Amore Elderly Care (Wednesfield) Limited

Bentley Court Care Home

Inspection report

29 Nordley Road
Wednesfield
Wolverhampton
West Midlands
WV11 1PX

Tel: 01902722100
Website: www.amorecare.co.uk

Date of inspection visit:
11 April 2017
12 April 2017

Date of publication:
23 June 2017

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 11 and 12 April 2017. Bentley Court is registered to provide accommodation with nursing for up to 77 people. At the time of our inspection there were 68 people living in the home.

At our last inspection the home was rated as requires improvement in all the domains.

There was a registered manager, however, at the time of our inspection we were informed the registered manager had left and the home was being run by an interim manager who had started the day before our inspection and would be in post until a replacement could be found. 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.

Although people told us they received their medicine when they needed it, we found improvements were needed in the management of people's medicine to ensure required medication was available so that people received their medicines as prescribed.
People told us there were times when there were insufficient staff to meet their needs. We saw there were sufficient staff available for people who chose to spend their time in the lounges however some people had to wait when they were nursed in their bedroom. People were supported by staff who knew how to manage risks to their health and safety and we saw staff put into practice their knowledge when supporting people. The provider operated a safe recruitment system which meant people were supported by staff who were suitable to work with vulnerable people.

People who lived at Bentley Court told us staff had been trained to meet their needs. Staff told us they received good training to help them support people and we saw them put into practice the training they had received. People's rights were protected through effective use of the Mental Capacity Act. Where people were deprived of their liberty the provider had made the appropriate applications to the local authority for this deprivation to be authorised. People's nutritional needs were met. People had access to other healthcare professionals when their health needs changed.

People told us staff respected their privacy and dignity. People told us they were supported by kind and considerate staff. We saw staff knew people well and positive relations had developed between people who lived at Bentley Court and the staff who supported them. We saw people had choices about their care, and staff respected the choices people made.

People told us and we saw people's care was not always responsive to their individual needs. People did not have access to meaningful activities. People and their relatives were happy to raise complaints about the care they received and told us when they had complained they had been listened to.

The registered manager had left their post and where concerns had been highlighted action had not always been taken to ensure people got the care they required to meet their needs. Staff told us they were not always supported in their role. Prior to leaving the service the registered manager had given people and their relatives the opportunity to be involved in the running of the service. The provider had ensured that they had notified us of events that had taken place within the service.

During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People's medicines were not always available for them and people did not receive medication as prescribed. People told us and we saw there were occasions when there were insufficient staff to meet people's needs. Risks to people's health and safety were managed. People were supported by staff who had been safely recruited.

Is the service effective?

Good

The service was effective.

Staff had received training which meant they could support people effectively. People's rights were protected because the provider had implemented the principles of the Mental Capacity Act. People's nutritional needs were being met. People had access to other healthcare professionals when their healthcare needs changed.

Is the service caring?

Good

The service was caring.

People told us they were supported by kind and considerate staff. Staff respected people's dignity. People had choices about their care and staff respected them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have access to meaningful activities. The care people received was not always responsive to their individual needs. People and their relatives were happy to raise concerns about their care.

Is the service well-led?

Requires Improvement

The registered manager had left their post and an interim manager had been appointed. Staff told us they were not always supported by the management of the service. The quality

assurance system in place had identified where some improvements were needed but they had not been implemented in the absence of the registered manager.

Bentley Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 April and was unannounced.

The inspection team consisted of two inspectors, one being a pharmacy inspector and a specialist advisor. The specialist advisor was a registered nurse who had knowledge of specialist nursing care needs of older people.

As part of the inspection we reviewed the information we held about the service. This included statutory notifications which are details of incidents that the provider is required to send us by law. We asked the local authority and the commissioners of the service for information. We used this information to help plan our inspection.

During the inspection we spoke with seven people who used the service and five relatives. We spoke with the interim manager and the deputy manager of the service as well as new members of the provider's senior management team. We also spoke with four members of staff. We carried out observations throughout the day to help us understand the experiences of the people who lived there. 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 care records for five people and 18 medicine records. We looked at other records relating to the management of the home. These included staff files, accident reports complaint logs and audits carried out by the registered manager before they left their employment.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2015 under the key question "Is the service safe?" we rated the provider as requires improvement. This was because people's medicines were not always managed safely. We found people were not always supported by sufficient staff to meet their needs. At this inspection we found the required improvements had not been made and in some areas they were now not reaching the standards required by law.

People told us they got their medicines when they needed them; however we saw people's medicines were not always available for them. We found three people's medicine had been unavailable at the beginning of the month because staff had not checked the monthly delivery from the pharmacy in good time. This meant two people had not received all of their prescribed medicine for two days. The third person's medicine, which was prescribed to reduce acid in the stomach, was still unavailable on the day of our inspection. Not receiving this medicine as prescribed can affect the person's quality of life. We spoke to the interim manager about these errors and they asked staff to contact the pharmacy to ensure people had their prescribed medicines available to them. Two people had been prescribed eye medicine. It was not noted whether the drops were to be placed in the right, left or both eyes. This may result in wrong and possibly unsafe treatment for the person. When people had been prescribed creams staff had to sign medicine charts to confirm the creams had been administered. We looked at three people's cream charts and two out of the three had not been completed and had been left blank. We checked the daily records of these people and found no mention for one person that their prescribed cream had been applied. This meant records did not always show whether people's skin was cared for properly. We spoke to staff about this and they were unable to confirm if this person had their creams applied as prescribed. We found when people had been prescribed thickening agents because they had difficulty swallowing the consistency required for their drinks was not always documented on their medicine records. This meant staff administering liquid medicines and giving drinks did not have the guidance readily available to them. If people's drinks are not thickened correctly there is a risk they may choke.

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

We received mixed views from people and their relatives about whether there were sufficient numbers of staff to meet people's needs. One person said, "The staff come when I press my buzzer [call bell]". A relative commented, "Yes, I think there's enough staff". Another person said, "Yes I feel they come when they know you need help". However, two people told us they thought there weren't enough staff at night to meet their needs and they had been kept waiting to go to the toilet. We saw staff were available to meet people's needs when they were sat in the lounge but when people were nursed in bed we saw they had to wait for staff to be available. One person who was nursed in bed told us, "Sometimes they come when I press my buzzer. Sometimes they don't". We saw on two occasions a person's call bell was not answered in a timely way. We saw one person shouting from their bedroom for a member of staff and no staff were available and we found it difficult to locate a member of staff. We saw staff congregated in corridors. We spoke to the interim manager about this and they told us they would be looking at staffing levels and deployment of staff.

We asked a member of the management how they monitored the times people had to wait for their call bells to be answered. They told us their current system was being upgraded to enable them to monitor this information more accurately. We found there were occasions when there were insufficient staff to meet people's needs.

People told us they felt safe. One person said, "I feel safe and secure here. I have been here three years". Another person said, "I feel safe, the people here make me feel safe". Relatives told us they thought their family members were safe. One relative commented, "I feel [name of person] is safe". Staff knew how to protect people from harm and how to report any suspected abuse. One member of staff explained to us how they protected people by making referrals to the local authority when abuse was suspected. We saw although the registered manager had left the service staff were aware of how to make referrals when abuse was suspected and referrals had been sent to the local authority to ensure people were protected from harm.

People told us and we saw risks to people's health and safety were managed by staff. Staff gave us examples of how they managed risks to people's health and safety. For example, one member of staff told us how they managed a person's health condition by ensuring they had regular blood tests. We saw when staff moved people they used safe techniques, we saw when people were at risk of sore skin staff had the knowledge about how to manage the risk and were putting into practice what had been documented in their care plan. We saw equipment staff used to manage people's risks was safe and where required the correct settings had been used. Records we saw confirmed what people and staff had told us. Risks to people's health and safety were being managed by staff.

We looked at the system the provider had in place to ensure staff were recruited safely. Staff explained to us the process they had followed when they first started working at the home. They told us they had to have an interview and bring in documents to evidence their identity and had to wait for their Disclosure and Barring (DBS) check to be completed before they began work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use services. The provider had ensured there was a safe recruitment system in place which ensured people were supported by staff who were suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

At our last inspection in December 2015 under the key question "Is the service effective?" we rated the provider as requires improvement. This was because people's rights were not always protected as the provider had not always applied the principles of the Mental Capacity Act. (MCA). At this inspection we found the required improvements had been made.

People told us staff asked for their consent before providing any care. One person commented, "They always ask my permission". Another person told us, "They [staff] ask me if it's alright before providing care". Staff understood the need to ask for people's consent before they supported people with their care needs, and gave us examples of how people did this. For example, one person gave a "thumbs up" if they agreed with their care being provided. . One member of staff said "We have to gain consent before we do anything". We saw that staff always sought consent from people, for example asking if they required any protective clothing at lunchtime.

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. Staff had received training and understood the principles of the MCA. One member of staff said, "It's whether a person can make a decision at a particular time". We saw when people lacked capacity to make certain decisions the staff had considered their capacity and had ensured that any decisions were made in their best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs). The MCA DoLs requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty so they remain safe. The interim manager was unsure of the exact number of people in Bentley Court who was being deprived of their liberty but during our inspection they compiled a list of the people who had authorisations in place. We looked at the records of four people who lived at Bentley Court and found staff were working within the guidelines of the authorisations.

People and their relatives told us staff had received training which meant they could support them effectively. One person said, "Yes they have to do training before they work. I think the training helps them look after me". A relative told us, "Staff are excellent". Staff told us they received training in areas which helped them to support people. One member of staff told us the dementia training they had received recently had helped them to support people living with dementia. They commented, "I know a lot more things I have to do now". Some staff told us they thought they would benefit from training in how to support people with challenging behaviour as people's behaviours changed. The interim manager told us they would look at supporting staff to access this training. One person told us, "Staff move me carefully in a

wheelchair". Staff confirmed they received training in how to move people safely. We saw the training they had received was effective as we witnessed staff moved people safely and with dignity. Staff told us the induction they received was thorough. It involved shadowing other staff until they felt confident to do the job themselves. One new member of staff told us," I felt I could do the job afterwards". People were supported by staff who had received effective training to support them.

People had mixed views about the food they were served. One person told us, "The meals are good". Another person told us, "They make me nice food". However, two people told us they didn't like the food and thought it could be improved. We spoke to the interim manager about this who told us they would speak with people and the cook to look at menu choices in the future. We saw people were offered a choice of where they would like to eat their lunch and were offered a choice of a vegetarian and a non-vegetarian option on the menu. We saw when people had special dietary needs, for example when their food needed to be served at a consistency which reduced the chance of people choking we saw staff serve the food at the correct consistency. Staff were able to tell us of people's likes and dislikes and how people preferred their drinks served. We saw where people had nutritional supplements prescribed staff were monitoring their intake. We saw people were offered choices of drinks throughout the day. People were offered choices of food to meet their nutritional needs.

People and their relatives told us they were supported to access other healthcare professionals when their health needs changed. One relative told us, "They get the doctor in and they always inform me". We saw in people's records health professionals were requested when people had difficulty with swallowing or when people's skin was at risk of breakdown. We saw when people had sustained falls professionals had been requested to try and prevent any further falls. We saw people were supported to access healthcare professionals to ensure they remained healthy.

Good

Is the service caring?

Our findings

At our last inspection in December 2015 under the key question "Is the service caring?" we rated the provider as requires improvement. This was because staff did not always have the time to spend with people and people's privacy and dignity was not always respected by staff. At this inspection we found the required improvements had been made.

At our last inspection we found people's privacy and dignity was not always respected by staff. We found on the ground floor rooms at street level did not have curtains to protect people's privacy. On this inspection we found the required improvements had been made and curtains were now present to protect people's privacy. People told us staff respected their privacy and dignity. One person told us, "They close the curtains to protect my dignity and close the door when they get me washed". A relative told us although it was their opinion that their family member should wear protective clothing to protect their dignity, staff had respected their family member's choice of not wearing the clothing. Staff gave us examples of how they protected people's privacy and dignity and we saw staff putting into practice what they had told us. For example, we saw one member of staff spoke quietly to a person when they needed personal care. We saw staff knocked on people's doors and waited for a response before entering. People were supported by staff who understood how to respect their privacy and dignity.

People told us they were supported by kind and considerate staff but felt the day staff were better than the night staff. One person told us they thought this was because a lot of the current night staff were agency staff who may not know them as well. One person said, "The staff are good. They are all kind". Another person said, "The staff are kind and considerate. The night staff are not as good though". People told us they found it difficult to understand some of the night staff as they were agency workers and could not always speak English clearly. Relatives told us the staff were kind. One relative commented, "The staff are excellent". Another relative commented, "Staff are marvellous with [name of person], they respect them". We spoke to the interim manager about night staff. They confirmed that they were using some agency staff owing to a number of staff leaving recently. They stated that they would hold a meeting for night staff to discuss people's needs further and confirmed that they had recruited new staff who had not yet started in their role which meant they would be reducing the number of agency staff used in the near future. We saw staff treated people with kindness. For example, we saw one person who was upset and we saw a member of staff sit with this person and they spoke to them about things they enjoyed. The member of staff sat with them until they had cheered up and left them smiling. We saw staff complemented people on their appearance following their recent visit to the hairdressers. We saw people were happy and relaxed in the presence of staff and laughed and joked with them. We saw people were supported by kind and considerate staff and positive caring relationships had developed as a result.

People told us they got choices with regards to their care. For example, one person told us" I go to bed when I want and I get up when I want". They went on to tell us they had asked to go out shopping and staff had listened and had taken them out shopping the day before. Another person told us, "They let me do what I want. They [The staff] are all alright". We saw people were offered choices of drinks throughout the day. We saw staff had time to spend with people and offered them choices about their care. For example, one person

told us how they liked a member of staff reading books to them. We saw staff offered choices about where they wanted to go or where they wanted to sit. For example, we saw a member of staff enter a room with a person and the member of staff took their time to ask the person where they wanted to sit and waited for a response to ensure the person was involved in the decision.

We saw people were encouraged to maintain relationships that were important to them. We saw friends and relatives visited their family members throughout our inspection and were able to spend time with them in their rooms or in lounges throughout the service. We saw staff chatted to visitors and were comfortable talking to them about their family member and themselves.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2015 under the key question "Is the service responsive?" we rated the provider as requires improvement. This was because people did not have access to leisure activities. At this inspection we found the required improvements had not been made and we found people still did not receive care which was responsive to their individual needs.

People told us there wasn't many activities for them to do. One person said, "There's nothing to do. You get up on a morning and spend the rest of the day watching television. I like dominoes and cards". Another person told us, "I read and watch television in my room. There are entertainers sometimes but it's not what I like". Staff told us they thought there could be some improvements in the activities offered to people at Bentley Court. We saw people who sat in the lounge were offered activities such as colouring. We saw staff repeatedly offered people pens and pictures to colour but people did not show any interest in joining in with this activity. We saw one member of staff gathered two people who were sat in the lounge to play dominoes but had not considered others people who may want to join in who had an interest in playing dominoes. The people sat in the lounge did not show any interest in this activity. We asked staff why they chosen the particular activity to gauge if this choice had been informed by people using the service but they could not offer us an explanation. We spoke to the interim manager about activities and they told us they would be looking at introducing more meaningful activities.

People told us the day staff knew them well. One person told us, "Yes they know me well. They know I like watching westerns on the TV". A relative commented, "We think [name of person] has improved since they have lived here. They continued to tell us staff had involved them in the care of their family member by asking what they liked and to bring in music or any other items which they liked to help with their family members wellbeing. Staff were able to tell us about how people preferred their care and how they supported people to have care which met their individual needs. For example, one member of staff described to us how one person chose to have their personal care needs met. However we saw people did not always receive care which met their individual needs. For example, one person indicated to us they needed to go to the dentist. We saw they had no teeth on their lower gum. We asked staff and they said they were in the person's room and they would locate them. Staff were unable to locate this person's dentures and their care records did not provide staff with the required information. The interim manager told us they would contact the dental surgery to organise an appointment for this person.

We looked at people's records which contained some information about how people preferred to have their care needs met and some information about their past. We saw records documented the up to date care needs of people living at Bentley Court. However we saw this information was not always passed on to staff in handovers so as staff could respond to people's needs. For example, one person told us they had not had their pad changed for over twelve hours, despite asking a member of staff to check for them. They told us they had sore skin as a result of this. Records we saw confirmed what this person had told us. We spoke with the nurse on duty who indicated this had not been passed to them and they were unaware of the person's sore skin. We asked staff to check this person's skin which also confirmed what the person had told us. We spoke with one of the managers in the home who took immediate action by contacting another healthcare

professional for advice and informed us they had spoken to staff on duty and would speak with staff on night duty following our inspection.

People and their relatives told us if they were unhappy with their care they would raise concerns with a member of staff. One person told us, "I feel confident to make a complaint. I did complain once and they listened to me and made changes". A relative told us, "I would feel happy to make a complaint if I needed to". We looked at how the provider responded to people when complaints had been made. The system in place ensured when people did complain they were responded to and the provider had ensured complaints were investigated and outcomes were documented.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2015 under the key question "Is the service well led?" we rated the provider as requires improvement. This was because the quality assurance system in place had not identified when improvements needed to be made. At this inspection we found some of the required improvements had been made, some issues had not been resolved and some new issues were identified during the inspection that the providers own systems had failed to identify.

At the time of our inspection there was a manager registered with the commission however they had not been present in the service for a few weeks prior to our inspection. We were informed they had recently resigned from their post. A new interim manager had been recruited and had commenced in their role the day before our inspection. People were not aware of the change in management. One person told us, "They are supposed to be having a new manager, but I am not sure if one has started yet". The interim manager told us they would be organising events to make people living in Bentley Court their relatives and staff aware of the change following our inspection. We saw whilst the home had been without leadership people had experienced care which did not meet their individual needs and people's dignity was not always respected by staff. The interim manager acknowledged there were areas where improvements needed to be made.

The provider had a quality assurance service which monitored the quality of the care people received. We saw that some of the audits the registered manager had completed had highlighted where there needed to be improvements in the service. For example, we saw they had noted that staff congregated in groups and this needed to be addressed. We saw where medicine audits had been completed they had been effective in identifying problems and action had been taken. However we saw that since the registered manager had left actions previously identified as necessary had not been followed up during the provider audits. For example issues related to medicine management and staff congregating in groups had not been addressed. We spoke with the interim manager who told us they had already identified areas in the home where there needed to be improvements made and would be addressing them following our inspection.

The interim manager told us they had organised a meeting with the night staff after the first day of our inspection to introduce themselves and to develop relationships with staff to support the development of a positive culture within the home. We received mixed views from staff about how they were supported by management. One member of staff who felt they were supported in their role told us, "If I have got problems I will speak to my team leader and I have regular supervisions to talk about my role". Another member of staff told us, "I have supervisions and appraisals. You can ask anytime. It's a nice place to work". Another member of staff told us they didn't feel as supported because they worked on the top floor of the service and felt they weren't as visible to the management team. Some staff told us they felt when they had reported problems to the previous registered manager they weren't dealt with and were now hoping for positive changes in the leadership of the service. We made the interim manager aware of staff's concerns who told us they had noted this and would be addressing it with staff following our inspection. We were informed by other senior members of staff who visited the service during our inspection that they were reorganising the senior staff within the organisation. For example a quality lead had been appointed. This person would

support the interim manager in ensuring improvements identified would be made.

People and their relatives told us although they had seen meetings advertised they had chosen not to attend them. Information we were sent following our inspection demonstrated that the former registered manager had involved people and their relatives in the running of the service and to participate in social events organised by the provider. Staff told us they had the opportunity to complete online questionnaires to give their opinions of the service but could also talk about this in their supervisions. The provider involved people, their relatives and staff in the running of the home.

The provider had ensured information about the service's inspection rating was displayed as required by the law. The provider had met their legal requirement in submitting notifications to CQC. The provider was aware they were required to notify us of certain events by law such as allegations of harm or abuse, and they had done so.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have a effective system in place to manage people's medicines.