Cooper Residential Homes Limited

Bethel/Bethesda Residential Home

Inspection report

Equity Road East
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Tel: 01455847505

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 15 August 2018 and was unannounced.

This was the fourth comprehensive inspection carried out at Bethel/Bethesda Residential Home. At the last inspection in August 2017 the service was rated as requires improvement. At this inspection we found there were areas that still required improvement.

Bethel/Bethesda Residential Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 34 people in one adapted building. On the day of our visit, there were 25 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality of the service to maintain the health, safety and welfare of service users. The provider had not ensured that people were always protected from health and safety risks associated with accessing areas such as the kitchen and laundry; or ensured there were adequate systems in place to make repairs to the home or the hot water system.

People could not be assured there were enough staff to meet their needs. Staff did not receive all the support they required to carry out their roles.

People could not be confident their complaints would be responded to appropriately.

The provider did not ensure that people could access all areas of the home as two communal areas were used for storage.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted. People had developed positive relationships with staff. Staff had a good understanding of people's needs and preferences.

People received care from staff that had received training to meet their needs. Safe recruitment processes were in place.

Staff understood their roles and responsibilities to safeguard people from the risk of harm. Risk assessments

were in place and were reviewed regularly; people received their care as planned to mitigate their assessed risks.

People were supported to have enough to eat and drink to maintain their health and well-being.

People were supported to be involved in their care planning and reviews. Their care and support was delivered in the way that people chose and preferred.

People were supported to access relevant health and social care professionals. There were systems in place to manage medicines in a safe way.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA). Staff gained people's consent before providing personal care. People were involved in the planning of their care which was person centred and updated regularly.

At this inspection we found that Bethel/Bethesda Residential Home were in breach of four regulations relating to staffing, safe care and treatment, receiving and acting on complaints and governance of the home.

This is the third consecutive time the service has been rated Requires Improvement. The actions we have taken are reported at the end of the full report.

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

Services in special measures will be kept under review 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.

Further information is in the detailed findings below.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bethel/Bethesda Residential Home on our website at www.cqc.org.uk

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.

People were not always protected from the risks associated with health and safety.

There were not enough staff deployed to meet people's needs or always provide people's medicines in a timely way.

People received care from staff that knew how to safeguard people from abuse.

People's risks assessments were reviewed regularly and as their needs changed.

The provider followed safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always met by the adaptation design and decoration of the premises.

Staff received the training to meet peoples' needs, however, they did not receive all the necessary support they required to carry out their roles.

People's care was delivered in line with current legislation, standards and evidence based guidance.

People were supported to eat and drink enough to maintain a balanced diet.

People's consent was sought before staff provided care.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not ensure there were enough staff or facilities.

People were treated with kindness and respect by staff.

People were supported to be involved in planning their care.

People's privacy and dignity were maintained and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not identify and respond to peoples' verbal complaints.

People received care that met their needs.

People received care that met their needs at their end of life.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have suitable systems in place to monitor, assess and make improvements to the health, safety, welfare and quality of care of people using the service.

There was a registered manager who understood their roles and responsibilities.

Bethel/Bethesda Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 15 August 2018 by one inspector, an assistant inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had previous knowledge and experience in care home services.

This was the fourth comprehensive inspection; the last two inspections were rated as requires improvement in August 2016 and July 2017.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with 12 people using the service and five visiting relatives and friends. We spent time observing people's care and how staff interacted with them. We also spoke with seven members of staff including the provider, registered manager, two senior staff, two care staff and the activities co-ordinator.

We looked at the care records for six people who used the service including daily records and medicines records. We also examined other records relating to the management and running of the service. These included four staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, complaints, incidents and accident reports and quality monitoring audits.

After our visit we asked the provider for more information relating to the management of the environment such as hot water, heating, access to kitchens and laundry and windows. We also asked for maintenance records and safety checks for records for wheelchairs, hoists, water, gas supplies, movement sensors and fire safety. We asked for information regarding staffing levels, staff recruitment and the working patterns of the registered manager. We also required information about the contingency plans for the service and the processes in place to pay sundry bills. We asked for this information to provided by 3 October 2018. We received the information on 3 October 2018. This took this information into account when we made judgements in this report.

Inadequate

Is the service safe?

Our findings

During our last inspection on 4 July 2017 we identified areas that required improvement in the deployment of staff and monitoring the safety of the environment. During this inspection the provider had not improved in these areas.

During this inspection, the provider did not always protect people from the risks associated with very hot water, equipment or substances that may be hazardous to health. People living with dementia, or people who were experiencing confusion from ill health had access to areas such as the kitchens and the laundry. Staff left these doors unlocked and open when they were not in use. The hot water supply to these areas can be over 40 degrees centigrade and are likely to scald an older person if used by them. In addition to the iron, washing machine and tumble dryers in the laundry and hot appliances in the kitchen, people had access to washing liquids and other substances that could be hazardous to health. People were also at risk of infection from accessing dirty clothing and bedding in the laundry. We brought this to the attention of the registered manager who arranged for systems to be put in place to ensure staff kept doors leading to the kitchen and laundry areas locked when not in use.

There was no reliable system in place to assess, monitor and evaluate the maintenance of equipment within the home. The provider took responsibility for all maintenance checks and employed contractors on an ad-hoc basis when work was required. The lack of reliable systems meant that essential checks on gas supplies, wheelchairs and hoists were not always completed. For example, the gas safety service was due in May 2018, this had not been carried out. We brought this to the attention of the provider who said they had not sourced a new gas provider yet.

There was no maintenance plan for the hot water and central heating. People did not always have access to running hot water to bathe. In the spring of 2018 the Bethesda side of the home did not have hot water or central heating. One person told us, "I can't have baths anymore, [staff] help me with good washes and blanket baths. This was hard when there was a problem and we had no hot water. They had to use jugs. I think it was for about a month but it's okay now.'' Staff told us, "At the time the provider bought some heaters, but not enough for one each. [The provider] asked families to bring in heaters to keep people warm, it was very embarrassing; we had to use them even though they had not been tested [for electrical safety]. There were no letters to the families to inform them of what was happening. We used hot water from the urn in the kitchen, but now that is broken we use kettles."

The home had installed a new boiler system for the Bethesda area of the home, however, people living in Bethel area of the home still did not have a reliable source of hot water. On the day of the inspection one person told us, "There's no hot water in my room again." A member of staff told us this person liked to have a shower, but they had to use kettles of hot water from the kitchen to fill their sink for them to bathe. They told us the hot water supply was intermittent, "I've reported it to [the provider] but nothing gets done. It's difficult for people [in Bethel] to have baths, showers and for cleaning." The provider told us a plumber had assessed the hot water system in the last few days and had adjusted some of the supply, however, the intermittent hot water supply had been on-going for months and had not been resolved.

The provider had not provided the resources for adequate safety checks to be carried out. For example, there were no regular checks of the water temperatures in people's showers and the running of water from areas not frequently used. These checks are necessary to ensure people are not exposed to very hot water or exposed to pathogens that can cause disease that could be present in water sitting in pipes, such as Legionella bacteria. The last water inspection had been carried out in July 2017 where the results had been clear of any pathogens.

The provider had not made suitable adjustments to the windows to ensure the safety of people living with dementia. Some people's windows did not have restrictors on to prevent people entering through the windows, or in the case of confusion, use the windows as an exit. One person living with dementia had used their window as an exit. In other areas of the home the provider had installed new windows, which were kept locked, not allowing people to open their windows to air their rooms.
The provider had supplied movement sensors to monitor people's movements in their bedrooms and in the lounges, where people were at high risk of falls. However, the technology they used was not effective in raising the alarm as there was a delay of 60 seconds. Staff told us, "The alarms do not work properly, they are set off for no reason or they don't go off when you enter the room. When they do go off, you can't tell which one is alarming." We met one person in their room who had a sensor in place, however, the sensor did not alert staff that there was movement in the room. People remained at risk of falls as there was no reliable system to alert staff when people at risks of falls mobilised. We brought this to the attention of the registered manager who told us they would check that all the equipment was working.

Although the provider carried out regular fire safety checks and updated staff regularly on the fire procedures, there was a lack of fire exit signs. We brought this to the attention of the provider who said they would attend to this. It is a concern that the provider had not identified the lack of fire exit signage during the regular fire checks. Some of the areas of the home were very cluttered with old equipment stored in vacant bedrooms and communal rooms, which could no longer be used by residents. The last comprehensive fire risk assessment was carried out in 2014. We contacted the local fire safety officer to ask them to assist the provider with current guidance.

The provider did not have a system in place to identify areas that required repair. The service had a three-star food hygiene rating from the local authority in June 2017. Three is a rating which shows the hygiene standards are generally satisfactory by the Food Standards Agency (FSA). Staff told us, "It's a shame we only got three stars, as the environment let us down. The provider doesn't carry out regular repairs or invest in the upkeep of the kitchens." One of the fridge seals had been recently repaired but the door still had not been repaired; staff told us they had to "make do" with a piece of metal to keep the door closed. The temperature in the fridge was 17 degrees Celsius. The food safety regulations state fridges should be kept at below 5 degrees Celsius to keep food chilled safely. The provider had failed to take the necessary action to ensure the fridge temperatures were maintained to keep food was stored safely. The provider failed to make the required repairs or upgrade the kitchens since their food safety inspection in June 2017.

People were not always protected from the risks of infection as the provider did not always provide the personal protective equipment such as gloves and aprons. Staff told us, "Every three weeks we run out of gloves and paper towels because [the provider] hasn't paid the supplier." All suppliers were paid by cheque; this caused a delay in receiving goods. Although there were infection control procedures, staff could only follow these when they had all the equipment and hot water. There were procedures in place for cleaning schedules however, these were not monitored for effectiveness, relatives pointed out that some of the areas were quite dusty and had cobwebs. One relative told us, "I wish they would wipe down the crash mats. I do think the cleaning has gone down a bit.'' The provider did not have reliable systems in place to mitigate the risks of infection.

People no longer had access to two communal areas due to the provider using these rooms as storage for old equipment and an office. In the room used as storage, the light fitting was broken, and a computer which had a keyboard suitable for people with poor eyesight was not set up for people to use. The provider also used vacant bedrooms and the main office for storage which meant these areas were no longer used for the purpose they were intended. The amount of equipment in these rooms prevented access to the water supplies for regular testing and the number of items stored throughout the home posed a fire risk. One member of staff told us, "I keep telling [provider] to clear the junk, it's like a dumping ground. It would be nice for people to have the choice where they spent their time." We observed the useable living space for people had diminished due to the amount of equipment being stored.

People are at risk of harm as the provider failed to identify or act to mitigate risks relating to health and safety measures. This constitutes a breach of regulation 12 (2a and b) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Safe care and treatment.

People could not be assured that there were always enough staff to meet their needs. One person who was at high risk of falls told us, "I don't always call [staff] if I feel okay. Staff are always rushing around they're sometimes rushed of their feet. I feel sorry for them rushing about so much.'' A relative told us, "I'm not sure if now there are enough staff. Once when two staff where here to hoist [name] out of bed, one of them had to go and respond to a call bell.'' One member of staff told us, "We are all overworked, we should have six staff on days, there are only four or five. All we can do now is just toileting and feeding, it's not very caring. I've asked [the provider] for more staff, but there is no change. [The provider] doesn't realise the new service users have dementia and require a lot more support, there is a big impact on residents and staff." Records showed that there had been a medicines error in July 2018; staff had recorded that they had been required to provide personal care during the medicines round, which contributed to their mistake. One member of staff told us at times they were the only person in the home that could administer medicines, which meant people's medicines were delayed.

The provider told us that they would normally have six members of staff on duty in the day when the home was full (34 residents). Although there only 25 residents at time of inspection, the provider had admitted people to the home who had higher dependency needs. One member of staff told us they were always rushing because "We are filling up with people with higher needs." We brought this to the attention of the provider who told us they had not realised the home required more staff; they did not have a system in place to measure the dependency and allocate staff accordingly. The provider had not ensured there were enough staff to meet all people's needs as they had not considered people's dependency.

There was not enough staff to monitor people who were at high risk of falls in communal areas. Staff were not allocated to supervise people in the communal areas, instead the provider had installed movement sensors to alert staff when people started to mobilise, however, these sensors were unreliable.

The duty rota showed that at times there were only four members of staff. Some staff worked extra shifts including one person who regularly worked both day and night shifts concurrently. We brought this to the attention of the provider who said this member of staff chose to work these shifts and had signed to say they agreed to work over 40 hours a week. There is a concern that this member of staff would not get enough rest and recuperation between each shift to ensure they could provide safe care. The provider had relied on the goodwill of staff to work extra shifts and had not identified they required more staff; they did not have any vacancies advertised. The provider had not advertised the vacant post of deputy manager and had not employed a person responsible for the on-going maintenance and repair of the home.

There were not enough staff to meet people's needs. This constitutes a breach of regulation 18 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Staffing.

People were protected by staff who understood their responsibilities to safeguard them from potential abuse. Staff demonstrated they knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. Staff told us they would report any concerns to the registered manager. One member of staff told us, "I would pass any concerns on to [manager]." The provider had raised safeguarding alerts with the local authority. There were systems and policies in place to investigate any concerns if required to do so by the local safeguarding authority.

People's risks were assessed and reviewed regularly, for example for their risk of falls. Risk assessments reflected people's current needs and people's care plans provided staff with clear instructions on how to reduce the known risks. For example, one person had been assessed as at high risk of acquiring a pressure ulcer. Their care plan gave clear instructions to staff on how to provide their care to prevent pressure ulcers, such as ensuring their skin was kept clean and dry, and assistance to help the person to move to relieve their pressure areas. Staff documented the care they provided which demonstrated they carried out their care as planned.

The registered manager followed the provider's recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

There were appropriate arrangements in place for the management of medicines, however, there were not always sufficient staff on duty with the skills and knowledge to administer medicines in a timely way. One member of staff told us, "At times I'm the only senior on duty, I have to give everyone their medicines, it takes a long time." Staff had received training and demonstrated they had a good knowledge and understanding of the medicines policy and how medicines should be administered and recorded. We observed that people received their medicines as prescribed and staff recorded accurately when they had administered people's medicines. People had regular reviews of their medicines by the GP.

The registered manager monitored and analysed incidents and accidents in the home, including the prevalence of falls. They shared the information with staff at handovers where they discussed possible solutions and learning from these incidents. The provider had implemented changes to access to the home to improve the safety and security. The provider told us, "We have improved the security, as there is now only one door for entry and the use of a visitors' book. We know who is coming and going now." However, the provider had not managed significant issues with water, supplies and staffing as these remained unresolved.

Requires Improvement

Is the service effective?

Our findings

People needs were not always met by the adaptation, design and decoration of the premises. During our previous inspection in July 2017, the provider had not always made suitable adjustments to the environment such as signage of rooms to indicate what each one was. This was important so people can orientate themselves around the home. During this inspection we found that doors remained unlabelled, making it difficult for people living with dementia to find their way around the home and to their own rooms.

The provider could not provide sufficient information to demonstrate that staff received regular updates in all areas, in particular the safeguarding vulnerable adults and fire safety. One member of staff told us, "None of us have had MCA training or DoLS training, we are still waiting for safeguarding training." The provider showed us that 13 of the 29 care staff had received MCA and DoLS training. All staff required training in manual handling to meet people's needs, however, the providers records showed 8 of the 29 care staff had not completed their manual handling training.

Although the provider held regular sessions which included scenarios in areas such as fire safety, these did not cover all areas required by the fire safety regulations. We contacted the local fire safety officer, who provided the service with the latest guidelines and information on how to access fire safety training.

Although supervision of staff was planned for every three months, there was no embedded system to ensure all staff received regular supervision. Staff told us they had not received supervision for over six months. Not all staff had their yearly appraisals; one member of staff had not had an appraisal for four years. Staff told us they did not feel supported; although the registered manager would listen to their concerns about issues such as staffing, supplies and the environment, they [registered manager] did not manage these areas and relied on the provider to act on these. The provider failed to have a suitable staff support and supervision in place.

The provider did not ensure staff received appropriate training, support or supervision to enable staff to carry out their roles. This constitutes a breach of regulation 18 (2a) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Staffing.

All new staff received initial training which gave staff the basic skills needed in their roles. The provider had supported staff to study towards vocational qualifications. Care and domestic staff had received training in infection prevention.

During our previous inspection in July 2017 we found that people were not happy with the quality of the food. During this inspection the quality of the food had improved. People told us, "The food is very good, especially the pastry" and "We enjoy the food. If you don't want the choices available they'll get you something else.''

People were supported to eat and drink enough to maintain their health and well-being. People received a

balanced diet. Where people had been assessed as at risk of losing weight, they were referred to health professionals such as their GP and dietitian for further assessment and advice. Staff followed the health professionals' advice. One person told us they only ate a little at a time due to a medical condition. They said, "I do love a glass of milk several times a day.'' We observed that staff provided milk regularly. Staff recorded how much people drank; those who were at risk of dehydration had daily targets which staff encouraged people to reach. Information about people's food allergies, diets or requirements were made available to staff who also knew people's likes and dislikes. Some people needed to avoid certain foods due to their prescribed medicines; staff ensured people were not given these foods.

The provider had systems in place to assess people to identify the support they required before moving into Bethel/Bethesda Residential Home. Staff had used the pre-assessments to create a plan of care which was updated as they got to know people or as their needs changed. People's risk assessments were based on best practice and evidence based care. For example, moving and handling risk assessments.

People had access to healthcare services and received on-going healthcare support. People told us they had regular health checks, one person told us, "The chiropodist comes regularly. An optician came a week or two ago." One relative told us, "I think the care is amazing. They're on the ball. They picked up a problem and got the doctor in as [name] had shingles.'' People were helped to attend health screening and specialist appointments. Records showed that staff sought prompt medical attention when required. For example, one person had a fall, they were on medicines that increased their chances of bleeding, staff had called the emergency services appropriately for an assessment.

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 MCA. The authorisation 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 on authorisation to deprive a person of their liberty were being met. The registered manager had made appropriate applications for DoLS authorisation.

The registered manager and staff understood their roles in assessing people's capacity to make decisions and people told us they were always asked about consent to care and treatment. People looked happy and contented in the company of staff and we saw staff took care to ask permission before assisting people. One relative told us, "[Name] gets to make decisions." Staff told us, "[Name] still has the capacity to make choices about their care, [Name] tells us how they prefer to [receive care]."

Requires Improvement

Is the service caring?

Our findings

We were told and we observed that staff were very caring and compassionate towards people's needs and wishes. People were happy with the care and support they received. People told us, "I am very satisfied. Staff couldn't be more friendly." and "I am well looked after." One relative told us, "The staff are very caring. I hear things like 'hello sweetheart.' They are gentle and I think they know [my relative]." People were treated with kindness and compassion. People had developed good relationships with staff. One person said, "Staff are fine, one is spot on we have a routine. We're like good friends." Another person said, "The male carer [staff] is good and I'm fond of [name of staff]. Some of the old staff still come and visit me.'' One member of staff told us, "I love the residents, the place is homely and welcoming."

However the systems in place to ensure there were enough staff deployed to meet the needs of people, the lack of access to hot water to bathe and lack of prevention of the spread of infection had an impact on people's dignity. People were living in a service where they could not access communal areas due to them people used as storage and people's concerns and feedback were not responded to.

Staff told us that the lack of enough staff meant they could not provide the care they wanted to. One member of staff told us "We are not able to give people the compassion they need because we are always rushing." People acknowledged the impact the staffing had on them; one person told us, "Some staff, well, we laugh together. Some staff don't have the time. I just wish they had a bit more time to talk. I love it when one or two of them bring in photos of their holidays.'' People told us they were very happy at the home. However, people acknowledged that staff were very busy, people told us, "I'm happy but sometimes the staff are very pushed."

People were given emotional support when needed. One person told us, "Staff are lovely. I feel that despite the age gap we're friends. Two of them [staff] I call them my sisters.'' Another person told us, "Staff are lovely people anything you ask for they'll do." Their relative told us, "With [my relative] and around the home, there are plenty of hugs and of course some nice banter.''

People were treated with respect. One relative told us, "[Name] is interested in fashion and looking nice, they [staff] look after her clothes." One member of staff told us, "People always choose what they wear, and what time they want to get up or go to bed. Some people prefer their meals in their own rooms." We saw staff talk with people with respect and respond to their requests. One person said, "Sometimes I may go to the dining room but rarely. I do go to the lounge for a singer I like. He's coming to sing for me and my family on my birthday."

People chose where they spent their time. For example, one person told us they spent most of their time in their room by choice. A relative told us, "[Name] enjoys the food and [Name] decides if they want to eat in the Dining Room."

Staff told us they were proud to work at the home, they told us they felt they contributed to the well-being of people; one member of staff told us they saw residents as their 'extended family'. Another member of staff

said, "I am proud of what we can achieve; [name] was in bed most of the time when they first came here, now they can get around and join in with the others." One relative told us, "The care is brilliant."

People were supported to maintain relationships with those who were important to them. Relatives and visitors were encouraged to visit the service and there were no restrictions on visiting. One person told us, "My visitors are made to feel welcome, they get a cup of tea."

The provider had policies and procedures that were inclusive. People from all cultural and social backgrounds were welcome to the home. The provider told us, "We have no religious criteria, we are open to anybody. We are a diverse home; our staff reflect that." People's religious needs were respected; two people had regular visits from their priests who gave mass in people's own rooms. People were supported to commemorate important celebrations and ceremonies that were important to them.

People's privacy and dignity were maintained. People were supported to make decisions and express their views about their care. They could have access to an advocate if they felt they needed support to make decisions, or if they were being discriminated against under the Equality Act, when making care and support choices. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people said how they felt about the caring approach of the service. People commented about their care and the support they received through regular residents and relatives' meetings. One person told us, "At a residents' meeting I said some of the meals were not nice but since then the meals have been great."

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance and staff were provided with training about the importance of confidentiality. Information about people was shared on a need to know basis. For example, one person's family used a password that to prove who they were on the telephone so that they could enquire about the welfare of their relative. We saw that people's files were kept secure in filing cabinets and computers were password protected to ensure that information about people complied with the Data Protection Act. Handovers of information took place in private and staff spoke about people in a respectful manner.

Requires Improvement

Is the service responsive?

Our findings

People told us they knew how to make a complaint; however, their complaints were not always resolved in a timely way. One person living in Bethel told us, "I complain about the lack of hot water on a daily basis, but nothing gets done." People told us that the provider did not resolve issues quickly. One person living in Bethesda told us, "The lack of hot water was poor. It was nearly a month. Before that there were heating problems which I think are resolved now. They [my family] had to bring an electric fire into the room which is still here.''

Staff told us they received peoples' complaints and passed these onto the registered manager and the provider. Staff told us the registered manager and the provider do not come to the home every day. One member of staff told us they felt "burdened by the complaints I receive as I pass on the information [to the provider and registered manager] but do not see any changes." They described how residents are "fobbed off with excuses for weeks."

There was a system to manage complaints. There was one written complaint recorded which had been responded to in line with the service's policy. However, the provider had not logged the verbal complaints made by people about the issues with the hot water and heating. One person said they had expressed their concerns at residents' meeting in the past. They told us, "I know about residents' meetings but I don't go they're a waste of time, the manager says, 'leave it with me' if you ask anything.''

The provider failed to establish a system to identify, record and respond to verbal complaints. This constitutes a breach of Regulation 16 (1 and 2) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Receiving and acting on complaints.

People's assessments and care plans considered people's values, beliefs, hobbies and interests. People, and where appropriate their relatives were involved in developing their care plans. One relative told us, "'We were fully involved and happy with [Name's] care plan and signed it." People's care plans were reviewed regularly or as their needs changed.

People received their care as planned. For example, one person required assistance to hoist them in and out of bed, they told us, "'They [staff] use a sling to get me in and out of bed which is fine.'' Another person told us, "I'm quite content and happy. Sometimes I go out in a wheelchair. I get help with showering and if I need help at any time I use the call bell and they come pretty quickly.''

People who required assistance to maintain their skin integrity received support to reposition frequently. Staff checked people's pressure relieving mattresses regularly to ensure they were on the correct settings to help relieve their pressure areas. One person who was at risk of acquiring pressure ulcers told us, "Staff help me move from side to side in bed and when I sit on my chair I have a cushion [to help relieve the pressure areas.]" Staff told us and records showed that staff checked people's skin each time they provided care. One person said, "They keep an eye on me. [Name of staff] reported that I had cracked heels and now I have

some pads to wear on my feet to help this."

Staff were vigilant and used equipment to help keep people safe who were at risk of falling out of bed. Some people were cared for in a bed that was low to the ground, and mattresses placed next to their beds in case they fell out, to prevent injury. Others had pressure mats to alert staff to people getting out of bed. People told us they felt safe. One relative told us, "We're happy [Name] is safe here. There's a pressure mat by their bed and staff couldn't be better."

People received care that met their individual needs and preferences. For example, one couple told us, "My husband and I are getting the support we want. We have separate rooms but spend the day together which suits us. We don't worry about activities but we do like to go and see the singer when he comes.''

Staff understood the need to meet people's social and cultural diversities, values and beliefs. The activity co-ordinator told us there were group activities such as a craft club [with an external volunteer], religious service and a non-religious reflective group. There was also a gardening club. In general, the same small group of people attended sessions. They wanted to encourage people to spend some time out of their rooms doing activities that were meaningful to them. They had spoken with people and their relatives about what was important to them. One relative had suggested cake decorating or flower arranging and this was being considered.

People were getting to know a newly appointed activities co-ordinator. Some of the activities were being changed to suit people's current needs, in particular the activities co-ordinator spent one to one time with people. People told us they really valued this individual time. One person told us, "She [activities co-ordinator] comes in in the morning to see me and have a chat. If you're down she listens and lifts your spirits so you get a better day.'' Another person told us, "I'm not one for joining in activities but I do enjoy the singer. I tend to stay in the room. I do enjoy the morning visit from [activity co-ordinator]. It's nice to have some conversation then.''

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. One person used their computer tablet to communicate with their family. Another person told us, ''One of the staff regularly gets me a large print book. I'm losing my sight and can still enjoy reading and I have special glasses for reading.''

People received care that provided relief from their symptoms towards the end of life. We observed staff providing care that was compassionate; they were very attentive and sought additional health professionals help when the person required additional support.

People had the opportunity to discuss with staff what it meant to be at the end of life and make their preferences known in an advanced care plan, such as remaining in the home or receiving care in a hospital. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care.

Inadequate

Is the service well-led?

Our findings

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found the provider did not have comprehensive systems and processes to assess, monitor and improve the quality and safety of the service for people receiving care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; good governance. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. During our inspection on 4 July 2017 we found the provider had made some improvements, but areas such as fire signage and care plan audits required improvements.

At this inspection we identified that although there was some quality monitoring, there were no established systems and processes to carry out regular audits and environmental checks. All the monitoring of the supplies to the home including gas, water, electrics and security was carried out by the provider. They also took responsibility for monitoring of staffing, staff training and supervision, equipment, repairs, complaints and fire safety. However, these were not carried out regularly nor were they robust enough to identify where improvements were required. For example, the provider was not aware that the fire signage was inadequate, the gas supply had not been checked for safety, the water checks were not complete or that there were not enough staff to meet people's needs.

The provider had not ensured that all the required health and safety measures were in place or been pro-active in ensuring people were protected from harm. The provider had not carried out environmental audits; they had not identified that people could be at risk from accessing areas that could cause them harm such as the kitchen or the laundry.

The provider did not have a suitable system in place to manage the repairs and maintenance of the home. The provider carried out all the checks themselves, but they did not have a system to know when the checks were due or take prompt action to make necessary repairs. People had complained to staff about the continued problems with the hot water supply in Bethel area of the home; however, these complaints had not been resolved as the issues continued. The provider failed to act to resolve peoples' feedback in relation to this concern.

The registered manager told us they felt frustrated by the lack of progress in improving the home. They told us, "The maintenance in the home is horrendous, it needs an overhaul. The hot water in Bethel is intermittent, the windows need restrictors to protect people. There is no system for maintenance in the kitchen, in all areas. There is so much clutter, it's a fire risk." They expressed their disappointment in the loss of the communal lounges to storage and explained how they and care staff passed their concerns to the provider with no success. One member of staff described the provider as a hoarder, they said, "It's not fair that people can't use all areas of their home due to the amount of stuff piled up." The registered manager could not make a difference to the staffing, laundry, maintenance, kitchen as they did not have a budget or the permission of the provider to make the necessary changes.

The provider failed to have a suitable system in place to ensure there were regular supplies to the home. The

provider told us they paid for all supplies by cheque; suppliers would only deliver when paid. On the day of inspection, a food delivery had arrived but the provider had not left a cheque to pay for the delivery. Staff negotiated with the supplier to allow the delivery to continue and they would contact the provider for a cheque. The supplier returned later that day to collect payment which the provider had prepared. The delivery was only made through the goodwill of the supplier. Staff told us that the supply of personal protective equipment (PPE) such as gloves, aprons and paper towels were not reliable, as the supplier would not deliver until they had been paid. This meant that every three weeks, staff ran out of PPE. The provider told us they had no other method of payment as they did not use on-line banking or credit or debit cards.

The provider had a contingency plan that made provision for the loss of key areas such as utility supplies however, there was no contingency plan for the loss of access to the provider. All systems regarding maintenance, staffing, supplies and monies relied on the provider being available. As the provider only used cheques to pay for supplies, did not provide a budget for any area of the home and created the staff rota themselves. There were no contingency plans in place to support the home to continue to operate if the provider was not available

The registered manager relied on the senior care staff to run the home daily. The deputy manager post had been vacant for around a year, this had not been advertised. Any absence by the manager was covered by senior care staff. On the day of inspection staff called the provider and registered manager to advise them of our visit. Staff told us, "The manager and the provider are often not around, today is a good example." Senior staff told us this left staff feeling unsupported and unable to resolve issues as they arose because they did not have a satisfactory response from the provider.

Although people told us they were happy at Bethel/Bethesda; this was primarily due to the attention and commitment of the staff who prided themselves on understanding the needs of people in the home. Senior care staff described working closely together to keep the home running and minimum impact on people. However, this could not continue as staff did not have all the working equipment they required, or hot water, adequate staffing or staff support. There had not been any care staff meetings since the last inspection. Staff had not had the opportunity to discuss their concerns with the provider, nor the provider to discuss their plans with staff.

The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality, health, safety and welfare of service users. This constitutes a breach of Regulation 17 (2a and b) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Good governance.

The provider supplied evidence of some maintenance of the home which demonstrated that people's rooms and some communal areas were updated and decorated over time. The replacement of the boilers in the Bethesda area of the home required considerable investment and time.

The registered manager took responsibility for the care people received including the risk assessments, care planning and medicines. These areas had improved and people were receiving their planned care. Audits of the care plans and medicines identified areas for improvement and actions had been taken to make the necessary changes. Findings from the audits were shared with staff to help them understand how to improve the care provided.

There was a registered manager who had managed the home since it registered with the Care Quality Commission in October 2010. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager understood and carried out their role of reporting incidents to CQC. The provider had made the appropriate notifications to CQC regarding incidents such as the boiler not working.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service. The provider did not have a website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People are at risk of harm as the provider failed to identify or act to mitigate risks relating to health and safety measures. Regulation 12 (2a and b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to establish a system to identify, record and respond to verbal complaints. Regulation 16 (1 and 2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs. The provider did not ensure staff received appropriate training, support or supervision to enable staff to carry out their roles. Regulation 18 (1 and 2a)

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality, health, safety and welfare of service users. Regulation 17 (2a and b)

The enforcement action we took:

We issued a warning notice which required the provider to be compliant with Regulation 17 in 28 days of the notice.