ADR Care Homes Limited

Bethany Francis House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bethany Francis 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. Bethany Francis House is an older type building and is located in the town of St Neots. The service can accommodate and support up to 34 people with their personal care; at the time of this inspection 23 older people were accommodated.

The inspection took place on 10 and 17 September 2018 and was unannounced. It was prompted in part following information received from the local authority, their safeguarding team and whistle blowers and, to check that the required improvements from our earlier inspection on 21 February and 12 March 2018 had been made. At that time, we found the registered provider was in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to tell us how they intended to make the required improvements. They told us improvements would be made by 30 June 2018.

At this inspection on 10 and 17 September 2018 we found the provider had not taken enough action and they were still in breach of Regulations. We found the provider lacked oversight of the service and there was a lack of robust systems and controls in place to protect people and keep them safe.

There was not a registered manager in post. The registered manager left Bethany Francis House in July 2018. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A new manager had been recruited and had been in post for four weeks prior to this inspection.

The provider did not have robust and effective governance systems in place and was failing to consistently assess, check and improve the quality and safety of the service and care delivered. There were no proper monitoring and review systems to inform, drive and sustain an ongoing plan for improvement and embed in practice.

There were not enough staff to provide people with adequate supervision, enough to eat and drink, continence support, help to reduce anxieties or support people with complex needs. They did not always respond in a timely manner to all of people's needs. Opportunities to take part in meaningful activity was limited and activities provided were not personalised or tailored to meet people's level of ability, choice or preference.

Management and staff showed they did not have enough knowledge and skills about how to support people safely and protect them from harm. There were significant risks associated with fire safety, aspiration and

choking, medicine management, incidents triggered by people's mental state and/or dementia related needs. Applications to restrict people lawfully when they had been assessed as lacking capacity had not always been made to the local authority supervisory body.

The quality of training staff received was not effective enough to show staff were able and competent to the needs of people using the service. The provider did not have systems in place to ensure they were up to date with best practice and there was a lack of effective learning from complaints and safeguarding incidents to reduce risks to people from reoccurring.

There was a lack of systems in place to receive, manage and record complaints. The provider did not have any records to show whether they had managed, resolved and learned from complaints received since the last inspection.

The provider had not notified the CQC of all incidents that it was legally obliged to let us know of.

Thorough risk assessments were not carried out routinely to identify and mitigate risks in relation to people's healthcare and support needs. People's care records did not provide enough or up-to-date information for staff around safe care, supporting people's wellbeing and protecting people from harm.

Following this inspection, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do at once to address them. An action plan was returned the next day. We also shared our concerns with the local authority and their safeguarding team. We took immediate enforcement action to restrict admissions to the service and force improvement.

The overall rating for the 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 will still be 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 in any of the five key questions it will no longer be in special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Peoples' individual care and support needs were not always met in a safe and timely manner as there were insufficient staff.

People's care records and risk assessments were not always updated as guidance for staff to meet their current needs.

People's prescribed medicine were not managed safely.

Staff had a lack of understanding on how and when to report safeguarding incidents that occurred.

Robust checks were not in place to recruit staff safely.

Is the service effective?

Inadequate

The service was not effective.

Staff were not trained to meet people complex needs and specific health conditions. Staff competency was not assessed.

Not all people who had been assessed as lacking mental capacity had applications to lawfully restrict their movements or receive covert medicines.

People with short term memory loss were not supported adequately to make choices about the meals they would like to eat.

Is the service caring?

Requires Improvement

The service was not caring.

Due to a lack of staff on duty, staff had insufficient time to spend positively interacting and supervising the people they supported.

People's dignity was not always respected by staff.

People's privacy was maintained by staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff were not always able to respond to people's care and support needs in a timely manner.

Activities did not always happen with the service to make sure that people were left unsupervised, unoccupied and unstimulated.

The provider could not demonstrate that complaints received were resolved to the complainants' satisfaction.

Is the service well-led?

Inadequate

The service is not well-led.

There had been no registered manager at the service since July 2018.

Systems in place to monitor the service were inconsistent and ineffective.

There was a lack of provider oversight of the service which meant that people did not receive a consistently good service.

Notifications of incidents that the provider was legally obliged to report, were not always notified to the CQC.

Bethany Francis House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection site visit took place on 10 and 17 September 2018. This inspection was to look at whether the provider had made the necessary improvements following their previous inspection and that CQC had received whistle-blowing concerns about the service prior to our visit. We started our visit at 4.30am on 17 September to review the night staffing situation due to concerns received. The inspection visits were unannounced and carried out by one inspector, an inspection manager and an expert-by experience on the first visit and two inspectors and an inspection manager on the second. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR) on 6 August 2018. 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. We looked at the information in the PIR and looked at other information we held about the service before the inspection visit.

Prior to our inspection we also reviewed information sent to us about the service from representatives from the local authority contracts and safeguarding teams. We also received information about the service from a representative of a local foundation trust/community nursing team. We looked at the notifications received by the Care Quality Commission (CQC) and other information we hold about the service. A notification is information about important events which the service is required to send us by law.

During this inspection we spoke with seven people living at the service, four relatives and a visiting friend. We observed how staff interacted with people who lived at the service to help us understand the experience of people who could not talk with us due to complex health needs.

We also spoke with the Directors, the manager, three senior care staff, one care worker and a cook/care worker. We looked at care documentation for six people living at Bethany Francis House, medicines records,

medicines policy, accident and incident records, three staff files, staff training records and other records relating to the management overview and running of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 21 February and 12 March 2018 we found that people were not protected against the risk of unsafe care, particularly in relation to medicine management, infection control, the environment and risk to health and welfare. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection, we found the provider had not made the improvements and people's safety and welfare continued to be at risk. We have judged the rating as 'Inadequate'.

The provider had not developed and trained their staff effectively to fully understand safeguarding and to properly apply policies and procedures when circumstances needed it. During our first visit to the service an inspector saw a sexual safety incident and promptly reported it to the manager. Staff told us that they were aware this person had behaved in this way before. However, the risk this posed for the person and to others had not been assessed and there were no recorded support planning arrangements in place to minimise the risk and keep people safe. At our next visit we found safeguarding policies and procedures had not been applied and the manager had not reported the incident to the local authority as a safeguarding concern. Staff were not aware of what was acceptable behaviour or what kind of behaviour would be considered sexual harassment or abuse.

To help to protect people, management and staff had not carried out an assessment to decide the level of risk this behaviour posed to the person, and others. There were no care planning arrangements to guide staff on how to support the person and help to prevent further incidents triggered by sexual disinhibition or some other feature of a person's mental state and dementia related needs. The CQC have raised this incident and concern to the local authority safeguarding team who take the lead on all safeguarding investigations.

The provider did not have effective systems and practices to protect people from behaviour that presented a risk to him or herself, or to others. There was a lack of risk management plans to guide staff on a right response to early signs of distress and anxiety. Staff, therefore, did not have the information needed to intervene effectively through personalised calming techniques or other agreed good practice approaches to reassure people. Information recorded in individual's behaviour monitoring records focused on impact and risks to staff. This showed a lack of understanding of the person and awareness of behaviours being a form of communication or expression of distress and anxiety.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Recruitment practices were insufficient to protect people from the risk of unsuitable staff.
There was no evidence to show employment history and previous employment references for new staff had been explored and recorded by the provider.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection in February and March 2018 we found that fire prevention and precaution measures were not satisfactory. At this inspection we found there continued to be fire safety deficiencies.

People's personal emergency evacuation plans (PEEPs), identifying the level and type of assistance each individual person needed in the event of an emergency evacuation, were not centralised to enable quick and easy access for staff, or others in an emergency. They were limited in detail and did not consider essential information for a safe evacuation such as a person's level of awareness and co-operation, vision or hearing impairment or any medication prescribed that may cause drowsiness.

The provider did not have a current working emergency escape plan to inform staff, and others, of the overall level of people's reliance on staff to aid a safe and prompt emergency evacuation such as evacuation strategies, escape time and travel distances.

Staff had not received adequate training in fire safety that included practical aspects of evacuation procedures for all people using the service and how to move people quickly, the use or not of any firefighting equipment or the use of the evacuation sledge.

Arrangements were insufficient for improving the safety of individuals with swallowing difficulties (dysphagia) from the potential risk of choking. People who needed specific food consistency to help their swallowing difficulties did not have a choking risk assessment that showed the symptoms they experienced in relation to how dysphagia affected them. There was also a lack of guidance for staff on the type and level of support people needed to mitigate their risk from choking. During our first visit the Speech and Language Therapist (SaLT) was assessing a person following a recent choking incident. One week later their care plan had not been revised and updated to include current and relevant guidance for staff, recommended by the SaLT, on how to support the person and keep them safe from the risk of choking. The CQC have raised this concern to the local authority safeguarding team who take the lead on all safeguarding investigations.

Another person, prone to urinary tract infections (UTIs) had not had their care plan revised and rewritten since November 2016 despite having a urinary catheter since June 2018 to manage their continence needs. Staff, therefore, did not have relevant and current information to guide them on how to support the persons continence needs appropriately and safely, including the importance of keeping correct fluid intake and output records. Staff were not properly completing fluid records. This meant the information they held was unreliable and therefore redundant in helping to ensure an individual's wellbeing by early identification of emerging risk such as dehydration or a blocked catheter.

People were not protected from the unsafe management of medicines. Not all staff carried out the administration of medicines safely despite having undertaken training. On one occasion a staff member removed people's individual medicines from their original named packaging and placed all together in a pot to take to the person; also known as 'secondary dispensing'. This is unsafe practice due to the risk of difficulty in identifying medicines should the pots be dropped, inadvertently mixed up or refused. The person who signs the medicine administration records (MARs) is signing to say they have seen the person taking the medicine. We saw a senior staff member signing all the MARs together either retrospectively or before people had taken their medicines. Again, this is unsafe practice because of the risk the person did not take the medicine for any reason and it would not be known.

Further risks to the safe management and administration of people's prescribed medicines included staff not recording the reason for people not taking their prescribed medicines, staff not offering to individuals their 'as required' prescribed medicines and insufficient guidance for staff to ensure anxiety relieving medicines are given as a last resort when all other options have failed. There were instances when we found staff had left medicines unsafe and insecure. Whilst the medicine room was locked the medicine trolley or stock cupboards were not secured within the room leaving them accessible to any staff who had access to the room. Although room and fridge temperatures were monitored no action was taken when temperatures exceeded the recommended temperature for the safe storage of medicines. Incorrect temperatures could reduce the effectiveness of medication putting people at risk.

There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. One person told us, "I usually wait patiently for [staff], I don't keep ringing the bell… When somebody falls down I go and find staff." A relative told us, "At weekends there are not enough staff… Two weeks ago my [family member] fell out of their chair, they didn't hurt themselves but that happened because there were not enough staff to look after residents in the lounges." Another relative told us, "There seems to be enough staff most of the time but not in the afternoons."

People living at Bethany Francis House were living with varying levels of dementia and many had difficulty in communicating their needs. This meant they were dependent on care staff for their health, safety and wellbeing and reliant on staff being visible for support. One person in bed with their call bell out of reach told us, "I wish I could escape from here."

We observed people in communal areas left unsupervised for long periods of time. Throughout both days of our inspection we observed people putting themselves and others at risk while staff were not in attendance. We saw a person assessed as a medium risk of falls, calling out and trying to get up out of their chair, however, there were no staff available to help which left them at risk of falling. Their care plan said that they needed help from staff to stand when getting up from their chair to keep them safe.

People left to eat independently had little or no interaction with staff which did not encourage or promote practical help to eat more either independently or with support. Staff left people unsupervised during lunchtime. We saw two people trying to eat their food using their knives and another person was trying, and not picking up their food with their fork, to eat. As a result, they ate very little of what they were served.

One relative told us, "My sister would like [family member] to be able to go to the dining room for lunch but once [family member] is in the lounge [they] stay there and [staff] bring lunch to them." We observed people sitting in communal areas for the duration of the inspection with little or no stimulation, interaction or movement. A lack of movement can affect the body's systems, including deteriorating lung function, cardiac function, urinary drainage (creating an infection risk), digestion, muscle wastage, joint flexibility and mental deterioration.

The provider and management did not have a correct overview of the complexity of people's current needs and level of dependency. Needs and risk assessments, and associated care plans were out of date and did not give a correct indication of people's current needs, particularly with regard to dementia related needs. Dependency level assessments did not accurately reflect people's dependency levels so it was not clear how many staff were needed to be available at all material times to ensure all people's needs were met safely.

Records showed and staff told us that the numbers of staff on shift were not consistent and on nights there were only two staff for the whole service. The provider did not have an effective system to demonstrate how staff numbers were determined including the right amount of staff at night staff that are sufficient to

effectively carry out an emergency evacuation plan.

The service did not have a contingency plan in place to remedy unforeseen staff absences and ensure staffing levels were sufficient and available at all times to meet people's needs. On 10 September 2018 two of the four care staff rostered for the morning shift took unplanned leave and only two care staff were initially rostered for the afternoon shift. The lack of staff seriously affected the level of care delivered to people. At 11.00am there were still ten people needing personal care and breakfast and eight people had still not received their prescribed early morning medication.

On the first day of our inspection we told the provider how concerned we were about the staffing levels and requested assurance that they would address them immediately. The provider brought more staff in from another of their services and booked more agency staff for the interim. However, we found on our second day of inspection staffing numbers were low again on Sunday 16 September with only three staff. The risk of people's needs not being met this day was compounded by having no kitchen staff that evening and care staff having to take on added ancillary tasks.

Premises and equipment was not sufficiently cleaned and maintained. The provider employed only one cleaner and there were no covering arrangements for when they were off. On the first day of our inspection we found the environment was unclean. We found many sinks to be dirty and carpets, armchairs and mattresses were soiled, stained and offensive smelling. The manager told us that the home had not been cleaned because the cleaner was off. During our second visit the cleanliness of the service had improved. However, one person told us, "When my [family member] visits they have to clean the tables." Staff spoken with understood their responsibilities in relation to infection control and hygiene. However, one staff member gave us an example of when they had run out of gloves when the service was between managers. They said that because they carried spare gloves in their car, they shared these with staff until the provider bought more gloves.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Inadequate

Is the service effective?

Our findings

At our last inspection on 21 February and 12 March 2018 we found people did not live in a clean environment, the environment of the home had not been maintained and that people's beds and bedding was not suitable. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. We have judged this rating as 'Inadequate'.

At this inspection we found that the provider had replaced some bedding and pillows but staff told us that there was still a need for towels and individual flannels. The provider had not considered the needs of people living with dementia and/or sensory needs to provide an enabling environment to assist them with recognition and orientation. For example, prime colours were not used for high definition and so white handrails were not distinguishable against a cream wall to people with dementia related needs and visual sensory loss. There was a lack of signage or memory boxes used to help provide visual clues to identify important rooms or areas and people's bedroom doors were not identifiable. Communal areas and corridors lacked stimuli to attract people's interest.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 21 February and 12 March 2018 we found training for staff was not managed effectively to ensure they had the knowledge, skills and competencies to carry out their roles and meet people's needs. People living at the service were at various stages of their dementia ranging from early onset to advanced stages; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice guidance. Staff had a limited understanding of how dementia affected people in their day to day living.

The providers' website states, 'At Bethany Francis we believe that the training and support of all staff plays a major role in ensuring high standards are maintained'. We found staff were not adequately trained and this was demonstrated in their practice and approach to the care and support people received. Skills were lacking in person centred care, engaging with people in purposeful activity, Mental Capacity Act, safeguarding vulnerable adults, understanding and responding effectively to the wider aspects of people's dementia related needs including unsettled or disinhibited behaviours and dysphagia (swallowing difficulties).

Support for staff learning and development was insufficient. The provider delivered training to staff in core subject areas by DVDs and e-learning. Whilst this level of training provided a basic introduction a more substantial training programme was needed to enable staff to develop their knowledge and skills to meet people's needs effectively. One staff member told us they needed and had requested more training on the Mental Capacity Act to help to embed their knowledge but this had not been forthcoming.

Prior to this inspection a health care professional told us that they were concerned about staff notable gaps

in knowledge about preventative pressure area care, identifying pressure damage and incorrect use of moving and handling equipment. Staff told us they had not received any practical moving and handling training since working at the service. They said they relied on the practical moving and handling training they had received at earlier employments and their competency in relation to their moving and handling practice had not been assessed. This placed people at risk from unsafe moving and handling.

Staff had not received training in relation to people's individual and specific needs associated with long-term conditions such as Huntington's Chorea, Diabetes, Multiple Sclerosis and end-of-life care, to enable them to deliver safe and appropriate care.

The provider did not equip new staff with a robust induction that incorporated the Care Certificate, a nationally recognised training programme that identifies a set of standards and introductory skills that health and social care workers should consistently adhere to and includes assessment of competency. Staff told us their induction consisted of watching some DVDs and shadowing a more senior staff member. One staff member said, "There was no practical training…I was observed during shadow shifts on my first two days but had no formal assessment." The provider did not have systems in place to follow up on new staff progress and there was a lack of overview to ensure that the quality expected from them was being delivered and any further training and support required was identified. This did not give new staff the opportunity or support to ensure their learning was effective and they were competent to meet the needs of people safely.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was not always working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles.

The principles of Deprivation of Liberty Safeguards (DoLS) had not been fully considered for people living in the service. Emergency applications had been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe. However, these had not always been followed up by another application to keep people safe, when the emergency application timeframes had run out.

There was a lack of understanding from staff about safe and effective covert administration of medicines. Covert administration of medicines is when they are given without the persons consent or knowledge and hidden in food or drink. It is only likely to be necessary or appropriate where a person actively refuses their medication but is judged not to have capacity, as determined by the Mental Capacity Act 2005, to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. We found that there were no documents in place to demonstrate capacity assessments had

taken place and best interest decisions were legally authorised for administering prescribed medicines covertly to two people.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were positive about the meals at the service. One person told us, "The meals here are small but they are lovely." Another person said, "I like the food." Cold drinks were not consistently available and accessible to people and there were no snacks or fresh fruit freely available to people. The level of support given to people to eat and drink varied throughout our two visits. Where people had advanced dementia and mental health needs, the support provided to them by staff was not sufficient to ensure they ate and drank enough. People ate very little of what they were served and this was not explored further by staff, increasing their risk of poor nutrition and dehydration. Poor nutrition and dehydration can quickly exacerbate some of the symptoms of dementia, making individuals feel agitated and more confused, as well as having a significant impact on their health and wellbeing.

People had access to health care professionals when needed. One person said, "The doctor will come here if I need them and the chiropodist comes regularly to do my feet." Prior to this inspection a healthcare professional told us that staff were not following their request to implement care monitoring charts for people but they had seen some improvement in this area over the last month.

Requires Improvement

Is the service caring?

Our findings

At the last inspection on 21 February and 12 March 2018 we found people were not treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had not made the improvements required to ensure the service promoted a caring and respectful culture.

At this inspection there were insufficient numbers of staff to support a need led personalised service and we observed care that was delivered in a task and routine based approach. A relative told us they were concerned there was not enough interaction with residents. Staff had little or no time to interact with people they were supporting which meant there were missed opportunities for staff to engage positively with people and promote a culture which supported people with all of their physical, psychological and emotional needs. When a person tried to stand up from their seat they were told by a staff member to not stand up, with no time taken to ask the person if they would like any help or where would they like to go.

People's dignity was not always promoted and maintained by staff. We observed staff talking to and about people that was not always respectful and referred to people in an infantile way. One staff member told us that a person had been, "Told off," as a result of their previous and current behaviour. We also overheard a person being told that they were a, 'Good girl'. We heard another staff member say loudly, "Where are you going?" to a person who was walking down a corridor. We also heard the overuse of terms of endearment to people, such as, 'Darling', which for some people may be received as disrespectful.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not use effective communication methods and visual prompts to actively support or involve people to make choices and preferences. People were asked verbally and well in advance what they would like to have for their main meal at lunchtime. People with short term memory loss did not remember their choice and were disappointed with what they were given.

People's privacy was promoted and maintained by the staff supporting them. One person confirmed to us that, "[Staff] always knock before they come into my room." Our observations showed that staff knocked on the door of people's rooms before entering them and personal care was carried out in private and behind closed doors.

People valued their relationships with the staff that supported them. One person said, "I like it here people are kind to me." Another person told us, "I enjoy living here." A third person said, "The staff are all friendly." We observed several examples of staff seeking assurance as to people's well-being, however these interactions were fleeting due to the lack of staff.

During our inspection, people's visitors were seen coming and going from the service and were welcomed by the staff.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 21 February and 12 March 2018 we found care and support was not planned in a personalised way and tailored to people's specific and individual needs. At this inspection we found improvements had not been made.

People did not receive personalised care that was responsive to their needs and there was no consistent and planned approach to support people. People's care records did not provide sufficient detail to give staff the information and guidance they needed to provide personalised care and consistent support that is responsive to their individual and specific needs, and reduce the risks to their health and wellbeing. They did not include enough detail about people's strengths and aspirations, past lives, hobbies, pastimes or social histories, which would help staff, understand the person and enable them to communicate and interact more effectively.

Following a choking safety incident, a person identified with swallowing difficulties, known as dysphagia, did not have a personalised care plan that identified specific symptoms experienced by the individual in relation to how dysphagia affected them. Care staff, therefore, did not have sufficient information to guide them on how to monitor and review this person, recognise when symptoms were worsening and identify emerging increase to their risk of choking. We found that other care plans looked at were vague in relation to the triggers, understanding and personalised support needed by people who at times presented distressed behaviour or behaviour that was challenging to themselves or others. This lack of detail of how to communicate this information effectively to all staff meant that monthly evaluations of peoples care records did not review what worked well or include revised and effective communication strategies.

Daily records completed by staff following care tasks, did not give any indication of how a person's day was spent nor did they give any reference to their wellbeing. Where there were notes that showed the person had not had a good day, there was no information as to why or how staff supported them at this time. This meant that the opportunity was missed for staff to learn from possible positive interventions, which could be used subsequently in similar situations to avoid distress and risk of harm.

There were no arrangements in place to support people with meaningful activity in the absence of an activity co-ordinator. Staff did not have time to promote people's wellbeing and meet their social needs. On our first visit the activity co-ordinator was on holiday. We observed people sitting, with the television or radio on in the communal areas of the service. Our observations showed that few people were engaged with the television and sat for the duration of the day unoccupied in the lounge. Towards the late afternoon /evening, some people's anxieties and frustrations were starting to escalate due to boredom and a lack of meaningful occupation.

On our second visit, we saw that people who chose to take part were engaged with the activity person in music, dancing and playing instruments. During this time, we could see how the wellbeing of those people improved for that period; they became alert, responsive with smiles and laughter. However, there were limited resources available around the home to interest and occupy people who were living with dementia.

For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation. We observed some people being left largely to their own devices which resulted in heightened anxiety levels, distress or social isolation.

Compliments had been received about the service and were on display. However, most of the compliments were not dated and a record of receipt not kept so we were unable to establish when they had been received. People told us that they were aware of how to raise a concern or complaint and that they would speak to staff if they had any, "concerns or worries." Concerns had been raised with the service since our last inspection. A relative told us, "My [family members piece of jewellery] went missing three weeks ago, I've told the staff, we've searched everywhere." Another relative said, "When [family member] arrived there was no raised toilet seat on their toilet, but they sorted it straight away, also the television did not work and that was quickly sorted." However, there were a lack of records to document these concerns and to demonstrate whether any other complaints or concerns had been received and how these had been dealt with. A lack of records meant that the manager would not be able to review these to see if there were any patterns of trends that needed addressing. This meant that the provider was unable to demonstrate to us that concerns or complaints received about the service were dealt with in line with their complaints policy; looked at as part of their governance to see if there were any patterns or trends emerging and whether the concerns were resolved, wherever possible to the persons satisfaction.

We saw that a number of people had a 'Do Not attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions in place. These documents set out the person's wishes or a decision made on their behalf by a medical doctor, in discussion with relevant family members. In the event of a cardiac arrest they were not to be resuscitated. Staff told us that they had not had end-of life training to support them. The manager told us that no one using the service currently was on end-of-life care. They said that in the event of a person becoming end-of-life, they would work with external health care professionals' guidance and advice when it became clear that people's health conditions had deteriorated. This would then enable staff to support people to have the most comfortable, dignified, and pain-free a death as possible.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 21 February and 12 March 2018 we found the provider's systems and processes to assess, monitor and improve the service were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we have judged the rating as 'Inadequate' because we found widespread and significant shortfalls in the way the service was managed with regulations not being met.

The provider had failed to give effective oversight of the service which had led to a failure to address recurring areas of risk to people's health, safety and welfare. Support and resources needed to run the service were not available and the provider was not running the service in line with their website which states, 'We at Bethany Francis focus on providing a positive person-centred approach towards residents' care, supporting each individual resident according to their precise needs.' This did not concur with our findings. There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met. Provision of care was task led rather than centred on the individual needs of people.

There had been no registered manager in post since July 2018 to oversee the running of the service. A health care professional told us that there had been four managers in the last three months which had been unsettling to staff and staff morale was noticeably low. A new manager and operations manager began employment at Bethany Francis House in August 2018.

When we explained our concerns to the provider they showed limited understanding of their responsibilities and what good care looks like. There was a heavy reliance on the new management despite their limited experience in managing a registered service of this type.

The provider was failing to continually assess the quality and safety of the service to drive improvement or find where lapses had occurred. Without this oversight the provider had failed to ensure improvements were made, embedded, capable of being sustained and that future shortfalls would be identified, appropriate action taken and lessons learnt. It was clear from our findings that the provider was not acting on issues of concern within the service and therefore outcomes for people using the service continued to be poor.

Staff vacancies were high and the provider was unable to recruit and retain staff. People were not supported by adequate numbers of competent and supported staff. A lack of shift leadership and oversight meant that the quality of care and support for people was not being checked to ensure it was appropriate and followed best practice.

The manager was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted. There were no arrangements in place to show how comments or concerns received from people using the service or their representatives were considered or managed to drive improvement.

The quality monitoring process had also not identified that staff had not had training in relation to the care and support people needed in line with their specific health conditions, and that staffs' competency checks around safe medicines management and safe moving and handling techniques. Staff lacked guidance and understanding on how to respond to concerns about people's safety and manage peoples' behaviours. This did not protect people, staff and others from the risk of unsafe care and treatment.

We found that the provider had not completed adequate audits of people's care records. Our review of a sample of these records identified that these were not up-to-date to reflect people's current care needs and how staff were to support these needs effectively and safely.

This evidence demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Prior to this inspection, information we received form a health care professional made us aware of a safeguarding concern they had raised since the last inspection. Records the Care Quality Commission (CQC) held about the service and looked at during the inspection, confirmed that the provider had not sent notifications to the CQC to notify us of this and other safeguarding incidents, which is required by law. The reluctance to report issues and concerns which may constitute abuse is of serious concern and potential mistreatment, neglect or risk of serious harm may go without investigation by the appropriate authority. Safeguarding concerns and incidents were not effectively recorded, investigated or sufficiently analysed to determine root cause.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Notification of other incidents.

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 18 Registration Regulations 2009 Notifications of other incidents 18 [1] [e] Not all notifications of events such as safeguarding concerns were notified to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 10 [1] Staff did not always support people in a dignified and respectful manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11 [1] [2] [3] [4] [5] Not all people using the service and those lawfully acting on their behalf had given lawful consent before any care and support was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13 [1] [2] [3] [6] People were not protected from safeguarding concerns as staff were unaware of what constituted a safeguarding incident, known risks to people were not documented to help mitigate and reduce further incidents and staff did not report safeguarding concerns to the appropriate external agencies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment 15 [1] [a] The environment people living at the service lived in was not always kept clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19 [1] [a] [b] [c] [2] [3] The provider could not demonstrate that robust recruitment checks had been made on all new staff to ensure that they were of good character and suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 [1] [2] [a] The provider did not ensure that there was enough suitably trained staff deployed during each shift to meet people's care and support needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 [1] [2] [a] [b] [c] [d] [f] [g] [h] People were not supported in a clean environment, with safe medicines management and with a suitable number of skilled and suitably deployed staff on all shifts. People risks were not updated and care records did not have to date guidance on how staff were to monitor and support people's assessed risks in line with external health care guidance.

The enforcement action we took:

We sent out a letter of intent to the provider (Nominated Individual) and asked them to send in an action plan to mitigate the risks found during the inspection. As the action plan did not show robustly enough that the risks would be mitigated a Notice of Decision (NoD) was sent imposing conditions to restrict any new admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 [1] [2] [a] [b] [c] [d] [e] [f] The provider could not demonstrate that a robust governance system was in place to monitor, find and improve all areas requiring improvement, in a timely manner to ensure that a safe, effective and good service is provided.

The enforcement action we took:

We sent out a letter of intent to the provider (Nominated Individual) and asked them to send in an action plan to mitigate the risks found during the inspection. As the action plan did not show robustly enough that the risks would be mitigated a Notice of Decision (NoD) was sent imposing conditions to restrict any new admissions to the service.