

Harbour Healthcare Ltd

Bentley Manor

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection took place on 23rd May and 5th June 2017 and was unannounced.

Bentley Manor is a two-storey purpose-built care home set in its own grounds. The home is in a residential area close to Crewe town centre, local shops and other facilities. On the ground floor one unit provides accommodation for people living with dementia. The first floor contains two units, one for people with severe and enduring mental health needs and the other provides nursing and personal care. At the time of our inspection there were 74 people living at the home.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We identified three breaches of the relevant legislation, in respect of safe care and treatment, safeguarding and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Overall the people and relatives we spoke with were positive about the care and support they received at Bentley Manor.

Staff knew the importance of keeping people safe, including being safe from abuse and harassment. However we found that whilst the majority of safeguarding concerns had been reported to the local authority we identified some incidents where local procedures had not been robustly followed. This meant that we couldn't be sure that people were fully protected.

We found that potential risks had not always been fully recorded in people's care records and appropriate risk assessments were not always evident. The registered manager assured us that people's care plans would be reviewed to ensure that appropriate risk assessments were in place. We saw that accidents and incidents, along with any pressure ulcers and weight loss or gain were regularly monitored.

Medicines were managed safely. We saw that a new electronic medication management system had been implemented. Staff told us that this was easier and safer to use.

We found that there were sufficient staff to meet the needs of people within the service. People told us that there were unfamiliar staff at night and weekends. There had been some issues around staff sickness and agency staff were utilised. The management team had focused on the recruitment of new staff and we saw that a significant number of staff had been employed and were undertaking induction training.

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. It was evident that the registered manager had a clear understanding of the MCA and its application. Records indicated that the majority of staff had attended MCA and DoLS training sessions and staff spoken with demonstrated an understanding of the MCA.

We saw that staff received an induction and regular training was provided. Staff told us that they received the training and support they needed to carry out their roles effectively. Staff were also supported through supervisions and staff meetings.

We found that people's nutritional needs were being met. People's views on the quality of the food were positive. People were supported to have sufficient to eat and drink and maintain a balanced diet and staff were knowledgeable about people's nutritional needs.

People and their relatives told us that staff were kind and caring in their approach. People were treated with dignity and respect. Dignity champions had been appointed to promote dignity within the home.

People received care that was personalised and responsive to their needs. Care plans were detailed and contained sufficient information to enable staff to meet people's needs. People spoken with told us that they were given choices about the way their care was provided.

People looked well cared for and well presented. However, we found that nail care could be improved.

There were varied activities going on and people could choose whether they wanted to take part. The home had two activities coordinators and there was a programme of events available. There was a complaints procedure available and people told us that they knew how to complain should they need to.

Staff told us that they had seen some improvements in the organisation of the service and were positive about the registered manager. Staff told us that they received supervision and felt supported.

We found that the home had some systems in place to assess and monitor the quality of service that people received, but systems to obtain feedback from people and residents were being developed. However, quality assurance systems had not been robust enough to identify the issues raised within this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

We could not be sure that people were fully protected because local safeguarding procedures had not always been correctly followed.

We found that risk assessments had been undertaken in some areas but had not always been recorded for specific individual risks.

There were sufficient staff to meet people's identified needs. However there were some issues with staff sickness and the provider was recruiting new staff.

The management of medicines was safe and a new electronic system had been implemented.

Is the service effective?

Good ●

The service was effective.

Staff had an awareness of the need for consent and understanding of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards were being applied appropriately to people within the home.

Staff spoken with had the knowledge and skills needed to carry out their roles effectively. Staff received an induction and regular training updates.

Staff were supported through regular supervision sessions and appraisals.

People could make choices about their food and drink and they were provided with the necessary support to maintain their nutritional needs.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and caring.

Staff respected people's wishes and preferences and people were involved in decisions about their care and support where possible.

We observed that people were treated with dignity and respect.

Is the service responsive?

Good ●

People had care plans which were personalised, detailed and reflected people's individual requirements.

People were supported to take part in activities to meet individual needs.

There was a complaints policy in place and people felt able to raise any concerns with staff. Appropriate action was taken in response to complaints.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There was a registered manager who was motivated and had developed a service improvement plan.

Staff told us that they felt well supported and that they could raise any concerns with the management team.

There were some systems in place to monitor the quality of the service but these needed to be developed further.

Bentley Manor

Detailed findings

Background to this inspection

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

This inspection took place on 23 May and 5 June 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day and one adult social care inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second day.

The registered manager had not received a Provider Information Return (PIR) before our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However this information was gathered during the inspection. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law.

We contacted the local authority before the inspection and they shared their current knowledge about the home. We checked to see whether a Health watch visit had taken place. Health watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had not taken place but we read the latest report available.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 18 people who lived at the home and six relatives/visitors, to seek their views. We spoke with 11 members of staff including one nurse, four care staff, the registered manager, deputy manager, regional manager, two domestic staff and the maintenance person. We also spoke with two visiting health professionals.

A significant number of people were living with dementia at Bentley Manor and were unable to tell us about their experiences, therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of five people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people in the communal areas.

Is the service safe?

Our findings

People told us that they felt safe and well cared for. Comments included "Yes I do feel safe" and "It's a comfortable place to live." One relative told us, "She (their relative) is definitely safe."

We reviewed how risks to individuals were managed. We found that potential risks had not always been fully recorded in people's care records and appropriate risk assessments were not always evident. Staff told us that one person was closely monitored due to behaviours as a result of their dementia and a previous safeguarding incident. They required a high level of supervision through the use of door sensors and staff observation. However, there was no specific risk assessment in place about these risks within the person's care records. Staff spoken with were aware of the potential risks and measures in place, but these were not clearly recorded. This meant that staff who were less familiar with people's needs such as agency staff, may not be aware of this information. We also saw in another person's records that a risk assessment had not been completed about potential risks to that person from another person living within the dementia unit, which should have been recorded. The registered manager said these people's care plans would be reviewed following the inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments relating to health, safety and welfare of people using the service and had always been completed.

Other records showed that other risks to people had been assessed and were linked to care plans, this identified the risk and the support that was required to minimise the risk. Risks that had been assessed included health condition support, mobility and skin integrity. We saw for example that staff used appropriate equipment such as hoists and specialist mattresses to manage the risks where required.

We saw that accidents and incidents, along with any pressure ulcers and weight loss or gain were regularly monitored. Where accidents and incidents had occurred these were recorded and we saw that a monthly analysis was also carried out to identify whether there were any themes or trends, so that necessary action could be taken to reduce further incidents. The registered manager completed a monthly report which was reviewed by the provider's quality team. Personal emergency evacuation plans (PEEPS) were in place and there were plans in place to support people in the event of an emergency. The home employed two maintenance workers. We spoke with one of them and reviewed their records. These demonstrated that regular checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. This included fire safety systems, call bells, water temperatures and electrical equipment.

The provider had policies in place for safeguarding adults and whistleblowing. These contained guidance on the action that would be taken in response to any concerns. We had been informed by the local authority in March 2017 that a safeguarding concern had been reported by the provider but that staff had not followed procedures fully regarding the timeliness of reporting and maintaining evidence. The registered manager told us that action had been taken since then to train staff and ensure that they fully understand the procedures, especially if there was a criminal element. A safeguarding champion had also been appointed

to promote safeguarding and update staff. Staff spoken with during the inspection with had an understanding of the signs of abuse and told us that they knew how to report any safeguarding concerns. We saw from the training records that staff had received training within their induction, as well as refresher training on the subject.

The registered manager maintained a safeguarding file and we saw that a number of referrals had been made to the local authority to report concerns. We found that the outcome of these had not always been recorded within the file, but the registered manager was able to provide this information verbally. There was a recent safeguarding incident which staff had appropriately reported to the management and which was subsequently referred to the local authority. However we found from the records and in discussion with the management that the local safeguarding procedures had not been followed correctly because the provider had started to investigate the concerns before they had referred the matter to the local authority. We also found that action had not been taken in a timely manner to ensure that residents were fully protected whilst an investigation was underway. We were informed about another safeguarding concern from April 2017, where it had been substantiated that staff had slept at break times during the night shift. We discussed this with the registered manager and found that the matter had been investigated internally within the organisation. However the initial allegation had not been reported under local safeguarding procedures and had therefore not ensured that there was external oversight of the investigation. This meant we could not be sure that people were fully protected.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not know and understand local safeguarding policy and procedures.

Providers also have a duty to notify The Care Quality Commission about any allegations or suspicions of abuse and we found that whilst we had been informed of the majority of safeguarding referrals, we had not been notified about all of them. The registered manager assured us that he would ensure that all members of the management team were clear about the guidance and requirements around statutory notifications.

We found that there were sufficient staff to meet people's needs and provide personalised care and support. During our inspection we observed staff responding to call bells quickly and saw throughout the day that staff were able to sit and chat with people. We reviewed rotas, call bell response times and spoke to people and staff about staffing levels within the home. Overall people told us that there were enough staff and their needs were met in a timely way, although there were a few comments telling us things could be improved, especially at night and the weekend. Staff were positive about staffing levels, a nurse commented "There's definitely enough staff" and a carer told us that was now a regular team of staff who worked well as a team.

The manager demonstrated that staffing levels were based on people's dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be adjusted. The provider used a staffing tool to assess the levels of staffing required. We saw that when required staffing was provided on a one to one basis. The registered manager told us that there were some staff vacancies and there had been issues with staff sickness, which impacted night shifts and weekends. Agency staff were therefore utilised to maintain sufficient staffing levels. The home was recruiting new staff and we saw that six staff were undertaking induction training on the day of the inspection. They were yet to recruit to two night carers and a nurse vacancy.

During the inspection a concern was highlighted to us which we raised under safeguarding procedures because staff had not supported a person throughout the night as required in their care plan. This concern was substantiated. The registered manager told us that following an investigation the reason for the concerns were due to the poor allocation of staff during that shift. They found this had not been managed

effectively by the senior staff. The registered manager told us that they were taking a number of actions to address these issues including the recruitment of a night manager, the registered manager undertaking shifts at the weekend and night visits and the trial of a free counselling service to support staff members if they wished to take part.

We were made aware and confirmed with the registered manager that staff were able to leave the premises during their break times and this included the night staff. This had been agreed by the provider under their terms and conditions. We asked for assurance that the minimum staff numbers were taken into account with regards to staff responding to emergencies. The registered manager confirmed that staff breaks were managed through an allocation system and advised that the home was over staffed to take into account, training, sickness and emergencies.

Effective recruitment processes were in place. We reviewed three staff files which evidenced that recruitment procedures were followed and applicants were checked for their suitability, skills and experience. In all the files we looked at we saw that either a Disclosure and Barring Service (DBS) check, or the authorisation number, which confirmed a check had been undertaken, was present. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions to try to prevent unsuitable people from working with children and vulnerable adults. We saw that where necessary disciplinary processes had been followed where unsafe practice had been identified.

We reviewed the safe management of medicines. The home had recently implemented an electronic system to manage medicines called the Boots eMAR system (Electronic management of administration records). This is a technology based management system which aims to make the administration of medicines safer. Staff used a laptop, which matched the right medicine with the right person and the right time. We reviewed records stored on the laptop and those viewed evidenced that medication had been administered appropriately. We spoke with a nurse who was positive about the system and said "everything is much easier and safer." The system enabled medicines to be audited on a regular basis.

A medication policy was in place and staff were able to access this. Staff responsible for the administration of medication had completed medication training and had undergone an assessment of competence prior to administering the medication. We saw that medication was stored in a medication trolley which was secured to a wall in a dedicated storage room. Separate storage facilities were available for controlled drugs and medication requiring cold storage. Systems were in place to record the fridge and room temperatures and the nurse told us that a new fridge had been ordered.

On the day of the inspection we were advised that the home had run out of stock of some items of medication for two people. We discussed this with the registered manager who had already taken action to ensure that the medication was received that day. We were informed that the items had been ordered in time but prescriptions had not been issued by the GP surgery. The new electronic system had resulted in some teething difficulties which were being addressed with the relevant surgeries.

Overall, areas viewed during the inspection appeared clean and well maintained. Staff had access to personal protective equipment and policies and procedures for infection control were in place.

Is the service effective?

Our findings

We asked people who lived at Bentley Manor whether they found the care and support to be effective. People spoken with told us that they felt that their care needs were met within the home. They said "The care is very good" and "The staff know me quite well."

Staff told us that they received the training and support they needed to carry out their roles effectively. Records showed that staff undertook a range of training and the majority of this was provided through a provider called ACC, who provide training courses on-line and through the television. The deputy manager told us that a training clinic was held every week to support staff to complete this training. The training matrix indicated that there was 95 % compliance with the training the provider considered mandatory and this was kept under review. Practical training was also provided in topics such as manual handling, medication, diabetes and wound care. We saw that competency assessments were also undertaken as appropriate.

New staff completed an induction which was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. A number of new staff were undertaking or had completed the Care Certificate. Staff told us that when they were first employed they had completed an induction which had included working alongside more experienced staff. During the inspection we observed that a number of new staff were taking part in an induction training session.

Regular supervision sessions and annual appraisals were undertaken. Records showed that these sessions were up to date. Staff were also invited and encouraged to attend staff meetings. Staff told us that they usually attended the meetings and they found them informative. We saw that the home had links with other organisations to promote best practice, for example they were taking part in the "React to Red Skin" project which aims to prevent pressure ulcer development. This meant that staff had access to a range of support to assist them in their role.

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).

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. It was evident that the registered manager had a clear understanding of the MCA and its application. Records indicated that the majority of staff had attended MCA and DoLS training sessions and staff spoken with demonstrated an understanding of the MCA. One staff member was able to tell us who was subject to a DoLS authorisation. The registered

manager had developed a system to ensure that there was a record of those people for whom a DoLS application had been made, with the outcome and date when the authorisation needed to be renewed

We saw that mental capacity assessments were completed where needed and family and health care professionals were involved with this assessment and best interest decisions made where appropriate. Where people had the capacity to understand they had signed their consent to aspects of their care plans and had been involved in discussions regarding their care. This showed that people's legal right to consent to their care had been respected.

Staff explained they understood the importance of ensuring people agreed to the support they received. We saw staff supported people to make decisions for themselves about their care. For example, we saw people were offered choices around where they would like to sit and whether they would like to take part in activities. A staff member told us "I always ask people what they want, they always have a choice, we're working in their home."

People were supported to have sufficient to eat and drink and maintain a balanced diet. Comments received were positive about the food provided, they included "I have meals in my room, the food is very well done" and "The food is good here." Each unit had its own dining area with kitchen access. We observed the serving of lunch on the first day of inspection and saw that people were able to choose to have their meals in their room, the lounge or in the dining room. We were able to sample the lunch and found the food tasted very good.

Where people required support to eat, staff supported people in an unrushed manner and offered encouragement where appropriate. We saw that food was served from a hot trolley and staff were therefore able to serve various quantities of food dependent on the individual need. People confirmed that they were given choices and people's individual preferences were catered for such as where a person was vegetarian. Drinks were readily available throughout the inspection and where people chose to remain in their bedrooms, we saw they had access to jugs of juice. We saw that when a person's dietary intake or weight changed significantly then the person's risk assessment was reviewed and a referral was made to other external professionals if needed to ensure people's nutritional needs were managed. Staff spoken with were clear about people's individual nutritional needs, for example where people required a soft or pureed diet.

Records maintained showed staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's needs. We saw that people had access to their GP, district nurses and other specialist such as audiology when this was required. We saw that referrals had been made to health professionals such as dieticians, mental health practitioners and tissue viability nurses when necessary. One relative commented "They'd let you know if anything was wrong. If she had a temperature they'd have the doctor out."

We looked around the home and found the environment to be conducive to the needs of the people who lived there. There had been a recent refurbishment which meant that the dementia unit was more spacious and enabled people to move around more freely. Thought had been given to the decoration of the unit, which had been specially designed for people with dementia needs. Rooms were comfortable, bright and decorated to a high standard. People had been encouraged to bring in personal items from home and many rooms were personalised and well furnished. There was an enclosed garden with seating and we saw that people were sitting outside on the day of our visit.

Is the service caring?

Our findings

People and relatives spoken with told us that staff were kind and caring. One person told us "They (the staff) are wonderful" and "The staff here are very good". A relative commented "All the staff are lovely with her." The atmosphere at the home felt friendly and welcoming.

We saw that positive and caring relationships had developed with people using the service and staff. During the inspection we observed how well staff interacted with people who used the service. We saw that staff chatted with people in a friendly manner and were kind and caring in the way they approached people. One relative told us "One carer (name) sings with her and her face beams, she loves it." We observed a member of care staff being very attentive with a person to ensure they were comfortable before eating their lunch and saw staff providing gentle reassurance to a person who had become distressed.

We did receive some comments from people that they were not as familiar with some of the night staff, as there were a number of changes and agency staff were often used. One person also raised an issue about the approach of a member of staff. However, when we raised this with the registered manager we found that this was being addressed.

We saw that the home had received a number of thank you cards and compliments about the care provided. Examples of these included, "A huge thank you for all your help and support" and "We are grateful for the care shown."

We found that people were supported and involved in planning and making decisions about their care. Where they were able to, people had been involved in the development of their care plans and had signed them to say that they had been consulted with. Although some people spoken with were unsure whether they had a care plan but told us that staff had discussed their needs and preferences. One person told us "You can have a lie in if you want." Another person said that they preferred to stay in their room and staff respected this. We saw that people were supported to have choice and control, for example we observed staff asking people whether they would like to watch the TV or listen to music. One relative told us "She gets choice. They don't make her do anything she doesn't want to."

Information and advice was also available in written format at the entrance to the home and on notice boards. This included information about activities, how to complain and advocacy support. We saw that there were regular residents and relatives' meetings held which enabled people to have a say on the way the home was run.

We found that people's privacy and dignity were respected and promoted. There was a dignity tree on the wall in the reception, which displayed comments and opinions about what dignity meant to people and reminded staff what was important to everyone as an individual. Staff dignity champions had also been appointed to promote dignity within the home. We observed that staff knocked on people's bedroom doors before entering and ensured that doors were closed when carrying out personal care. A person living at the home commented, "Of course the carers are kind" and told us they were treated with dignity and respect.

The care records demonstrated that staff had awareness of treating people with dignity, for example it was recorded that staff would provide "discreet supervision" to a person to ensure their safety. One member of staff gave an example whereby it was very important for a person to wear particular clothing on a Sunday and said that staff ensured they respected this.

People told us that relatives and visitors were able to visit at any time without any restrictions. They told us ""We can visit any time we like" and "My friends are made very welcome."

Is the service responsive?

Our findings

Feedback received confirmed people were generally of the view that the service was responsive to individual needs. People told us, "They've been brilliant,"; "I've no complaints" and "They look after you."

People received care that was personalised and responsive to their needs. We saw that assessments of people's needs had been completed prior to them moving to the home and this information had been used to develop their care plans, so they received appropriate care and support. We observed that people living at the home overall looked clean and well cared for, however we did note that two people had dirty nails. The registered manager informed us that he was monitoring nail care and reminding staff about its importance. People who stayed in bed had access to a call bell and overall felt that staff responded to their needs in a timely manner. Staff were knowledgeable about people's needs and how they liked to be supported. One relative explained "Staff know exactly what she wants even though her speech is not good." People's preferences, likes and dislikes were respected. For example one person told us that they liked to stay in bed and staff respected this.

We saw that care plans reflected how people liked to receive their care. The registered manager informed us that work had been undertaken over the past few months to re-write all of the care plans onto the new provider's documentation. Staff told us that they read people's care plans and were regularly informed about any changes through daily handover meetings. We found care plans were detailed and included specific information about how best to support people. Examples included information about personal care preferences, such as one person liked to have water on their bed side table and the lights left on at night. Care plans contained information including people's life histories as well as information about their communication, nutritional, mobility, continence and personal care needs amongst others areas. We found that care plans were updated and reviewed on a monthly basis. However, although there were some risk assessments in place, these were not always sufficient in all areas of risk. We have discussed this further in the safe section of this report.

We saw that staff maintained daily records to evidence that support had been provided to people. Charts were kept to demonstrate that people had received support with for example, positional turns or food and fluid intake.

Care records demonstrated that staff responded to changes in people's needs. For example, a person had fallen at the home just prior to our visit. We saw that staff responded appropriately and contacted the person's relative to inform them. They took advice from the GP, as well as recording and observing the situation appropriately. Relatives said they were kept updated and staff would contact them if there were any concerns. A visiting health professional told us that staff seemed to follow any guidance they offered about people's health needs.

Most people told us that there were activities going on and that they could choose whether they wanted to take part, although not all the people spoken with said they were aware of the activities available. The home had two activities coordinators who organised group activities, entertainment and also supported people

on a one to one basis. The home had introduced an activities coordinator specifically for the dementia unit and staff told us that this had made a significant improvement. They told us "People are more occupied now that the activities coordinator is based on the unit." We saw that a weekly activities plan was available.

During the inspection we observed that people were taking part in painting, indoor bowls and bingo. We saw that staff interacted well during the bingo session encouraged people to take part; people were smiling and laughing during the activity. One person told us how they had enjoyed a trip out to a local farm shop. The home subscribed to the Daily Sparkle newsletter, which was a tool for sparking conversation and included interesting information such as "this day in history". People's spiritual needs were supported. We reviewed a care plan which contained Information about the person's spiritual needs and staff were able to tell us how they supported the person to meet this need.

There was a complaints policy in place. People and relatives told us they felt comfortable raising any issues or complaining to the care staff or management. They told us that they believed any concerns raised would be acted on appropriately. There was a complaints procedure displayed in the communal area. We checked and found that the service was recording complaints. A number of complaints had been logged and responded to appropriately by the management. The deputy manager was able to tell us the outcome of these complaints. However we found that the records did not provide a clear overview of the outcomes of all of the complaints raised

We recommend that the registered manager implements and maintains a system to provide a clear overview of all complaints received, action taken and the outcome.

Is the service well-led?

Our findings

Bentley Manor was registered under a new provider called Harbour Healthcare in June 2016. The registered manager transferred under the new provider and was registered with The Care Quality Commission (CQC). He was well supported by a wider team, including a deputy manager, regional manager and quality team. On the first day of the inspection the registered manager was on annual leave and therefore we liaised with the deputy manager. When we returned to complete the inspection the registered manager was available.

The management team engaged well with the inspection process and responded positively to any suggestions regarding possible improvements to the quality of care. The service had already developed a service improvement plan to make improvements and following our inspection sent us an update which included information about the issues identified during the inspection. Cheshire East Council's (CEC) quality assurance and contracts team have been supporting Bentley Manor to make improvements and have been monitoring their progress against an action plan with monitoring visits. Recent feedback from CEC confirmed that they had found that the provider continued to work on these actions.

The service had a variety of policies and procedures to guide staff in their role and responsibilities. These policies were provided by an external organisation, who sent regular updates to the registered manager. Staff members we spoke with had a good understanding of their roles and responsibilities and were positive and motivated. There were regular team meetings and staff were supported through supervision sessions. We saw that staff performance was monitored and where necessary action taken to address any issues.

The registered manager worked closely with the deputy and other senior staff and held a daily meeting with them. Staff said this was a useful way to communicate with each other about relevant matters and gather updates. During the inspection we observed one of these meetings and saw that this enabled senior staff to communicate well. We found that the management team were very knowledgeable about people's needs.

Staff told us that the service was well-led. They advised us that the registered manager and management team were very supportive. Staff felt able to approach the registered manager with any concerns. Staff informed us that they worked well as a team and that there was always a member of the management team on call. Comments included "Since (the manager) has been here it's so much better more organised and better communication" and "The manager is approachable and would address any concerns."

Overall people told us that they knew who the manager was, although we received a few comments from people who were unclear whether they had met the manager. Comments included, "I get on well with (the manager), he has been responsive and will come for a chat regularly." Relatives told us that the registered manager was accessible, his office was in the main reception area and we saw he had an open door policy. People and their relatives had been involved in decisions around the running of the home through regular residents and relatives meetings. However there had been no satisfaction surveys since the provider had taken over the service. The registered manager told us that a staff survey was currently being developed.

We found that the registered provider used a variety of methods in order to assess the quality of the service

they were providing to people. There was a quality assurance system in place to regularly check a number of Key Performance Indicators (KPIs). KPI's are objectives that the service measures to check how effective they are. We saw that numerous areas were reviewed on a regular basis, including safeguarding, weight loss, pressure ulcers amongst others. They were reviewed by the regional manager to ensure that appropriate action had been taken where necessary. The regional manager visited the service regularly to undertake a "key outcomes audits" which assessed a number of areas. Audits were also undertaken in a number of other areas including, care plans, catering, premises, medication and people's dining experience.

However, we found that the provider had failed to have robust systems in place to recognise and address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found as part of our inspection, which are detailed in the safe section of this report. The provider did not meet all the standards set out in the regulations.

This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not operated effective systems to assess and monitor their service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risk assessments relating to health, safety and welfare of people using the service and had always been completed.

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
Treatment of disease, disorder or injury	Staff did not know and understand local safeguarding policy and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not robustly in place to identify and assess risks to health, safety and welfare. Also, the provider had not operated effective systems to assess and monitor their service.