Bentley House Limited

Bentley House Care Centre

Inspection report

Twenty One Oaks
Bentley
Atherstone
Warwickshire
CV9 2HQ

Tel: 01827711740
Website: www.bentleyhousecarecentre.co.uk

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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

We inspected Bentley House on 27 January 2016 and 4 February 2016. The first day of our inspection visit was unannounced.

Bentley House provides personal and nursing care for up to 50 older people, including people living with dementia. There were 45 people living at the home when we inspected the service. The home was divided into a number of units. One section of the home was called 'The Lawns' and provided accommodation for people living with dementia. This area had a separate lounge/diner and conservatory area. Another unit of the home provided accommodation for people receiving physiotherapy. This unit had a separate room for physiotherapy sessions. People with nursing needs were provided with accommodation over two separate floors at the home. There was a large lounge, dining room, and conservatory on the ground floor of the home for all to use.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

Medicines management required improvement to ensure people received their prescribed medicines safely and that medicines were stored in accordance with manufacturer's guidelines. People were supported to access healthcare from a range of professionals inside and outside the home, and received support with their nutritional needs. This assisted people to maintain their health.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, staff did not always understand the principles of the MCA and DoLS. The manager had arranged training in this area to be delivered within a month of our inspection visit. This training would ensure staff had the knowledge to support people effectively and in accordance with the legislation. Where decisions needed to be made in people's 'best interests', for example regarding the management of their finances, these decisions had not always been recorded in their care records. The manager was reviewing people's care records to ensure, decisions made in people's 'best interests' were always recorded in line with the principles of the MCA.

Care records were personalised and reflected people's care and support needs. However, not all the records we reviewed were up to date. Following a recent review, the manager was in the process of improving care records and was incorporating end of life care plans for people in the near future.

People were protected against the risk of abuse as the provider took steps to recruit staff of good character, and staff knew how to protect people from harm. Safeguarding concerns were investigated and responded

to in a timely way to ensure people were supported safely.

People had an opportunity to take part in interests and that met their needs and their personal preferences. Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run.

Quality assurance procedures were in place to identify where the service needed to make improvements, and where issues had been identified the manager took action to continuously improve the service. However, quality assurance procedures did not always identify areas where improvements needed to be made.

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.

People felt safe living at the home. People were protected from risk because staff knew how to safeguard people from potential abuse and there were enough staff available to care for them safely. The provider recruited staff of good character to support people at the home. However, medicines were not always stored and administered safely. The manager was implementing improvements to the management of medicines at the time of our inspection visit.

Is the service effective?

Good

The service was effective.

Staff completed an induction programme when they started work at the home so they had the skills to meet the needs of people there. However, all staff had not received training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) so that they understood how to support people and protect their rights under the MCA. Where people could not make decisions for themselves, some decisions that were made in their 'best interests' were not always recorded. However, the manager had identified these issues as an area for improvement and had plans in place to ensure training and records were improved. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

Care staff treated people with respect and kindness and knew people well. People had their privacy and dignity respected and staff supported people to maintain their independence. People were involved in making decisions about their care. People were consulted about their care preferences at the end of their life. This was being recorded in a care plan so everyone was aware of people's wishes.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in accordance with their interests and hobbies. Care records described the care people needed and how staff should support them, in accordance with their wishes. People were able to raise complaints and provide feedback about the service. Complaints were responded to in a timely way and action was taken to make improvements.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The management team was approachable and there was a clear management structure in place to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. People, their relatives and staff were asked for their feedback on how the service should be run, and feedback was acted upon. However, quality assurance procedures did not always identify areas where the service could improve. Where issues had been identified the manager took action to improve the service.

Bentley House Care Centre

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 was 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 27 January 2016 and 4 February 2016. The first day of the inspection was unannounced. This inspection was conducted by two inspectors and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported this inspection had experience and knowledge in nursing care.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

We also reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they planned to make. We found the PIR reflected the service provided.

We spoke with seven people who lived at the home and two people's visitors or relatives. We spoke with two nurses (one of which was the clinical lead), four care staff and one activities coordinator. We also spoke with the cook, a housekeeper and the registered manager.

We 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 looked at a range of records about people's care including six care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided. We reviewed records of

the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the home. One person said, "I do feel safe here. I don't have any worries." One relative told us, "My relative is really well looked after here, I have no concerns about their safety."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information on how staff could raise issues of concern with the provider. All the staff knew and understood their responsibilities to keep people safe and protect them from harm. Staff told us their training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were confident the manager would act appropriately to protect people. One staff member said, "If I saw or heard anything I would report it to the manager. I also know how to contact the local authority if I have any worries."

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of candidates prior to them being recruited to work at the home. For example, criminal record checks, identification checks and references were sought before staff were employed to support people. One member of staff told us, "I had a disclosure and barring check completed, and had to wait for my references to clear, before I started work."

We observed medicines being administered on the first day of our inspection visit. Staff who administered medicines were permanent staff who had received specialised training in how to administer medicines safely. Their competence to administer medicines was checked regularly by the clinical lead nurse. Each person at the home had a Medicine Administration Record (MAR) that documented the medicines they were prescribed. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines.

Some people were prescribed medicines that needed to be administered under certain circumstances such as when people were in pain, these types of medicines are referred to 'as required' or PRN medicines. We found there were not always instructions in place to inform staff under what circumstances PRN medicines should be given. For example, in one person's records it showed they were prescribed four different medicines for pain relief. There were no instructions for staff to describe when they should be given and under what circumstances. We were concerned this put the person at risk of not receiving their medicines when they needed them. One of the nurses we spoke with told us, "If there was not an instruction in place, nursing staff would make a clinical decision about what medicines the person needed and when they should have them."

We found some procedures for the safe management of medicines were not being followed. Staff were directed to sign MAR records when people received their medicines. However, we saw there were gaps in

some people's medicine records, which meant we could not be sure people had received all their prescribed medicine. In addition, procedures were not in place to ensure the effectiveness of medicines were maintained. The temperature of the storage areas of some medicines was not being monitored. This was important as some medicines are required to be kept at a temperature below 25 degrees centigrade to ensure they remain effective. We saw some medicines were being kept in areas which were warm, due to the central heating system being turned on. In addition, we observed two items of medicine that were in liquid form that had a reduced 'shelf life' after they had been opened. Staff had not recorded the date these medicines had been opened so they could be destroyed after the correct period of time. We brought this to the attention of the manager who agreed they would change the way in which medicines were managed to ensure they remained effective and records were accurately maintained.

On the second day of our inspection visit (a week later) the manager confirmed, "Staff have had follow up training in the administration of medication." They added, "We are now recording the time of when 'as required' medication is given to ensure people receive their medicines at the right time, and with an appropriate gap between their medicines. We are checking that medicine instructions for all PRN medicines are in place, and we are completing daily checks on medicines and medicines records to ensure gaps are followed up."

During our inspection visit we saw there was an area in home that had rucked carpets. We were concerned this was a trip hazard to people at the home, as we observed a person being supported with their rehabilitation walking in this area. We brought this to the attention of the manager during our inspection visit. The manager explained the home was going through some refurbishment at the time. We observed some general repairs and maintenance taking place around the home. The carpets we had identified as a trip hazard were due to be replaced as part of the on-going maintenance work.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. This was to ensure people were kept safe and received continuity of care.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Most of the risk assessments we reviewed were detailed, up to date and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, staff undertook checks of people's skin where they were at risk of developing skin damage. People had the equipment they needed, such as specialist mattresses to minimise the risks to their skin. Staff we spoke with had a good understanding of the risks related to each person's care. One member of staff told us, "We know about the risks to people from talking to each other and getting to know people. We use the correct equipment to support people and check equipment regularly to ensure it is safe to use."

We reviewed six care records in detail for people who lived at Bentley House. In one of the records we found the person's risk assessment was not up to date. For example, it stated the person could bear their own weight. The records also stated the person should be assisted to move with one member of staff, using a walking frame where appropriate. We saw the person could not bear their own weight and asked the manager about this. The manager stated the person's records required review as their circumstances had recently changed. When we visited the service on the 4 February 2016 we saw that the person's records had been reviewed and updated to show their current abilities and needs.

People gave us mixed feedback about whether there were enough staff available to care for people safely

and meet people's care and support needs. Most of the people we spoke with told us there were enough staff at the home to meet their individual needs. However, one person told us, "There are enough staff most of the time, but you can wait at busy times." Another person said, "You can always do with more staff." We observed there were enough staff during our inspection visit to care for people effectively and safely. Staff were available to respond to people's requests for assistance. We saw that in addition to the nurses and care staff on shift, there was the manager (who was also a registered nurse) available to cover care duties at the home when needed.

We asked staff whether they felt there were enough staff at the home to meet people's needs safely. All the staff told us they felt there were enough care staff employed at the service to assist people effectively and safely. There were a number of different staff roles. Some staff were trained nurses who supported people with nursing needs and assisted people with their medicines. Care staff were assigned to each unit of the home to provide care and support. In addition to these staffing levels, other staff members worked alongside care staff, such as activities co-ordinators, cleaners and kitchen assistants. This meant care staff could concentrate on providing care support to people who lived at the home.

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. The provider and manager used this information to determine the numbers of staff that were needed to care for people on each shift. We asked the manager about the number of staff vacancies at the home, they told us they currently only had one vacancy for a care worker on their night shift. They added, "We only use agency staff when we have vacancies or when staff are absent. We currently have enough staff to cover all our daytime shifts."

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One person said, "I think the staff are good, they know what they are doing and they know how to help me." A relative we spoke with said, "My relative is well cared for, the staff know how to meet their needs."

Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. One member of staff said, "The induction was very thorough and gave me the skills I needed, it covered everything I needed to know." The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was following the latest guidance on the standard of induction care staff should receive.

Staff told us the manager encouraged them to keep their training and skills up to date following their induction programme. The manager maintained a record of the training staff attended, so they could identify when staff needed to refresh their skills. Each member of staff received an individual training programme tailored to their specific job role. Staff told us they were supported with regular meetings with their manager to discuss their role and any training or development needs. One member of staff said, "Our training is always kept up to date." Staff told us the provider also invested in their personal development and they were supported to achieve nationally recognised qualifications.

However, staff did not always use their skills effectively to assist people at the home. For example, we saw two examples of staff not using safe manual handling techniques to assist people to move safely. On one occasion we saw a person being assisted by two members of staff to transfer from their wheelchair to an arm chair. Both staff members supported the person using an underarm technique which could have caused the person discomfort or injury. No equipment such as a rotunda or frame was used to assist the person, even though equipment for safely moving the person had been identified in the person's care records. We brought this to the attention of the manager during the first day of our inspection visit. They stated, "Staff are currently having refresher training for manual handling techniques. All staff will be briefed on the correct way to move people immediately." On the second day of our inspection visit we reviewed a training schedule which showed staff had received refresher training. One member of staff told us, "We have just received a briefing regarding manual handling techniques." They added, "All staff know what they should be doing and how to move people safely." On the second day of our inspection visit we observed staff using the correct moving and handling techniques when they assisted people to move.

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 are called

the Deprivation of Liberty Safeguards (DoLS).

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had reviewed each person's care needs to assess whether people were being deprived of their liberties. Several people had a DoLS in place at the time of our visit which demonstrated the manager had made the appropriate assessments in accordance with the MCA. However, staff did not have a consistent understanding of the principles of MCA and DoLS. For example, one member of staff told us, "I haven't done any training in the MCA, I don't know if all the people here could consent to their care." The manager explained training in MCA and DoLS was being organised for staff, and was due to be delivered before the end of the month. We saw evidence of the training being sourced and the training materials that were due to be used. We were confident the manager was addressing the need for staff to have up to date MCA and DoLS training to perform their work effectively.

Not all staff understood they should ask people for their consent and respect people's decisions to refuse care, where they had the capacity to do so. We found staff did not always ask people for their consent or permission before they performed tasks for them. People we spoke with however told us staff did respect their rights to make decisions about their care. One person said, "I haven't been asked to give consent to my care as such, but staff are polite and explain what they are doing.

We reviewed people's care records to see whether they had a mental capacity assessment and where a person lacked the capacity to make all their own decisions, any decisions made in their 'best interests' had been recorded. We saw people had this paperwork in their care records, as the manager had recently introduced the paperwork into the home. The manager was undertaking recorded mental capacity assessments where people could not always make their own decisions. Where people lacked the capacity to make all of their own decisions, the manager was consulting with relevant health professionals and people's representatives to make decisions in people's 'best interests'. Where this information had not previously been recorded on people's records, the manager was undertaking a review to ensure this was documented correctly and people's rights were protected.

We observed one person who had the capacity to make some of their own decisions whose family was managing their finances. We could not tell from the person's records whether this was with their consent, as there was no formal arrangement recorded on how their finances should be managed. We raised this issue with the manager during the first day of our inspection visit. When we re-visited the home on the second day of our inspection, the manager had raised the issue with their local safeguarding authority and had spoken with the person and their relatives to record this decision formally.

Most of the people we spoke with told us they enjoyed the food on offer at the home. One person told us, "The food is fine". Another person said, "The food is really good." We observed three mealtimes during our inspection visit. There were a number of dining areas available for people to use. Dining tables were laid with table clothes and cutlery to make the mealtime experience enjoyable. The dining rooms were calm, and there was a relaxed atmosphere. Where people needed assistance to eat their meal, staff assisted people at their own pace and waited for people to finish before offering them more food.

People were offered a choice of meal each day. People were asked before their meal was prepared what they would like to eat. In 'The Lawns', where people were living with dementia, staff told us people were also shown their meal before they were served the food. They said, "When people see their meal, if they don't like what's on offer, we can always prepare an alternative." The cook confirmed, "We can always provide people with alternatives if they don't like the meal choices."

People were offered food that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes. One member of the care staff said, "Soft or pureed food is always nicely displayed so that it is appetising." They added, "We are always informed of any specialist dietary requirements for people."

People were offered drinks and snacks throughout the day in accordance with their needs. We saw people had access to drinks in their bedrooms, in the dining areas and in the lounge areas. One person commented, "They [the staff] are always coming around with hot and cold drinks." This supported people with maintaining their hydration.

Nursing staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, physiotherapist, dietician and dentist where a need had been identified. We found people were referred to see health professionals in a timely way to address their healthcare needs. One person we spoke with told us they had access to health care professionals when they needed it. They told us, "I have help from a physiotherapist and I have to say it has been excellent. It's made a massive difference to me because I am improving all the time and becoming more independent."

People's GP visited the home each week and other health professionals such as the physiotherapist team visited the home daily. We found advice given by health professionals was being followed.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with respect and kindness. One person told us, "The staff treat me like a human being, they are always kind." Another person said, "I like it here, the staff are kind and they know me well." One relative told us, "I wouldn't want my relative to be anywhere else. They are kind and really caring. The staff have been marvellous."

We observed staff interacting with people at the home in a respectful and caring way using people's preferred names. Staff communicated with people effectively using different techniques. We observed staff touching people lightly on their arms or hands to provide them with reassurance and comfort. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. People smiled at staff and appeared to enjoy their interactions. One member of staff told us, "The team here is brilliant. I love my job. I really enjoy spending time with the people here. The staff really care."

People told us they made everyday choices about how they spent their time. We saw most people at the home spent time in the communal areas of the home according to their preference, rather than in their rooms. When we arrived at the home, on both days of our inspection visit, we saw some people were up having their breakfast and other people stayed in bed until they were ready to get up.

People told us their dignity and privacy was respected by staff. We observed care staff respected people's privacy when entering their rooms. Staff knocked on people's doors and announced themselves before entering. However, we found that people's care records were not always kept securely, so that only authorised staff were able to access people's personal and sensitive information. This was because several care records were left outside people's rooms during the first day of our inspection visit. We brought this issue to the attention of the manager. The manager explained, "We had already identified that we needed a place to put care records inside people's rooms. They should always be left in people's bedrooms." On the second day of our inspection visit we saw the manager had installed a holder for each person's care records inside their bedroom, to ensure records were always stored appropriately.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home and were supported to maintain links with friends and family. One person told us, "My family can come at any time." We saw people and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome.

People told us, and we saw, people's bedrooms were their own personal space, and each one was different. There were ornaments and photographs of family and friends, personal furniture and people had their own pictures on the walls according to their choice. The PIR confirmed people could choose their room décor and how they wanted their room arranged when they came to live at the home.

Some people at the home were nearing the end of their life. We asked the manager whether those people had been consulted about their wishes at the end of their life. The manager told us people were consulted

about their wishes just before they passed away. However, the manager acknowledged that this could be more clearly documented and that people could be consulted earlier. The manager had already identified this as an area for improvement and had organised some training with McMillan. The manager had also reviewed end of life care planning and had new care documents in place which were ready to be implemented.

The new care records documented people's preferences clearly. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. Records were designed to show people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to. The manager confirmed that people would make these choices in consultation with health professionals, their relatives and staff, so that their wishes could be met.

Good

Is the service responsive?

Our findings

Throughout our inspection visits we saw staff had a friendly and caring approach to people and were responsive when they requested support. Most of the people we spoke with told us staff assisted them promptly when they asked for their support. One relative told us, "I feel my relative's needs are met, the staff do check on them." However, one person told us they would like staff to assist them more quickly. They said, "Sometimes I am left at the table following my meals for too long." They added, "It really upsets me." We observed people being supported by staff in the dining room. The lunchtime meal service took around an hour to an hour and a quarter to complete. On the second day of our inspection visit we saw some people asked to be taken back to their room before the meal service had been completed, staff responded to the request and assisted people promptly.

Staff were able to respond to how people were feeling and to their changing health or care needs because they had a verbal and written handover at the start of their shift. We reviewed the records from a recent handover. The records showed each person at the home was discussed including any changes to their care or their health needs. Handovers were attended by the nurses on duty and senior care staff. A nurse told us, "The handover provides us with information about any changes since we were last on shift so that we can respond to people's individual needs."

Care records were available for each person who lived at the home. Records gave staff information about how people wanted their care and support to be delivered. For example, care records included information on maintaining the person's health, their support needs and their personal preferences where these were known. The PIR confirmed care planning was undertaken with the person and their loved ones where appropriate. Care reviews were undertaken monthly by staff so that people's care records reflected their current support needs. Reviews also took place each year with the person and their representatives to ensure people continued to be involved in making decisions about their care and support needs.

However, we found an issue with one of the care records we reviewed. The care record showed one person who needed to be moved or repositioned every two hours to prevent them from developing damage to their skin. Charts were in place for staff to record each time the person was moved. The nursing and care staff we spoke with knew the person's needs well. However, when we reviewed the care records we saw the charts were not always kept up to date and did not show the person had been moved every two hours. Staff told us the person was being moved as they should be, but sometimes the records were not always completed accurately. We spoke with the manager and the clinical lead regarding this issue, who confirmed the person was moved every two hours. Although we found these issues with the care records, we found no impact on the care the person received. Staff told us that generally care records were kept up to date and provided them with the information they needed to support people responsively.

People took part in group activities in different communal areas of the home, as well as individual one to one activities. This was possible as more than one activity organiser was available to offer people support. People were given information about forthcoming events so that they could plan ahead. A list of planned events was on display in the communal areas of the home for people to refer to. Events that were planned in

advance included trips into the local community, church services, coffee mornings and visits from entertainers.

We asked people whether they enjoyed the activities on offer at the home. People told us they did. One person told us, "We had a Burns night and it was great. I got a chance to try some really lovely whisky." We reviewed the information from a recent customer satisfaction survey where one person had commented, "There are activities I really enjoy." However, one person told us they would like to go out in their local community more often. They said, "We don't go out unless we have relatives who will take us. I am lucky my family come regularly." We spoke to one member of staff who told us, "People usually go out more when the weather is nice. Unfortunately we have had some poor weather recently." They added, "The home has a mini bus available for people to use on a Wednesday to go out."

People were supported to take part in activities according to their own personal preferences. We found each person had a record of activities which had been discussed with them, identifying things such as interests and hobbies they might enjoy. The activities co-ordinators confirmed this was used to plan group activities, events, and individual one to one time with people. We saw photographs around the home of various activities people had enjoyed. People were encouraged to take part in flower arranging, quizzes and gentle exercise. We saw staff sat with people, chatted with them and assisted them to read the newspaper when they chose not to join a group activity. We saw other people chatting with their relatives and friends which they enjoyed. We spoke with a member of staff who said, "We offer a range of activities for people to take part in. People can choose what they want to do."

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had acted on the feedback they received in complaints to improve the quality of their service. They responded to complaints by discussing the issues with the complainant and reaching a resolution that suited all concerned. However, there were no complaints received at the home during the previous twelve months.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service. People and staff told us the manager was approachable. The manager operated an 'open door policy' and encouraged staff and visitors to approach them in their office. One person told us, "I know the manager; they come around and check things every day." Another person said, "I would feel comfortable raising any concerns if I had any. I would speak to the manager."

The provider completed regular checks on the quality of the service they provided. The provider visited the home each week and conducted a regular 'walk around' as part of their quality checks. The provider directed the manager and the clinical lead to conduct regular quality checks on different aspects of the service. Regular checks included health and safety checks, medicines checks and checks on people's care records. Where these had highlighted any areas of improvement, action plans were drawn up to make changes. For example, a recent issue had been identified regarding the procedures night staff needed to follow. In response the manager had drawn up a night staff handbook to ensure staff had the information they needed to complete their work.

We found that some quality checks had not identified where improvements needed to be made. Auditing procedures required development so that issues could be more easily identified in the future. For example, recent medicines checks had not highlighted the need to improve procedures to ensure medicines remained effective. Care records were not always up to date. For example, we reviewed records which required updating in people's risk assessments, charts of when people were moved by staff and the recording of 'best interests' decisions. However, the manager did act to make the necessary improvements. This demonstrated the manager took action following our feedback to improve the quality of the service provided at the home.

The manager told us the provider was supportive and offered regular feedback and assistance to support them in their professional development. For example, the provider encouraged the manager to attend regular training to keep their skills up to date. They also discussed issues around quality assurance procedures and areas for improvement at the home. The manager said, "The provider is supportive and will listen to my ideas about any improvements that are identified." They added, "We are implementing some refurbishment plans to improve some areas of the home at the moment. This is in response to a recent audit and our regular maintenance checks, which the provider is supporting."

There was a clear management structure within Bentley House to support staff. The registered manager was part of a management team which included a clinical lead who was a trained nurse. Nurses were available to support care staff on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. One staff member said, "The clinical lead is very good, both the manager and them are very supportive." Staff told us there was an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. One member of staff told us, "I find the manager really supportive. I have had some issues and they have been really helpful adapting my working conditions for me."

Staff had regular team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were held within teams. For example, nursing staff met to discuss clinical information. Regular night staff met to discuss procedures for their shift. An agenda was drawn up before each meeting and staff were able to contribute their suggestions for discussion. A recent meeting record showed staff had discussed the needs of people in their care. Staff told us they had an opportunity to raise any concerns they had, or provide feedback about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

We found some staff training needed to improve to ensure staff they had the skills they needed to support people effectively. For example, we identified not all staff had the knowledge they needed to support people in accordance with the MCA and DoLS. The manager had already identified this training needed to be delivered to staff and had planned the training within a month of our inspection visit.

People could provide feedback about how the service was run and their comments were acted on by the provider. The manager told us they encouraged feedback from people, visitors and relatives. We observed there was a feedback form available in the reception area of the home which was accessible to everyone who lived there, visitors and relatives. The manager said, and the PIR confirmed, quarterly meetings at the home were scheduled with people who used the service. Meetings were planned in advance and included discussion on activities, events and menu planning. The manager told us, "We used to have relatives and visitors meetings, but these have been discontinued for the time being due to lack of attendance."

The provider also carried out six monthly quality satisfaction surveys to gather feedback. We were able to review some comments from a recent survey and feedback forms which showed people gave positive feedback about the home. The manager said, "We are also asking people to complete feedback forms when they leave the home now." They added, "Any information we receive is reviewed and where we need to take any action this is followed up straight away."

The provider had sent statutory notifications to us about important events and incidents that occurred at the home. They also shared information with local authorities and other regulators when required. They had kept us informed of the progress and the outcomes of investigations they carried out. For example, in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements to minimise the chance of them happening again.