Signature of Hertford (Operations) Limited

Bentley House

Inspection report

Bentley House
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26 February 2016
07 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Bentley House was registered on 02 February 2016 to provide accommodation and personal care for up to 90 older people who may also require nursing care. At the time of our inspection 50 people were living at Bentley House.

At this inspection on 18, 26 February 2016 and on 07 March 2016 we found breaches of regulations 09, 12,13,14,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. Subsequent to our inspection the Provider and Registered Manager, voluntarily suspended the further admission of those people who had nursing needs to the service.

The home had a registered manager in post who had been registered since February 2016. 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 had not reviewed and responded appropriately to incidents or accidents to keep people safe from harm. Risk assessments had not always been developed to positively manage risks which meant that identified issues relating to people's health and welfare had led to people experiencing harm. People's medicines were not always stored safely and information was not always available to staff about how to manage medicines. People were supported by staff who had undergone a robust recruitment process to ensure they were of good character to provide care to people.

Staff felt supported by the manager who enabled them to carry out their role effectively. Staff had not all received training relevant to their role including those staff who were in a supervisory capacity. Some people's nutritional needs were not met and their food and fluid intake and weight was not robustly monitored. Where these people ate very little or none at all, this did not prompt a review of their condition. This meant that these people suffered harm as a result of this. People were able to choose what they ate from a varied menu, however some people told us the food was not always satisfactory for them. People we spoke with told us they had access to a range of health professionals however records showed that people were not always referred when needed.

Staff spoke with people in a kind, patient and friendly way and respected peoples dignity. People did not receive a robust assessment of their care needs prior to arriving at Bentley House, and people told us that the original care plan promised at assessment was not provided. Communication within Bentley House meant that complaints and concerns were not always responded to, and staff and people or their relatives were not provided a regular forum to raise their views.

People did not receive high quality care that was well led and regularly monitored. People's personal care

records were not regularly reviewed, completed or updated when required, and people felt the manager was not as visible around the home as they should have been.

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's needs were not safely responded to when they required assistance.

People living at Bentley House were not protected from the risk of harm or abuse.

People were not responded to in a timely manner when they summoned assistance.

People's medicines were not managed safely.

People were supported by staff who were recruited following a robust process.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were cared for by a regular staff team who felt supported.

Staff had not received the training they required to carry out their role.

People's consent was sought prior to care being delivered, however the requirements of the Mental Capacity Act 2005 had not always been followed and people were both restrained and deprived of their liberty unlawfully.

People were not always supported to eat and drink sufficient amounts and people's weights were not always monitored.

People were supported by and had regular access to a range of healthcare professionals, however due to communication difficulties between management and staff their needs were not met or responded to promptly.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not feel they were always listened to and could shape their own care.

People did not feel that the care they requested and agreed to was consistently provided.

People's personal preferences, interests and wishes were documented, however these were not always consistently met.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's individual social needs were not always supported.

Peoples identified needs were not responded to in a timely manner.

People felt their views were not consistently listened to by management and that they were not able to influence theirs or their relatives care.

People were aware of how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were not effective in assessing and reviewing the quality of care people received or mitigating identified risks to people's safety and welfare.

A lack of communication and monitoring regarding peoples care had led to individuals experiencing harm as a result.

Records relating to peoples care were not always accurately maintained.

People and staff feedback that identified concerns had not been thoroughly reviewed or actioned by management.

People felt that the management team were not as responsive or visible as they could have been.

Bentley 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 met 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 under the Care Act 2014.

This inspection took place on 18 and 26 February 2016 and was unannounced. We carried out this inspection following the concerns raised with us by members of the public as well as health professionals that Bentley House may not have been providing people with care that was safe and met their needs, particularly in relation to end of life care and meeting people's nutritional needs. We carried out a further inspection on 07 March 2016 because we received further information of concern relating to the same issues. The inspection was carried out by two inspectors and a specialist nursing advisor.

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. We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed how staff offered support to people who used the service. We spoke with eight people who used the service and ten relatives, nine staff members, two unit managers, two nurses, the catering manager, the registered manager, deputy manager and members of the senior management team including the provider.

We received feedback from a healthcare professional and from a representative of the local authority social work team. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to 16 people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Inadequate

Is the service safe?

Our findings

Staff did not promptly respond to people when they summoned assistance. People we spoke with told us that when they requested assistance they would have to wait for a long period of time before staff assisted them. One person said, "I have my sleeping tablet every night at 9.10pm, but last night I had to wait until 10.15pm. The agency nurse was busy elsewhere, and when I sought help nobody responded." One person's relative told us, "Last night [person] wanted to go to the toilet, [person] says they have to wait a long time when they push the buzzer round their neck so last night didn't call for help when they wanted to use the toilet. In the end they had a fall at 6 o'clock this morning." We verified this with the person by speaking to them with their relative.

We observed during the inspection that call bells were often ringing without being responded to promptly. We observed examples where call bells were not responded to for over 15 minutes, however we found that staff were not always busy assisting other people, but were at times sat on chairs unoccupied, or in the case of a member of the management team who were occupied selecting their lunch menu, however not on a scheduled rest break. One person who was seeking assistance was observed to go unanswered for 16 minutes. We spoke with this person who told us that, "I need to wait for everything if I ring my bell. It is very embarrassing to wait to use the toilet or to get any help."

Staff feedback about staffing levels was mixed. Some staff told us there were enough staff to meet people needs. One staff member said, "Here we don't have problems with not enough staff." However, they also said that when people needs changed and they required more support they had little time to complete care records and other care tasks attributed to their job roles. One staff member said, "Usually staffing is ok but there are times when is not. It is difficult to do all the paperwork when people are agitated." Another staff member said that they felt the high use of agency staff was not benefitting people or regular staff. They told us, "I would like to see the back of the agency and have more permanent staff." They corroborated this by telling us that some of the agency staff knew how to care for people and were competent, however others they said required constant prompting and monitoring which took up their time, meaning they were not as available to respond to people's needs.

People's needs had not been safely met and responded to by sufficient numbers of staff deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe however that staffing levels varied across the home and on the dementia unit there was a high ratio of staff to people with one carer to every two people. The registered manager told us that were using a high proportion of temporary agency staff. They told us that recruitment had been an area that had proved difficult with very few staff applying for vacant positions; however recruitment was an on-going issue. They had arranged a meeting to discuss longer term temporary arrangements with a local agency, and had also met with the provider to review staffing levels.

People's care needs were not assessed thoroughly or reviewed when their needs changed to mitigate the risks of unsafe care being provided. We found that in some examples, care plans had been developed with

an accompanying risk assessment that clearly explored the risk and had a clear plan of care for staff to follow. For example, we reviewed care files for people who had minimal support needs and found that assessments in relation to falls management, moving and handling and nutrition were completed. Where needed these were reviewed and provided sufficient information for staff to follow.

However, we also found that where risks to people's health and welfare had been identified, staff had not reviewed and managed the risk to people. Prior to our inspection the local authority informed us of one person who had been reviewed by their team and found to not be sufficiently hydrated. They also concluded that staff were unable to meet the palliative care needs of the person and subsequently they were moved to another home. This person also was found to not be using pressure relieving equipment even though they were receiving end of life care and immobile in bed and at high risk of their skin integrity breaking down. When we looked at training records for staff we found that three of the six nurses employed had not received end of life training.

Staff told us that they had received training prior to administering medicines to people. They also told us that they underwent competency assessments on an annual basis. Staff told us they expected these competency assessments to be delivered imminently. However, training records we looked at showed us that not all staff had received training for medicines. We looked at the training records for 33 care staff. Of this number 12 had not completed their medicines training. Both care and nursing staff were responsible for administering medicines to people. Of the six nurses employed, one had yet to complete this training. Where staff were responsible for supervising and competency assessing others, we saw they had not received the competency assessment training required. Therefore, the observations of staff administering medicines to people was not based off of best practise guidelines and therefore could not be relied upon to be an effective method of identifying and managing poor practise.

We found that best practice guidance was not always followed when medicines were opened as staff did not always record dates on boxes and reconcile medicines regularly. This helps staff be able to accurately account for medicines should there be an error discovered. In two instances on the medicine administration record (MAR) chart of one person, the medication regime had been hand-written. In these circumstances, there should be two signatures confirming the entry however in this case there was only one.

There were gaps in the MAR charts where staff had not recorded when medicines were administered, or when they were not offered. For example, one person had pain relief prescribed for four times a day this was not always given. We found three gaps on the MAR, and confirmed for two of these gaps the medicine had not been given. However on the third occasion this had been given and the MAR went unsigned. We found in a different person's medicine records that there were two tablets less in stock than there should have been. Staff could not be sure that people had not received there medicine and there remained a risk people may inadvertently receive an additional dose.

This meant that some of the people who lived at Bentley House had suffered harm due to poor assessment and review of their care needs. Staff had not responded when people required assistance and people experienced poor care particularly in relation to their end of life needs. Additionally people's medicines were not managed safely as staff had not had the required training and people had not always received their medicines as prescribed. These areas were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about living at Bentley House were mixed. Some people told us they felt safe and very much enjoyed living at the home. One person said, "It's a nice community, the staff are very kind and I have never felt as if my safety has ever been compromised." However another person told us, "I know things have

happened here recently that makes me feel uneasy, I just hope they can get things organised so I do feel safe, I used to feel very at home here."

Staff were knowledgeable about safeguarding procedures, and were able to describe to us what constitutes abuse. Staff were clear that they would immediately report any concerns to the unit manager, lead carer or nurse in charge. Staff were aware of external organisations they could report their concerns to such as the local authority and CQC, however at the time of the inspection staff had not raised concerns in relation to the concerns identified.

Incidents were logged by staff and sent to the relevant manager. They reviewed the incident however they did not investigate thoroughly possible causes and also did not review peoples care needs robustly in response. Staff had reported on 11 occasions that one person had suffered falls within a month. Each incident was managed in isolation, where the nurse reviewed the person, then concluded there was no injury and observed the person for a short period of time. We found that the care plans were not reviewed to manage the persons increasing falls, which left them at further risk of harm. In an incident report that we reviewed for this person we found the lessons learned recorded were that, "[Person] should have been in bed and not still sitting in the chair as it was past their usual bedtime." This incident report was completed by the nurse on duty, the action noted by the manager was recorded as, "Does [person] need a falls risk assessment?" However no review at the time of inspection had been carried out. This person continued to be at risk of injury from falling because staff had not reviewed the recent history that suggested they were falling more frequently.

A second person, had two falls recorded within a month. The registered manager had requested the person was referred to the falls team as a preventative measure, and that their care plan had been updated to reflect the increase. The response from the unit manager was, "[Person] has been referred to the falls team a number of times, but [relative] does not wish for them to see them as they feel it is a waste of time due to the number of falls [Person] has had. I know they have been referred to the falls team by the paramedic today." There was no evidence of follow up on this incident, and no review of the person's risk of falling. Staff had not considered the use of things such as sensor mats or increased observation to mitigate the risks.

When we looked at how the incidents were managed, the registered manager told us that analysis was not robustly undertaken to identify patterns and trends. This information was then not shared with staff to encourage learning from events that had occurred. Where incidents suggested a pattern had emerged action plans had not been developed, and were therefore monitored to make sure they were delivered to mitigate the risks of harm to people. We found that the approach to the identification and management of risks was a reactive response to incidents, some of which had become serious and life threatening in some examples. The registered manager told us that the clinical administrator was updating the injury analysis to include times, themes, and staffing, so they can respond pro-actively to possible areas of risk, such as a high level of falls in the early hours of the morning, pressure sores, dehydration and challenging behaviour. Whilst these measures will ensure people in future are protected from the risk of harm, several people living at Bentley House had suffered harm through a neglect of the care needs. We have reported elsewhere in this report that people received a poor quality of end of life care, nutrition and hydration leading to hospitalisation, and a poorly managed approach to assessing and reviewing people mobility resulting in them being restrained.

Where people had suffered harm or the registered manager suspected harm may have taken place, they had not notified the Care Quality Commission of each event as they are required to do. For example, one person repeatedly refused care and treatment; they were suffering with a deteriorating wound since residing in Bentley House. The district nursing team supporting the person discharged them due to the person's

agitation and refusal to comply with dressing changes.

Similarly, for one person who was end of life, the registered manager told us that the GP did not prescribe break through pain relief when required. They said the GP did not have the time to do so. The registered manager says that they have raised this in a different safeguarding investigation that had been raised after the incident; however they did not raise it at the time with either the local authority or CQC.

Information about how people or their relatives and visitors could raise concerns were not prominently displayed. There was a small poster in the entrance lobby; however none were placed on the separate units where people spent their time. One relative told us, "I didn't see any posters in the entrance, but it's not really a place where you hang around, and I think it is a good thing to have information about where we can raise issues outside of here [Bentley House]." This meant that people and their relatives were not made aware of organisations they can raise their concerns with. At a meeting we attended in December 2015 at Bentley House, we advised the manager at that time to ensure safeguarding information was prominently displayed. However, this was not done.

This meant that incidents relating to people's care were not reviewed or monitored when they were identified as being at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were recruited following a robust recruitment process. People completed an application form, and references had been taken up prior to appointment. They also had a criminal records check in place prior to an offer of employment being made. Staff confirmed that checks had been applied for and obtained prior to commencing their employment with the service.

Requires Improvement

Is the service effective?

Our findings

During this inspection we found that suitable arrangements were not in place to ensure that people's consent to care and treatment was obtained in all cases. We also found that the requirements of the Mental Capacity Act 2005 (MCA) had not always been followed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were unlawfully restrained. For example, one person when they arrived at Bentley House was assessed to require one female staff member for personal care. This was four months prior to our inspection. Daily records of care we reviewed demonstrated that the person became resistant to staff providing care. We saw from these records that three carers had provided care on occasion to either bathe or change dressings. For example, one entry noted, "Three people including the nurse needed to offer personal care to [Person] as was resistant. [Person] was soiled and had to be changed including dressings." However, the current care plan for this person had only assessed them as requiring one female carer. The staff had not reassessed the person's resistance to personal care, or followed the requirements of the Mental Capacity Act 2005 to ensure the intervention was in the person's best interest. Staff had not considered alternative methods to support them with their personal care, such as pain relief prior to assisting them. An application to the DoLS team had not been made at the time of our inspection. On 07 March 2016, we further reviewed this person's care. At this inspection we found an application had been made to the DoLS team for authorisation to restrain them whilst providing care, however, a best interest process had not been followed and a care plan to direct staff how to provide care had not been developed. The unit unit manager reviewed the care this person received to ensure it was subsequently carried out as assessed in the care plan, by the correct number of care staff.

Staff had a limited understanding about the requirements of the MCA and DoLS. When we looked at the training undertaken by employed staff we found that of three of the unit managers, two had not completed MCA awareness training. Additionally 12 of the 29 employed carers had also not completed this training. Staff told us that DoLS were in place because people were not able to safely leave the building on their own. However, were unaware if there was a need to make an application for people who had lap belts on in wheelchairs or who were assessed as requiring bed rails to keep them safe. One person told us they felt their liberty was restricted by the service arrangements. They told us they needed a staff member to help them mobilise when they were out and this was not always possible as staff was not available. They told us, "If I went out last week for shopping, they [management] will not allow staff to take me out this week because they have other people as well."

One person had a specialist low bed provided because they were at risk of falls from bed. They had been assessed as requiring bed rails, however were observed to be attempting to get out of bed by trying to swing their legs over the bed rails. We identified further examples where people were restrained in their wheelchairs by use of a lap belt, again without considering the requirements of the MCA 2005 or Deprivation of Liberty Safeguards. Applications had not been made as required for any of these people until we returned on 07 March 2016 where we also found that lap belts were not used unless the best interest process had been followed. However where it was noted the provider and registered manager had begun to make improvements and undertake the required assessments, this was due to the observations and feedback made by inspectors and not as a result of their internal processes.

Due to people being unlawfully restrained, this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's weights were inconsistently monitored and did not follow the provider's policy when people began to lose weight. For example, a person had been assessed as high risk of malnutrition and was required to be weighed weekly. The person had not been weighed since 29 December 2015 although they had lost weight.

Throughout the inspection we found examples of where people were not routinely prompted to have a drink even though they were assessed as high risk of dehydration. Where people had not drunk a sufficient quantity of fluid, or had refused a meal, this had been documented but not followed up by a senior staff member. This meant people who were identified as being at risk of dehydration of malnutrition did not have their needs responded to.

For example, one person had lost a significant amount of weight in December 2015. This did not trigger a review of their needs and no action was taken. Staff had not then ensured their food and fluid intake was routinely monitored. We saw numerous dates between February and March 2016 where this person was recorded as only eating 'minimal amounts,' and consumed no or minimal fluids.. On 23 February 2016 the GP was seen to refer the person to the dietician due to concerns about their weight. The person was seen to continually deteriorate, developed a urine infection, continually refused food and drink and complained of nausea. Subsequently they developed constipation. The relatives of this person raised their concerns with the management team, however action was not taken until the relative returned later that day and insisted the emergency services were called. This person was later admitted to hospital suffering from dehydration and malnutrition. Staff at Bentley House had not monitored or responded to the persons deteriorating condition to avoid the person coming to harm.

We found that there had been no training provided to any staff in relation to nutrition or hydration support. Staff had completed training in food hygiene so they were able to prepare people's meals, however were not aware of how to specifically support and identify people at risk.

We asked five staff members on one unit if they were aware of people at risk of malnutrition or dehydration. Each staff member told us they did not think anybody was at risk. We later identified three people assessed as very high nutritional risks and losing weight that staff were not routinely aware of. As a result these people were at increased risk of malnutrition and dehydration.

We spoke with the catering team about peoples dietary needs, however found that they were not always kept informed of people's specific requirements, particularly those at risk of weight loss. They joined us for feedback to the management team at the end of the first day of inspection and told us they were shocked when told of the issues around weight management. They told us that if they were kept informed, they felt confident they would be able to provide bespoke meals to help with managing this. Although people at risk

of weight loss were prescribed and given supplements to encourage weight gain, they were not always provided with the meals that would support this. We saw after our first day of inspection that kitchen staff were required to attend daily meetings with unit staff to be informed of any risks to people so they could be proactively monitored. Although this is an area that the registered manager sought to improve during our inspection, this remains an area that requires improvement to ensure people are supported by an appropriate diet.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had regular supervisions where they discussed training needs, developing needs and they received feedback about their performance. One staff member said, "I have supervisions regularly. I love this place. I feel supported by my manager."

Staff told us they had regular training which included dementia awareness, safeguarding training, and manual handling. Staff were also being encouraged to undertake national vocational training. However, when we reviewed a copy of the training provided to staff we found many had not received the training the provider deemed to be mandatory training. We saw training for nurses had expired in areas such as dementia, infection control and moving and handling. Training had not been delivered in areas such as managing syringe drivers, skin integrity, palliative care and tissue viability. Care staff training lacked similar areas in mandatory training. When we looked at the training the unit managers had received, we found they had not completed the mandatory units. The registered manager accepted that training for staff was an area that required immediate improvement. They told us they had recently appointed a new human resources administrator who was reviewing and organising training for staff.

The home operated on a ratio of approximately 50 percent of agency staff supporting people. When temporary staff first came to work at Bentley House, they were provided with a basic induction that covered areas such as layout of the building, using the electronic care planning system, and emergency procedures. However, they did not have their skills and experience assessed. When they began work, the registered manager was provided with an overview of their skills and experience by the agency supplying the worker. This meant people were supported by staff that did not have the required training and competency to safely care for them. For example, agency staff worked with people with both dementia and end of life needs who did not have the specialist knowledge to do so.

Where staff felt they could approach their line managers for support, we found the systems in place to provide staff with the knowledge to safely assess and provide safe care were inefficient. This meant that all levels of staff in the home had not received appropriate training and professional development to enable them to carry out the duties they are employed to perform. Since our inspection the provider and registered manager have provided us with a comprehensive action plan that prioritised induction and training for all staff to commence shortly. However, these measures were not in place at the time of our inspection.

Due to staff not having the appropriate skills, knowledge and competency assessments for their role, this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed feelings about the food provided. One person told us, "The food here is very good." Another person told us, "I am not impressed with the food overall. Some days is nice some days not." People told us that although the food provided was very well prepared and presented; they did not always want to eat the high end meals. One person said, "It's nice at the weekends to have a special meal or a nice roast,

but I like my shepherd's pie and sausages, that's what I'd prefer than all this [pointing at her meal] every day." One person's relative told us, "The food is amazing, don't get me wrong, and the chef is exceptionally talented, but is a lot of rich food the best thing to give them?" We gave our feedback to the registered manager and chef who both said they were aware of the concerns raised, and were in the process of reviewing the menu choices given to people.

On the day of the inspection the food provided looked well-presented and of restaurant quality. People were offered a variety of options. Staff asked people what they wanted to have and there was a restaurant style service. Meal times were relaxed and pleasant with staff sitting down with people at tables and assisting them discretely where they required assistance. Staff talked with people and used diversion techniques such as looking at books, magazines and pictures between two courses to ensure people stayed and waited for their meals where they were distracted.

However, people who lived with dementia had not been presented with a visual choice as well as verbal choice and we saw people were nodding to choice number one and two as well. Staff made little effort to establish if they understood the choices offered.

The chef aimed to ensure that people's dietary needs were met and provided a range of options for people with specific dietary requirements such as diabetes, allergies or simply just a preference. They regularly spoke with people to see if they had enjoyed their meal, and were knowledgeable about how to support people's weight with high calorific diets. They monitored the waste food that was not eaten from each unit, and where there were excessive amounts they were able to review this with the respective manager.

People and relatives told us that professionals visited the home to support people`s health needs. They told us that the GP held a clinic there once a week, and if they wished to see them then they were quickly referred. We saw evidence of specialist services attending such as speech and language therapists and dieticians for when people had difficulties swallowing or maintaining their weight. However, communications were not always clear between Bentley House and services such as the GP and pharmacist. There had been historic issues that the manager had identified around the management of people's prescriptions and current concerns around the referral of people for specialist services. The registered manager had spoken with the practise manager of the GP surgery relating these concerns and a meeting had been held. However, this meant that although there were arrangements in place to seek support from external health professionals these had not always been effective in getting prompt care.

We have referred our findings to the Local Authority Safeguarding team due to people being at further risk of harm.

Requires Improvement

Is the service caring?

Our findings

People told us they did not feel they were able to raise issues or concerns with management and be listened to or have their views taken on board. One person told us, "Some staff talk to me like I am stupid, I feel offended." One person's relative told us that the care staff were responsive and that they felt they could discuss any concerns with them. However they also said that the management did not keep them informed of changes affecting their care. One person's relative said, "One area of concern was changing the keyworker for [Person] without even telling us. I have long told them of the need for consistency but they didn't listen. They don't have any sense or need to communicate with me at all."

One relative told us they have repeatedly reported to staff and nurses that their relative was finding it hard to swallow their pain relief in tablet form. They asked staff to ensure the tablets were changed to a different form to be easier to take. However staff failed to act on this and they had to take matters in their own hand and asked the GP to prescribe a different form.

During the inspection we became aware of an incident involving a person's relative informing the management team that a person's condition was deteriorating and asked them to review. They returned a couple of hours after they raised their concern and found their relative in the same poorly condition they had reported. No action had been taken by the manager to respond to this person's views.

All the people and their relatives spoken with were unhappy with the service they received mainly because they felt it had not been explained exactly what the service offered in the care package could provide and what was or was not included, which they felt generated extra costs. They told us that had a thorough assessment been carried out by care staff they would have had a better understanding of how a person's individual needs may be met. One relative said, "In the beginning this place was heaven sent. We came because promises were made to us about the consistency and continuity of care that would be provided. In my view, the ability to knowingly be able to provide long term care that would change over time was secondary to selling the lifestyle." A second relative told us, "We came here because they assured us that they had palliative care and could offer [Person] end of life treatment. They didn't listen to our views and offered a place even before assessing [Persons] immediate health needs." During the inspection this person was moved to another specialist service due to the inability of staff to care for the person's individual care needs. This was because they had not ensured a care plan was in place that was appropriate and met the needs and preferences of the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed throughout the inspection that staff knew the people they supported well. People were seen to be tidy, clean and appropriately dressed in clean clothing. Where people felt there was a difference between the quality of care from the agency staff and the permanent staff, our observations made no distinctions. For example, we observed one agency staff support a person with dementia extremely positively when they became distressed and distracted them by using references to the person that were individual and specific

and they could only have known by spending time with them. We saw a permanent staff member support a person who became tearful and restless when they heard another person shouting from their room. They held their hand reassured them and diverted them towards the kitchen to have a cup of coffee together. The person had calmed down and they enjoyed their hot drink. When staff entered people's rooms they did so after knocking and waiting for people to respond. Where people did not respond, we saw a carer slowly enter the room whilst calling their name and announcing they were coming in.

Care plans had documented areas such as past history, likes, dislikes, wishes and aspirations, hobbies and incorporated these with guidance provided that instructed staff how to provide person centred care to that person.

Care files and other information about people's medical histories and personal information were kept securely and confidentiality maintained.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. When we looked at the care records for people we found these were not consistently completed or reviewed. People did have an assessment of their likes, dislikes and preferences about how they wished to receive their care, however this did not translate consistently to the care they received. For example, where people's care needs were minimal, such as requiring assistance and prompting from care staff, we found the care plan sufficient to inform staff of how to provide care, choices around how people spent their day, and when they wished to receive their care. Where people were at risk of falling for example, they were given an alarm fob that they could use to summon assistance if required, and their appropriate assessments were updated.

However, for people who required a greater level of support and care, such as those with nursing needs including palliative care or skin integrity needs, the responsiveness of the care did not address the individual needs of people. We found that people in this group did not get the appropriate care and support when they needed it. For example, we spoke with one person who told us they had suffered from falls because they got tired quickly walking with their walking aid and were unsteady on their feet. They had been a recent fall where they lost their balance and fell. They had caught their arm in their walking aid and their watch they were wearing caused a large skin tear to their arm. There had been no reviews of these persons mobility, or a referral for a specialist assessment, even though they had sustained a number of falls and communicated their needs. A second person expressed suicidal thoughts and had voiced that they had felt depressed. Staff had not then discussed this with the GP or sought to refer the person to specialist mental health services.

The provider had recently implemented an electronic system of recording and monitoring people's care. This system used a handheld device that staff entered the care they had provided to people such as the amount of fluid or food they had eaten, whether people were repositioned on time, checked to ensure they were safe, received their prescribed medicines or that they had received their personal care. These were recorded as a 'Must Do' action and this alerted staff when this was overdue. We reviewed the 'Must Do' actions that had not been completed during for the previous 24 hours and found that 68 were outstanding. This meant that on 68 occasions during the previous day people had not received care for specific needs at the time they required this. The registered manager and senior management team had identified several areas where information had not been recorded correctly in the system, and were in the process of making the appropriate changes.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People told us that complaints were not consistently managed well. One person told us, "Depends on who you talk to really, but no they do not move heaven and earth to respond." A second person told us, "If I go to [Manager] then things happen but otherwise complaints I have made to them have never been passed along."

Where complaints were raised with the registered manager, they had investigated and responded to people both verbally and in writing. However, people were clear when they told us that issues were not resolved as

competently when raised with members of the care team or unit managers.

It was difficult for people or relatives to provide constructive feedback to the management team as meetings were not regularly held. The registered manager provided us with the minutes of the last meeting held in November 2015. In this meeting people raised concerns about the staffing levels, quality of food, and activity provision. However there had not been a follow up meeting to review the issues raised. Those people who did not attend the meeting had not had a copy of the minutes sent to them so they could also be aware of the discussions. The last staff meeting was also held in November 2015, however areas where staff could review and learn from raised issues or concerns were not discussed. From a copy of the meeting schedule we saw these meetings were due to be held monthly, but had not consistently been carried out. The registered manager and senior management team sent us an action plan that addressed these issues. In this document they identified the need to ensure meetings were held regularly and communicated to staff, people and their relatives. Minutes from meetings will be distributed so all parties are aware of what has been discussed and carried out.

However, at the time of the inspection the management team had not listened and learned from people's experiences, concerns and complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Bentley House offered a vast range of activities and stimulation to people, ranging from lunch time visits to the pub, day trips, bird of prey displays, arts and crafts, live music and a dedicated cinema for people to use. There were activity staff employed that passionately went about their work engaging and encouraging people to join in activities and were constantly looking for ways to develop the service. There was an ethos among the activity staff that they were able to cater for any persons individual interests so long as they were informed. We observed one group activity on the dementia unit which was based around music and dance. People were actively encouraged to engage and participate, and all those who joined in were seen to be having fun. Those people who we were told could be difficult to engage with due to their behaviour also joined in with others and were visibly part of the community in the home.

On the dementia unit there were a range of reminiscence items and rummage baskets for people to use to both occupy their time and stimulate memories from their past. Staff told us they spent time with people and their family when they visited to find out more about people`s hobbies and interest to be able to meet people`s social needs. At the time of the inspection staff were seeking family recipes to develop a cook book to make meals a more homely experience.

On the day of the inspection staff had taken two people for a walk. People thoroughly enjoyed the sunny weather and had chatted about their walk over lunch. One person said, "This was a lovely walk, the weather is so nice. I thoroughly enjoyed it." Some people not in the dementia unit told us they were unhappy that they could not go on more outings or shopping outside the home.

However, for people who were cared for in bed or chose to spend time in their rooms there was not the range of contact with people or activity staff. One person told us that they were only spoken with when staff brought them a meal, provided personal care or when they pressed their call bell. The proportion of people who were unable to engage in group activity or outings in Bentley House was quite small in comparison to those who could, however small things that could have made a difference to people such as helping them read a book, turn on the radio or spend time talking and give things such as manicures or the sports results did not happen consistently. This led to people feeling disconnected from the home and in some cases isolated. One person said, "I just want to be at home because I don't want to be here, it's not my home and it's lonely." When we asked what could be done by staff to support them, they said, "It's hard because this

isn't my home, but not sitting and thinking on my own would help." This was an area that requires improvement to ensure that all people are able to feel part of the community at Bentley House.

Requires Improvement

Is the service well-led?

Our findings

There were minimal robust or effective systems in place to assess, monitor and review the quality of service provided. The provider had a system in place to monitor and manage the effectiveness and safety of the service provided. We saw that monthly governance audits were carried out that looked at areas such as incidents, injuries, infection control, staffing levels and health and safety matters. The last monthly governance audit was completed in January 2016. This was incomplete, and had not reviewed several of the key areas that had been identified by the registered manager as a concern. For example, training had not been assessed, even though high numbers of staff were known to not have received training. Incident analysis did not consider themes or trends, and where issues were identified an action plan had not been developed. Where incidents were identified, we found that the registered manager reviewed and completed the sign off for actions taken, but did not always communicate this to the unit managers. This meant that an entire level of management, responsible for the day to day review and care of people did not receive the information they needed to effectively monitor and review the overall service people received.

The provider carried out their own six monthly review of Bentley House which was a broader assessment of the home. In addition they carried out a review of incident management and safeguarding in response to the inspection carried out at Bentley House at the request of the Operations Team. The findings of the provider confirmed the CQC inspection findings in many areas. They concluded that the incident management policy had not been followed; the middle level of management was not kept aware of events happening in the home that were not significant, and that action points identified had not been followed through when required. They noted that care plans were not updated when people's needs changed to reflect the current needs, even though they had themselves identified these as requiring improvement in visits in November and December 2015.

As a result of the CQC inspection and provider feedback to the Registered Manager, we found on date 07 March 2016 that some areas of improvement. For example, where people's needs had changed staff were reviewing their care plans and making referrals were needed. A review of the process in the home for incident management was underway to ensure all staff were aware of any potential risks and that actions were taken.

Surveys had been completed in relation to people, relatives and staff satisfaction. The results of these surveys had been analysed by an external independent organisation and then returned to the provider. We looked at the results of these surveys and found there to be a mixed response. In the survey completed by people living at Bentley House we saw that all people felt staff were helpful and friendly, and the majority of people felt the home was clean and felt safe living there.

However, less that 40 percent of people were satisfied with the service overall. This was indicated as less than half expected by the benchmark in all the Providers homes. Areas identified for improvement were around food choice, communicating in a timely manner, and ensuring staff members were available when people needed them. No action plan had been developed to address these and other concerns. Where the majority of people indicated they were satisfied, no further consideration had been given to how to further

improve.

The staff survey showed that overall nearly 80 percent of staff felt they were satisfied in their job. However, when the detail of the responses was reviewed we found there were significant areas to improve. These included staff feeling they have feedback from their manager, their suggestions being listened to, staffing levels, appraisal and supervision frequency. Staff were asked if they felt their opinion of working at Bentley House had improved over the previous twelve months. Only 34 percent of staff felt it had, with nearly half saying they did not feel they would continue working for Bentley House in the next twelve months. No action plan was in place to address the concerns raised through the survey, and worryingly, with a depleted workforce the provider or registered manager had not sought to further understand why people felt they may leave working at the home.

Prior to our inspection the Registered Manager did not have a service improvement plan in place to address, monitor and implement improvements or continually develop the service. A robust system of auditing within the Bentley House had not identified key areas of improvement such as care planning, daily recording, and incident management or safeguarding concerns, staff exit reasons or food choice and quality.

After the inspection the Registered Manager and Operations Manager developed a comprehensive plan which addressed the issues concerned. This will be shared with the senior and executive management team within the provider's organisation on a weekly basis so improvements can be monitored. However, it was clear that a cohesive and robust system for monitoring the care people received was in place but ineffective in keeping people safe. The registered manager and a representative of the provider told us, "I think in future we will just treat the agency carers the same as our staff and invest in them with the same training, supervision and development that we give our own." The manager arranged a meeting with the agency to discuss the support options on the last day of our inspection; however the agency failed to attend the meeting. The registered manager told us they will continue to review.

There was not an accurate record of people's care maintained that documented the care they required and how this was reviewed, assessed and met their needs. Records were incomplete, with a variety of care plans missing, incomplete or not reviewed from people`s files that were pertinent to their care. For example, reviews of people when their mobility needs changed following a fall, or an assessment of people's nutritional needs where they were noted as not eating or drinking well. Where the service employed a high number of agency staff, there was a substantial risk that without a documented care plan people may receive inappropriate care.

Daily records and observations of people throughout the day were not clear as the daily entries in care notes were not always completed. Incident reports we looked at had been completed but did not contain sufficient information to demonstrate how the incident happened and how the risk would be mitigated in the future. Risk assessments around concerns such as nutrition and weight management that were required had not been completed. Where these had been developed they had not been reviewed in the previous month as required by the provider's policy. We found in numerous examples, that care plans had not been reviewed when changes to people health needs required them to be reviewed. This meant an accurate record of a person's care and treatment had not been maintained.

People and relatives told us that the issue of communication in Bentley House was their principal concern. One person told us, "You just don't see the managers much; I couldn't tell you who the top dog is." One person's relative said, "To be a present management team you need to lead the staff from the front, and if we don't see them, how can they lead."

We found that the relationship between the various strands of management in Bentley House had become fragmented, lacked oversight and responsibility, and overall did not communicate well with each other. Where staff did not work effectively together as a team reviewing and monitoring risks as they emerged, this led to the irreversible harm that people experienced as a result.

During and after the inspection, improvements were made, however, all of the improvements implemented were as a result of the reviews of the local authority and the Care quality Commission. Subsequent to this inspection the Provider took the decision to voluntarily suspend nursing admissions to Bentley House, as they identified the current systems in place were not sufficient to meet the needs of these people.

Due to the ineffective systems in place to monitor the quality of the service and to mitigate risks to the welfare of people, this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications had not been made to the commission as required. Where there are events or incidents that happen in the service that mean people are at risk or have suffered actual harm the registered manager is obliged to inform the Care Quality Commission. We identified through reviewing care records and incident records that these had not been completed.

This was a breach of Regulation 18 of the Health and Social Care Act Registration Regulations 2009.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) (e) Incidents which occurred whilst services were being provided at Bentley House that were required to be made to the Care Quality Commission had not been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Receiving and acting on complains. Regulation 16 (1) (2) There were not established and effectively operated systems for identifying, receiving, recording, handling and responding to complaints or for reviewing and learning from concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) Staffing. People's needs were not responded to when

they summoned assistance. There were insufficient numbers of staff deployed to ensure that key tasks were completed in relation to people's care.