in place for all staff and recruitment records that were available were incomplete. Not all staff had completed application forms prior to employment and applicant interview notes were not kept.

The provider took action to mitigate immediate risk, when asked to do so by inspectors.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last fully comprehensive inspection, this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● The provider had introduced a Malnutrition Universal Screening Tool (MUST), and the Waterlow tool, which is a tool to identify the risk of pressure ulcers developing. Staff had not received training in the use of these tools. MUST and Waterlow charts were not fully completed, or outcomes acted upon. Staff told inspectors, "I don't know what MUST and Waterlow is" and "if I'm honest I don't have a great understanding of this [MUST and Waterlow]". This meant people were at risk of potential malnutrition and skin conditions not being identified, acted upon or preventative measures taken.

Staff were not sufficiently trained and supported to have the necessary skills to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Staff received refresher training in a range of subjects throughout March, June and July 2021. Training was delivered by a mix of in-house DVD's and external providers. Measures were not in place to ensure learning was put into practice for example, no competency checks were completed. This meant the provider could not be assured of the effectiveness of training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to admission. Information was not always detailed or personalised. Where people's needs had changed, records were not always updated. This meant staff may not be aware of people's current needs and choices in how their care is delivered.

Supporting people to eat and drink enough to maintain a balanced diet

● People ate Halal food. Guidance on the process for storing, preparing, cooking and serving Halal foods was not available for staff reference. The deputy manager explained the process and stated guidance would be made available.

● People we saw eating did not require adaptations. However, all care plans detailed suggested adaptations, even though these were not appropriate to most people. This meant that care plans were not personalised to people's individual needs with regards to eating and drinking.

● People were supported, by staff, with eating and drinking. One person said, "The food is alright I have what I want." Relatives said, "it's ok, they [their relative] sometimes complain, the meat can be tough", and "meals wise, we are happy with the meals."

A staff member said, "There is a daily set menu, but if they [people] are not happy with the offer for that day

they [people] can have a different meal or sandwich".

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care;
● The provider did not always enable timely healthcare services. An occupational therapy assessment, originally requested in July 2020, was not followed up until July 2021. This affected the persons mobility, independence and socialisation. This person said, "I do as I'm told I am not bothered."

Adapting service, design, decoration to meet people's needs
● Access between the garden and the dining room was not wheelchair friendly. We noted the care worker lifted the wheelchair over the bottom of the door frame. This may place people at risk of harm from an unsteady transfer.
● Environmental and health and safety checks were completed. Where repairs or improvements were needed, these were recorded in the maintenance book. A member of the maintenance team said, "I take care of the place, maintenance, washing carpets, replacing light bulbs, checking boilers, I walk round every day to check what needs to be done and do the planned daily things". Relatives told us, "The home is not bright and cheerful" and "I feel it [Bethany House] is outdated, gives me a feeling of sadness, it needs to be more uplifting when I go there, if the decoration was lighter in colour it would fill me with more confidence".

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA
● Mental capacity assessments had been completed. Some best interest decisions were in place. One person was assessed as having full capacity. On the same day as this assessment, a best interest meeting took place regarding the person's medication. This indicates further training may be required to ensure staff fully understand the MCA. The manager told us, "I carry out the mental capacity assessments. If people lacked capacity, I would make a referral, currently there are no DoLS in place."

Inadequate

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last comprehensive inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

● Dignity and respect were not always afforded to people when they were sleeping.
In a shared room, the privacy curtain had been removed for cleaning, leaving people without privacy for two nights.

● People living at the home were washed and dressed by 0730. People were then left to sleep in communal areas, without privacy. One person stated they were tired and had a restless night. The person was asked if they could have stayed in bed. This person said, "no I had to get up". The person was asked if they could have stayed in bed if they wanted to. The person said, "I hadn't thought about it." Staff members told us they wake people and get them up early. Staff members said, "all eight residents up and washed, we usually get two up at 0630 and six by 0730, this morning one was up already" and "yes we wake them up, we have been told to do this by the senior on the morning shift".

● There was an unconscious staff culture, where people's equality and diversity not always being respected. One staff member described a person by their ethnicity and sex rather than their name. Other disrespectful terms were also used to describe people. These descriptors did not support people's equality, diversity, dignity and respect.

This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

●Individual staff were caring however we found that the providers processes did not always support staff in their caring role. For example, there was not always enough information to ensure personalised care and support and staff were not recruited safely, to protect people from unnecessary risk of harm.

● People and relatives had mixed views about the service and staff. One person said, "Good, no problems at all". Relatives had mixed views, they said, "There have been occasions where [name of relative] personal care was not good and needed to be tidied up" and "I have never known [name of relative] to be so happy."

Supporting people to express their views and be involved in making decisions about their care

● People were not always supported to make day to day decisions about their care and support. Records showed that care was delivered in a set routine rather than in a way people chose. One care plan set out which room a person would be in at specific times each day. People were all supported to get up at the same time each day. Relatives told us, "[name of relative] has food downstairs but would rather have it upstairs but has been told no by staff" and "[name of relative] wanted to stay up late but felt obliged to go to

bed".

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last comprehensive inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were last updated five months ago. They were not detailed or personalised and did not identify people's choices in how the service should be delivered. The manager said "[The provider] stopped the care plan audits taking place, as care plans needed to be changed."
- Information about how medical conditions may impact on care delivery and safety, was not available. One person's care plan stated, "On occasion becomes agitated, but can become calmer with reassurance and attention". The care plan did not set out the triggers causing agitation, or what staff could say to offer reassurance. A staff member said, "I remove myself from a situation related to behaviours that challenge and come back when the person is calm". This meant people's needs may not be safely met.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers'.

- People's preferred communication needs were not captured as part of the care planning process. Preferred methods of communication were not agreed with relatives of people using the service. This meant people may not be supported to communicate in a way that suits them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not engaged in meaningful activity or stimulated during the day. People got up early and spent a lot of time sitting in front of the TV and sleeping.
- Personalised activity plans were not in place. Every person's care plan contained a generic statement about social needs, activities and mental stimulation. One person said, "Enjoy the bingo sometimes, I'm mobile so go out for walks in the garden, it's a bit uneven." Relatives said, "Not a great deal of activity" and "[name of person] would take part in activities but nine times out of 10 wants to watch TV." This meant activities did not take account of people's choices, past hobbies, life experiences or current needs.
- Relatives expressed concerns about keeping in touch with people during the pandemic. A relative said, "Communication with family is quite poor, would be nice to have updates during periods when we can't visit, not been told about changes to visiting, or updates to restrictions" and "I rang up periodically, sometimes I spoke to [name of relative], sometimes it was not convenient for me to speak to them, either it was lunchtime or they [staff] were busy. The home hasn't let me know about changes to visiting rules".

Improving care quality in response to complaints or concerns

● The provider had a complaints policy but there was not a complaints record in place. The provider stated there had not been any complaints. The provider did not have oversight of people's or relatives concerns regarding the service.

End of life care and support

● End of life care and support was not required during this inspection. Care plans did not include personalised information of how people may prefer to be cared for and what would be important to them in their end of life journey.

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection we found the provider did not have a clear system of delegation, or effective leadership. The provider did not have oversight or regulatory compliance. The provider did not create a positive culture. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements have not been made and the provider is still in breach of Regulation 17.

- The provider was also the registered manager. The provider did not have an effective system of delegation. Two senior care workers shared the role of deputy manager and their individual roles had not been defined. Deputy managers, senior care workers and staff all performed check list audits. The provider did not have a system to check the quality and effectiveness of check list audits, which did not feed into a quality assurance overview. The provider did not have a quality assurance action plan.
- The provider had not demonstrated effective leadership and direction to staff. The provider failed, and allowed staff to fail, to follow Public Health England's (PHE) guidance on the effective use of PPE. People were therefore exposed to potential risk of harm.
- The provider did not have oversight of medication administration. Robust audits were not in place to monitor the medicines systems. Staff were checking their own work. Medication administration records, medication check list audits and second tier check list audits were completed by the same member of staff. Check list audits were brief and did not identify the issues found at this inspection. The provider did not sample or check the quality and effectiveness of medication check list audits. The audit was not effective, and people were therefore placed at potential risk of harm.
- The provider did not have oversight of audits to monitor health related conditions. The provider's check list audits did not identify that skin conditions were not always risk assessed, referred to a health care professional, or consistently recorded. This left people at risk of harm.
- The provider did not have oversight of kitchen management. There were no systems in place to monitor and improve health, safety and hygiene issues identified by the environmental health inspector. Therefore, people were not protected from foodborne illness.
- The provider did not have oversight of the recruitment process. Systems or processes were not in place to ensure fit and proper persons were employed. Systems were not in place, and therefore the provider did not

identify the repeated failure to manage the DBS process and act on DBS information, in the best interests of people using the service. People were therefore placed at risk of harm.
● The provider did not have oversight of staff practices. Processes were not in place to check night staff practices. This meant the provider was not aware staff were waking people up early in the morning to get them washed and dressed before the day staff came on duty. This meant people did not have choices in when their care and support was delivered.

Systems were either not in place or robust enough to ensure compliance with regulations. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The providers systems and processes failed to identify the issues found at this inspection. The provider did not have oversight of the service and this meant the provider did not have oversight of incidents which could trigger a duty of candour response.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider engaged with people using the service and some of their relatives. One person we spoke to had mixed views about the home and said, "I am happy, occasional disagreement, but ok."
● Records did not indicate people were engaged and involved with the service. Relatives expressed mixed views about being involved with the service. One relative told us, "They called me to say [provider] was holding a meeting following the last inspection and we could ask questions, the meeting was cancelled and never re booked but I had some questions to ask". Another relative told us, "I know things need to be worked on, but things can be rectified. I asked about something recently and was assured [provider] was dealing with it".
● A copy of the last inspection report was displayed on the notice board; however, the ratings were not prominently displayed. Due to the pandemic relatives did not have the opportunity to see the report and the provider did not share the findings from the report with relatives of people using the service. One relative told us, "I did not know they had been rated inadequate".

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 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider did not ensure people employed were of good character, safe to work with vulnerable people and had the necessary competence and skills to undertake their role. |

**The enforcement action we took:**

We imposed urgent conditions on the providers registration.