Amore Elderly Care (Wednesfield) Limited

Bentley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook a responsive inspection of Bentley Court on 17 and 19 December 2018. This inspection was unannounced on the 17 December 2018 and announced on 19 December 2018. This inspection was carried out as we had received concerns about people's safety from partner agencies.

At our previous inspection of Bentley Court care home on the 9, and 18 July 2018 we found the provider had breached some regulations. These breaches were due to a lack of assurance as to people's consent being sought and systems in place that should have ensured the quality of service provision not being effective. Following the last inspection, we asked the provider to complete an action plan to show what they would do to address these breaches of regulation. We received an action plan but at this latest inspection, despite some improvements, we found there was still a breach of regulation in respect of the service's governance. We also found further breaches of regulation in respect of deployment of staff and ensuring person centred care was delivered.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

Bentley Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bentley Court can accommodate up to 77 people in one purpose built property. There were two units, one for people with nursing needs and one for people that lived with dementia and nursing needs. The care home also accommodates people under retirement

age. There were 65 people living at the home when we inspected.

At the time of our inspection there was a registered manager (who was present at the time of the 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 were informed at the inspection that the registered manager had given notice and was leaving the provider's employment the same week.

People were not consistently protected as risk assessments did not always show how risk to a person's safety was best minimised. There were occasions where people with fluctuating needs were not protected by the staffing deployment and numbers. Systems for the management of people's medicines had not always ensured they were managed correctly. Staff knew how to respond should they have concerns that a person was abused. People were protected by the provider's systems for recruitment of staff.

People living with dementia were not always given a choice of meal in a way that promoted their choices. Meal times were not always conducive to allowing people to have the support they needed to eat and enjoy their meals. People had inconsistent support to ensure they had enough to drink. People living with dementia could have access to a more appropriate environment that allowed their needs to be better met. People's right to consent was understood and sought by staff and any restrictions applied to enhance people's safety were agreed. People were supported by trained staff, with the provider also having identified further training needs they planned to support staff to take up. People had access to community health services as needed to promote their health.

People were not always treated with dignity and respect. People were not always able to have the support needed to express their views and make choices regarding their day to day life. We saw care was on occasions task not person focussed, this a concern for some of the staff who wanted to provide better care to people. People's independence was promoted and people were supported to maintain friendships and contact with families.

People's records did not always reflect what were their current needs and preferences and people did not always feel involved in planning their care, whilst others did. People's preferences were known to staff, although staff felt they could be supported to know people better. People had access to activities if chosen, but there were times when there was not always sufficient staff to ensure more dependent people had access. People knew how to complain and we found when this happened the provider responded appropriately

Despite the provider having systems to monitor the quality of the service, these were not always effective and as a result we found there were still numerous areas where improvements were needed, as well as breaches of regulations. People said they could approach management, some telling us their views were sought but staff did not always feel supported by management.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe

People were not consistently protected by up to date assessment and planning to mitigate risk to their safety.

People did not consistently have appropriate support from sufficient staff to keep them safe when their needs fluctuated.

Staff were aware of how to respond to allegations of abuse.

People's medicines were not always managed correctly.

Is the service effective?

Requires Improvement

The service was not always effective

People did not always have a choice of meals and the meal time experience was not always conducive to supporting people to eat their meals. People were given inconsistent support with their dietary and fluid intake.

There was scope to improve the physical environment for people living with dementia.

People's right to consent was sought by staff and any restrictions on their liberty were agreed with the local authority.

People were supported by staff that were trained, with the provider supporting staff to gain further training.

People accessed community healthcare as needed to promote their health.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always supported in a way that ensured they were treated with dignity and respect.

People were not consistently supported to express their views and make choices regarding their daily living, and we saw care was on occasions task not person focussed.

People's independence was promoted.

People were supported to maintain friendships and contact with families.

Is the service responsive?

Requires Improvement

The service was not always responsive

People had mixed views about their involvement in planning their care and we saw some people's records did not consistently reflect their current needs, wishes and preferences.

People's needs likes, dislikes and personal preferences were known to staff, although there were concerns, from staff, they did not always know people well enough.

People had access to leisure opportunities if chosen although there was concerns that there were not always sufficient staff to ensure more dependent people had access.

People could raise complaints and these were responded to by the provider.

Is the service well-led?

Inadequate

The service was not well led

Systems to monitor the quality of the service were not always effective and as a result people's safety was not always promoted.

There were failings in several areas in respect of service monitoring where improvements were identified in audits but not addressed.

People felt they could approach management, although not everyone felt their views were sought, and acted upon. Staff did not always feel well supported.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 19 December 2018 and was unannounced on the first day and announced on the second. The inspection was carried out by two inspectors, an inspection manager and specialist adviser who was a nurse.

The inspection was prompted by concerns we received from partner agencies including Wolverhampton City Council regarding concerns about people not receiving appropriate care that kept them safe and ensured their needs were met. We were also aware that there had been an unexpected death last year which is subject to on-going investigation from other statutory agencies.

Before our inspection we looked to see if we had received any concerns or compliments about the home since our previous inspection. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information we had received from other agencies, including commissioners of services. Commissioners are professionals who may place people at the home, and fund people's care. We considered this information when planning our inspection of the home. We considered this information along with action plans the provider had submitted to us following previous inspections. The provider had not been asked to complete an update to their Provider Information Return for this inspection. This is information we may request from providers from time to time so we can check key information about the service, what the service does well and improvements they plan to make. We took the information we had about the service into account when we planned this inspection.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. We therefore used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand whether

people's needs were appropriately met and to identify if people experienced good standards of care.

We observed staff providing care and support to people in the communal areas of the home. We spoke with nine people who lived at the home, and 11 visitors (people's friends/relatives) to gain their views on Bentley Court. We also spoke with the registered manager, the deputy manager, four senior managers, five nurses, 12 care staff, two activities co-ordinators, two housekeepers and the cook. We looked at nine people's care records to see how their care needs were identified and how people's care was planned. We looked at other records related to people's care such as medicine records, daily logs and risk assessments. We also looked at a range of documents produced by the registered manager/provider which were used to audit and monitor the quality of the service.

Inadequate

Is the service safe?

Our findings

Our last inspection report for Bentley Court was published on 13 September 2018 at which point we rated this key question as 'requires improvement'. This was due to systems needing to be embedded and sustained to ensure that people were always cared for safely. At this latest inspection we found there were further concerns and this key question is now rated as 'inadequate'.

The provider had failed to ensure that there were sufficient staff on the dementia care unit to ensure the needs of people living on this unit were consistently met, and they were consistently safe. There provider used a dependency/staffing tool that identified the care and nursing staff needed on the dementia unit. We found, whilst this number of staff was available, people were at risk of receiving unsafe care. The dementia unit ran the length of the building and we saw on numerous occasions one person walking around unaided who was identified by the provider's clinical risk register as walking 'without purpose day and night' and falling regularly. A Nurse confirmed this person needed to be checked by staff every 15 minutes because of this risk, but we saw no recent records of these checks for the dates of our inspection and a nurse told us there were no records available for the last few days to validate these checks. We saw staff were busy monitoring the service users in the communal lounges, providing personal care to other people or maintaining a drinks trolley to encourage people's fluid intake which would make it difficult to maintain these checks, partly due to workload and partly due to the overall size of the dementia unit. Staff at one end of the unit would not be able to hear or see what may be happening at the other end of the dementia unit due to the distance from one communal lounge to the other. A member of staff told us they could not leave the main communal lounge on one end of the dementia unit due to the assessed risks of service users in the lounge falling or becoming anxious and challenging.

There were 26 people identified on the provider's clinical risk register as at risk of falls. We saw staff were not always able to respond to these people and ensure their safety. We saw this on occasions led to staff seen trying to encourage people to sit down in communal areas when they wanted to leave the lounge area, and the staff not being able to accompany them as they had remained in the communal area to supervise people at risk in these rooms. Staff were therefore unable to ensure people's safety when walking with purpose through the dementia unit.

We saw there was insufficient staff available to divert people from entering other people's bedrooms. We saw a domestic mopping up urine in a bedroom and they told us a person had recently entered the bedroom (which was not theirs), and urinated on the floor. The person whose bedroom it was seen to be in bed. The domestic confirmed this a regular occurrence, and said the person would go in other bedrooms on the dementia unit and their own and urinate on the floor, and while the domestics tried to ensure they mopped up the urine as soon as possible as they were aware it was a slip hazard. We saw in another person's bedroom as the door was open and saw urine was on the floor. No care staff were in view at the time and the domestic said the person needed frequent monitoring to ensure such occurrences did not happen. Relatives of people living on the dementia unit told us they were concerned there was insufficient staff to prevent people living at the home entering other people's bedrooms uninvited. They said "People sometimes wait for assistance. 11.30 before they can get up due to staffing, people take their clothes, no

staff to support. Think [their loved one] is safe but not sure. Two weeks ago, there was a [person] in the communal area masturbating, no staff intervened, they need more staff". Another relative confirmed they were concerned about similar issues and added there was one person who was sometimes naked in communal areas and told us, "Could do with more staff at weekends". A member of staff we spoke with confirmed this was a regular occurrence and there was not always enough staff to divert people. Staff working on the dementia unit told us, "Staffing is an issue, maybe one more would benefit, care is task focussed". Another member of staff said, "Two new admissions and staffing levels not reviewed, could do with one more staff, I have raised with the manager". A third member of staff said, "Don't get time to give quality care, it's task focussed not holistic".

In contrast to what we found on the dementia unit we found people on the nursing unit felt their needs were met in a timely way.

This showed the provider had not ensured that there were staff deployed appropriately on the dementia care unit to ensure the needs of people were consistently met, and they were safe from harm.

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

Where people had been identified as presenting challenges to staff, care plans and risk assessments in respect of how staff should respond did not always identify triggers to the person becoming challenging. In addition, there was no clear protocols for responding to challenges for staff to follow that reflected the training they had received. This was highlighted by staff telling us when responding to challenges three to four staff could be involved. The involvement of this number of staff would not reflect a low arousal response that the training advocated and on the contrary, may have the effect of escalating a person's behaviour and creating greater risks to them and staff. The lack of evaluation/debriefing sessions with staff after a challenge indicated that a valuable opportunity to learn lessons may be missed.

We found some people's risk assessments were not been updated, for example, we found a report where a person had a recent fall, and their risk assessment and falls log had not been updated. We saw it was recorded in the person's care records that 'staff to monitor [the persons] whereabouts at all times'. We asked the registered manager if this meant people needed on to one care and they told us no person was funded for this level of care, but there were people that needed frequent monitoring. Another person's falls records was not up to date and a nurse told us, "It should have been recorded". A relative told us they felt their loved one was safe at the home and said staff, "Were doing everything to reduce the falls, for example [referral to] falls team" as well as measures such as a crash mat and low bed. This showed that while risks to people were not always captured there was evidence for some people appropriate measures were taken to protect people. In contrast to the above, we did see some people's risk assessments detailed how the provider looked to minimise potential harm to people in respect of risks such as choking, skin damage, and moving and handling. For example, we saw regular audits of risks to people, such as their weight, any accidents/falls and changes in health so necessary changes to a person's care was identified and implemented.

People did not consistently have their medicines in a safe way. For example, we saw that an agency nurse on the second day of inspection, where it was their first shift at the home, had been asked to carry out the medicines round without an induction. We saw they ensured they had help from other permanent staff, although said this was declined when requested from the nurse on duty due to, "Short staffing". We looked at medicines administration records (MARs) for six people and found these were accurate and well recorded with no missed doses, and there were entries if for any reason medicine was refused.

We found examples where safe medicine administration practice was not observed. We found one person had run out of their individual thick and easy (a thickening powder for drinks when people are at risk of choking) and when checked the nurse found these had only been supplied earlier in the month. We looked at the container for the supplement and found there was no label identifying who this was prescribed for. The nurse confirmed it may have been used for all the people who took that medicine, hence the person had none in stock. Medicines should only be administer to the person they are prescribed for, The provider did not ensure safe practice was maintained.

One person told us, "I have my pain medicine when I need them, I can have something stronger if I need it. Two nurses sign for medicines". Another person told us, "Medicines are OK, staff wake me up and I can self-administer if I want". We saw nurses administering medicines and this was done appropriately and safely, with nurses taking the time to provide the person with any assistance needed, and check to ensure the medicine had been taken.

The registered manager demonstrated a good understanding of her responsibilities under safeguarding procedures and we found we were notified of numerous allegations and incidents they had reported to the local authority since the last inspection, some incidents where there was no actual harm. The registered manager explained what actions they had taken for each safeguarding alert raised since our last inspection. We did note there were some incidents where people who lived at the home had been involved in altercations and while appropriate actions had been identified, we had concerns as to whether staff on the dementia unit would be able to ensure that people were monitored to prevent any repeats of such incidents. Staff had received training in how to recognise and safeguard people from abuse and knew what action they should take if they were concerned a person was at risk of harm. A nurse told us the registered manager was active in communicating issues to safeguarding and CQC to keep people safe within the home.

People and relatives, we spoke with had no concerns with the cleanliness of the home. Staff told us they had access to personal protective equipment (PPE), we saw this was available throughout the home and saw staff used it. We saw staff washed their hands and used gloves and aprons as needed. Communal areas of the home we saw were reasonably clean and tidy. We were invited into some people's bedrooms and found these to be clean and well-maintained and we saw domestics were responsive in attended to unexpected spillages. We saw audits were completed and cleaning schedules were in place to ensure the cleanliness of the home. We did however find some brown staining on one person's bed rail cover which we brought to staff's attention.

The registered manager and provider understood what they need to do to ensure recruitment practices were safe. We checked the recruitment records for three staff recently employed and found the provider's recruitment practices to be safe. We saw these included checks on the professional identity numbers (PINs) for any nurses employed to ensure they were permitted to practice as registered nurses.

Requires Improvement

Is the service effective?

Our findings

Our last inspection report for Bentley Court was published on 13 September 2018 at which point we rated this key question as 'requires improvement'. This was due to a breach of the law in respect of the need for consent. We had found that people had restrictions in place without Deprivation of Liberty (DoLS) agreements. There were also some concerns that people did not always have the appropriate support to have meals they wanted, sufficient drinks and a good meal time experience. At this latest inspection we found the breach of the law had been addressed but there were still areas of concerns and this key question remains 'requires improvement'.

At our previous inspection people's views were mixed about whether they enjoyed the food offered, and we found similar at this latest inspection. One person told us food, "Well cooked, I enjoy the meals, sometimes I choose my meals, not always. I can have other food if I don't like it, I can have supper. They always encourage drinks, plenty when I want them". A second person said, "Food is ok, I can choose, it's always the same, unappetising, basic food". We observed meal times on both units and found a variation in the meal time experience.

In the nursing unit we saw people were offered a clear choice of meals at lunch time and one person we spoke with on the nursing unit said, "I'm diabetic but I get a choice of foods". They told us staff asked them their choices before meal times and these lists we saw were used by staff. We saw one person on 17 December wait 30 minutes for their meal.

Meal time on the dementia unit we found was not as relaxed and we observed a delay in serving lunches to a number of people. People were sat down up to thirty minutes before the meal arrived this leading to people being visibly anxious. We saw one person pulling the plate with another person's meal on as they did not have their meal. We saw another person leave the dining table after waiting and not receiving their meal (within fifteen minutes), and the same person was seen to refuse all food after that experience when asked by staff. This person was assessed by the provider as needing a fortified diet which indicated concerns regarding their diet. We saw staff tried to support people in a timely way but were not always able to respond as they were busy supporting other people. We saw a person became anxious and saying, "I want some more to eat" with a 10-minute delay before being given a pudding.

People were not consistently supported to make choices with what they wanted to eat. For example, as staff asked people their choice of meal the day before, people on the dementia unit may have forgotten their choice before the meal time. Despite this their meals were plated up and given to them without showing them their meal, offering a choice, allowing them sensory stimulation, and checking it was still what they wanted. One person when asked what they were having for lunch told us, "I don't know, whatever I get". We saw people had no choice of puddings offered beyond the consistency people had dependent on the ability to swallow.

Records showed that on 18 December 2108, 27 people on the dementia unit were not reaching their identified optimum fluid intake targets as assessed by the provider. A nurse told us this was due to being

short staffed, and confirmed six people reached their optimum fluid level target and twenty-seven did not. We saw on the 19 December 2018 there were systems in place where nurses and the registered manager reviewed people's fluid intakes at 11am in a daily management meeting. We observed this meeting and saw the manager was robust in making her expectations clear as to those people that needed encouragement with fluid intake for the rest of the day. Management of fluid intake we saw was more consistently managed on the nursing unit and people we spoke with felt they were given drinks when wished.

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 understood the need to seek consent from people prior to supporting them, and we saw they put this into practice, asking people for their consent before providing care. We found the provider was acting in accordance with the MCA. Records we saw confirmed where they may need assistance to make decisions, and who should be involved in this decision-making process so the person's 'best interests' were considered.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity and there were any restrictions we saw a DoLS was now in place or had been applied for with the local authority. We did find though that people's capacity assessments accompanied the DoLS but these were not decision specific. Good practice would identify domains where capacity may vary and they may be able to make some decisions, but not others. This is of importance where someone's rights and dignity are affected by restrictions placed upon them, for example with the use of bedrails.

While not all staff we spoke with were aware when asked who was subject to a DoLS a nurse showed us a list of people in the nurse station and when checked this was up to date. Staff we spoke with could explain to us what the MCA meant in terms of their gaining people's consent and we saw numerous occasions where staff gained people's consent, for example prior to giving medicines or offering personal care. This indicated an improvement in staff knowledge since our previous inspection.

We found assessments of people's needs were in place. These records contained information about people's needs, choices and reference in some instances to reasonable adjustments that may be needed due to any personal characteristics protected by law, for example age, gender, race, sexuality and disability. Some assessments we looked at we found sensitively detailed people's requirements and in some instances, it was apparent that staff have taken time to identify these preferences and record them. A visiting professional told us, "They are good in terms of assessment and help deciding what [person] needs". This was not consistent in all records we looked out though and five staff told us that if people's life histories were better recorded they would have a better understanding of the person. We found for some people with dementia and anxiety their specific needs in relation to their dementia and how challenges to staff were to be managed were not clear. For example, there was no information as what may be the precedent to a person challenging staff, and no clear direction as to appropriate strategies that would reflect the behaviour management training (NAPPI) staff had received.

Staff gave us differing accounts of how to manage challenges from one person. Some of the staff we spoke with told us that three to four staff were involved in the management of a person's challenges, which did not reflect the low arousal approach (NAPPI) training they had received. A senior manager acknowledged that behaviour management training in isolation was possibly not effective and they were looking to train staff to

train others and enable them to draw up effective behaviour management plans for people, and evaluate incidents to inform this approach. In addition, this would allow training for agency nurses that were booked to work at the home for extended periods, as at the time of the inspection they told us they had not received NAPPI training. There remains the potential of harm to people or staff from inappropriate responses to challenges to staff. A number of staff told us they had suffered injuries due to people's responses when anxious.

At this inspection we received mixed views whether staff were well trained. One person told us, "Staff are trained OK, the staff are lovely" but "A lot of agency who don't know what to do, I have to explain". The provider told us how they had been making a concerted effort to reduce the number of agency staff used and when using agency nurses was block booking them so they were familiar with people who lived at the home. We did see records that clearly showed a reduction in the use of agency hours since our last inspection. A relative told us they thought staff were well trained as, "Notice they look after [their loved one]", a second relative telling us, "Staff are great they look after [their loved one] well". Staff we spoke with were happy with the level of training they received although some had concerns that some staff had 'failed' moving and handling training. We saw this was identified on the training record. We spoke with the member of staff who trained staff in moving and handling and they told us they had further sessions planned, with some training taking place on the second day of our inspection. We saw from the provider's training record that staff had received training in several core areas of competence, and where they had not completed this training it was in most instances assigned a due date.

We spoke with some newer members of staff who told us they completed an induction to ensure they had the knowledge required to support people. One member of staff said, "The first day I shadowed some of the staff, finding out where things were, getting to know people and their needs. This continued for three weeks". They added they were allocated training as well. Staff who were new confirmed they were required to complete the care certificate which is a set of standards aimed at developing staff's skills and knowledge enabling them to provide safe care to people.

Staff shared mix views about how well they felt supported. One member of staff said, "I have only got to ask and will get help", another that, "No support from managers, staff don't feel listened to. Not happy". We saw staff did have planned one to one meetings and appraisals with the line manager to discuss their role and any training needs and some staff were positive about this been recommenced, where as some others saw their one to one as a means of the manager telling them what they had done wrong. The operational lead confirmed clinical supervision had been put into place more recently for all clinical staff, and training needs re assessed. We were informed that dementia training and management of violence and aggression was in the process of being delivered to staff.

We found improvement was need in the environment for people living at the home. We found the nursing unit met the physical needs of the people who lived there and was pleasantly decorated throughout. However, the dementia unit needed attention though as there was in places limited light (although some lights were seen to be switched off), damaged décor, some stained furniture and a need for more signage to help people living with dementia to navigate the building and find their bedroom for example. We saw that memory boxes were fitted outside people's bedroom doors (these to contain items of significance to the individual) but very few contained anything. The provider was aware of the need to redecorate the dementia unit and said this was agreed and would be completed, with plans to physically divide the units so that there were four as opposed to two. They also told us they were considering moving the dementia unit downstairs so that people living with dementia, where mobile, would be able to access the enclosed garden area.

People we spoke with told us they had access to external professionals such as opticians and doctors. One

person told us, "I had my eye operation done here, they were really good, my eyes are so much better now. I see a GP when I need one. Dentist visits and sorts my teeth. Opticians come in and update my glasses". A relative told us if needed staff will, "Phone the GP, as for the optician [the person] would not wear glasses and a dentist would cause distress "but added staff would call professionals in if needed. Another relation told us their loved one, "Should have had their hearing checked two years ago". We checked and found they had recently been referred to hearing services. We saw people's records showed appropriate contact with health professionals although the registered manager made us aware one person had developed a pressure ulcer. There was no recorded evidence of this wound in the person's records before it was reported by the registered manager to a health care professional and local authority safeguarding. The registered manager told us they were unsure that everything may have been done to avoid this injury and was following their duty of candour. After the registered manager had reported the injury we saw an appropriate wound management plan was in place, treatment commenced, and a referral made to the tissue viability nurse.

Requires Improvement

Is the service caring?

Our findings

Our last inspection report for Bentley Court was published on 13 September 2018 at which point we rated this key question as 'requires improvement'. This was due to the care people received presenting as task focussed and people's privacy and dignity being compromised on occasions. At this latest inspection we found these concerns remained and this key question remains 'requires improvement'.

We found the provider had failed to ensure people always had care that was appropriate, met their needs and reflected their individual preferences. For example, we found one person had brown detritus under their long nails which looked like faeces. Another person's relatives told us their loved ones, "Nails, need cutting, hair needs cutting and is not receiving personalised care, small things that make them decent". These concerns reflected a complaint brought to our attention by Wolverhampton City Council on 05 September 2018. A social worker had been advised by the person's relatives that their feet were often dirty and they could be left to walk in bare feet, as well as dirty fingernails.

One person's communication plan stated that they were hard of hearing in one ear and used a hearing aid. A relative told us they had told staff the person's hearing aid was missing. We asked staff if they could find this hearing aid and a nurse confirmed it was missing, as we saw the person was not wearing it. The Registered Manager told us that the person was reluctant to wear their hearing aid, and was having ear drops in too soften a build-up of wax, and therefore the lack of a hearing aid was not a critical issue. We looked at the person's care records and these had not captured the information the Registered Manager had told us about the person's preferences in respect of their hearing aid and treatment. The person's care records stated their hearing aid as lost on 03 October 2018, and the GP had been contacted to make a referral for a new aid the same day, although there was no record staff had the chased the progress of this referral. In addition, we found the person's spectacles could not be found. The relative told us these spectacles had been missing for a year and their loved one should have been due a hearing test two years ago. There is therefore a risk that the person may be more isolated due to poor hearing and sight as well as dementia and not all reasonable steps had not been taken to address this.

One person was not able to speak in English. We saw this was recorded in the person's communication plan and confirmed by Staff. Staff said they had access to key terms in the person's first language (which we saw on a wall chart accessible to staff) but they still found communication with the person difficult. The Registered Manager confirmed there were two staff that spoke the person's language and could communicate with the person. The person's communication plan stated the staff speaking the person's first language should be utilised when on duty to communicate with them. There were only two staff employed that could speak the person's language so it would not be possible to use them over a 24- hour period, seven days a week as staff confirmed when asked. The provider informed us after our inspection that there was some joint working with the family to meet this person's communication needs. Steps to ensure this person's communication needs were met still needed review.

We saw a person was attempting to stand and we saw a member of staff was, when they stood putting their hands gently on their shoulders to encourage them to sit and directing them to sit. The person was

identified at risk of falls, and records showed the person had fallen eight times since the 17 September 2018. The person was indicating that they wished to stand and the member of staff still encouraged the person to sit, not considering why they wished to stand. After ten minutes another member of staff spoke with the person and identified they wanted the toilet, at which point they took them. The person's wishes were not immediately considered or understood and there was a delay in the person been taken to the toilet in accordance with their wish. This may have led to discomfort or potentially incontinence that was avoidable.

A member of staff, on the second day of our inspection, told us that a person was incontinent in the lounge. The member of staff said to us as they were assisting other people they did not have time to change the person at that time. We saw the person was sat in the lounge and had a lap blanket on, so we could not see any visual signs they had been incontinent but there was a 30-minute delay before another, different member of staff came in to the lounge and took the person to their room to be changed. In addition, a staff member told us on the same day they were unable to get a person up as they did not have any of her clothing to hand as it was in the laundry. They told us they would have to wait for the laundry assistant to bring them down as they did not have the time to collect them This meant a person needs and preferences were not attended to promptly.

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

Despite our concerns with the consistency of the staff approach we did hear some people felt staff respected them and were kind and caring. One person told us," I get wonderful care, I love it here". Another person said, "Lovely here, they treat me really well, like friends, they always ask how you am. They (staff) do everything for me". We heard positive comments from people and relatives about staff on the nursing unit. A relative told us the staff, "Are a lovely bunch of girls. They are polite and kind". With another relative telling us, "They are a great, caring, look after (their loved one) very well, friendly will do anything for them"." This reflected what some staff told us about how important ensuring people received the right care was to them. We saw staff on several occasions were clearly trying to provide people with dignified care. We saw staff respected people's privacy, by knocking on people's doors and asking their permission before entering their room. While there were several people we saw with doors open those we asked confirmed they preferred them open when in their room.

People told us where able they could maintain some independence. One person told us, "They (staff) know what I can do for myself and only help with what I can't do". Staff were aware of the need to encourage people's independence, on telling us, "If they can do it we let them".

We heard from people and visitors that there were no restrictions of visiting except for protected meal times. One relative told us, "There is no restriction on visiting and you can get a drink". Another relative told us, "Family visit every day, take turns, big family". We saw people could see their visitors where they wished, and there were communal rooms available on both floors as well as people's own rooms if privacy was needed. The registered manager told us that where people need support, for example with making complex decisions they had been allocated an advocate, and we saw documented evidence that people had accessed advocacy services when needed. An Advocate is a person that would represent the views of the person on their behalf to others.

Requires Improvement

Is the service responsive?

Our findings

Our last inspection report for Bentley Court was published on 13 September 2018 at which point we rated this key question as 'requires improvement'. This was due to us finding that people had mixed views about whether they were involved in their care, and some commented there was a lack of activities. At this latest inspection we found there were still areas of concerns and this key question remains 'requires improvement'.

We found that the provider was not always compliant with the Accessible Information Standards (AIS) and how this should be implemented. The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. We found systems to support effective communication so people could express their preferences at any given time were not always robust. For example, we saw there were people who could not always communicate with staff due to language barriers, some people were hard of hearing and may need communication that used different sensory prompts. We saw the dementia unit had a board in the dining area where there could be display visual prompt as to what was available for meals, but we saw this was not used by staff.

People's views about their involvement in the planning or review of their care, was mixed. People on the nursing unit were positive about their involvement. One person told us they did not recall seeing their records, but their care was as they wished it to be so was happy. Another person was happy with their involvement and said, "I decided how I wanted my bed, they put things how I like them. They meet my needs, no problems". A relative told us they had been involved in their loved one's care and staff," Keep up to date on the phone straight away" and "Happy with the care they get". Another relative (of a person on the dementia unit) told us their loved one, "Does not receive personalised care" and "Don't feel listened too, no one talks to us, there is no handover".

We found some people's records did not always reflect people's current care, for example, we found there was no care plan for a person's psychological needs, which would be relevant when the person had advanced dementia and could not communicate their needs. We did ask the nurse if there was a plan in place and their comment was that the person had no psychological needs. In addition, there was no record of care reviews and no information under the relative's comments section although we were aware they visited frequently. We did hear from one relation though that. "I'm part of reviews, regular involvement". We also saw a few social workers visited during the inspection to review people's care and both people and relatives were involved. We also saw some care plans where set goals had been achieved through the care and liaison between health professionals and the nurses at the home. We saw one person's plan demonstrated staff had taken time to find out their preferences and record them, with details in their plan personalised. Some staff on the dementia unit told us that the lack of life histories for some people meant they felt they had limited knowledge of some people.

Staff had differing views on how useful staff handovers to share information were. Some staff told us the team leader did the allocations for staff at the start of their shift and would update them of any current issues on the units. Another member of staff told us the handover used to involve all staff but had changed

and they felt they were getting minimal information. We observed a 'flash' meeting, these held every day at 11am with the registered manager and all heads of units. We saw there was a good exchange of information at this meeting, for example the registered manager checked on the current fluid intake for people and directed which people needed to be encouraged to drink. We were also made aware of 'safety huddles' that would be held with staff on the units to share key information on shift changes and we saw some evidence of these taking place.

We saw activities co-ordinators were employed for organising events and pastimes for people who lived at the home. We saw that group activities were advertised on a board in the units, these changed daily. One activities co-ordinator said on the dementia unit they provided, "Activities spontaneously due to need" which fitted better with people's choices when living with dementia. One person told us, "I do go to shows sometimes" and, "There are church services if I want them". In contrast a relative told us their loved one, "Used to go to church but no services here". We saw a theatre visit on one day of our inspection on the nursing unit and people were really engaged, with people from the dementia unit coming downstairs to attend. We were made aware there were planned communal events coming up over Christmas. Some people we spoke with told us they preferred not to join in activities, and liked to remain in their bedroom, but were clear this was a choice. One person told us, "I don't join in activities, I enjoy watching the TV". Another person said, "I do go out, but I prefer to stop in my room". We saw an activities co-ordinator encouraging people on the dementia unit to engage with activities, but said it was difficult at times as they did not have staff to support them, as care staff were so busy. Another activities co-ordinator said, "Need more staff to do physio etc. to get people back on their feet. Need more staff, has improved, but needs more". We saw people on the dementia unit did not always have varied stimulation. For example, we saw one person whose records said they liked to socially mix was on bedrest. Although they had their TV on and a DVD playing this was seen to be repeated numerous times. The registered manager did tell us that the person was awaiting an adapted wheelchair that would allow them to take the person into the communal areas safely.

There was information about how to make a complaint or provide feedback about the service available in the reception area of the home. One relative told us, "I get frustrated as I'm not listened too", and "It's no good complaining". Other people were positive about their ability to complain and be listened to though. One person said, "No concerns but I would go to manager if I did", another, "Registered manager listens to me". One relative told us the (registered manager), "Will sort out any issues straight away", another "Never complained before, but would speak to (registered manager) if needed and confident they would sort". We saw any complaints and feedback from people or relatives were recorded and investigated to allow an appropriate response, and inform development of the service. We were also made aware by relatives that there were meetings where they could raise any issues if they wanted. At the time of the inspection we saw there was no complaints tracker in place to assist with the monitoring of any themes from complaints. The registered manager however completed one and sent it to us the day after our inspection.

We looked at how the provider managed end of life care. We found decisions about whether people should be resuscitated following a cardiac arrest (DNARCPR) were in place where this was what the person wanted or in their best interests. Where people wanted to engage in discussions about end of life arrangements, we saw the person or their representative had been involved in the discussion with health professions. Planning for end of life care we did find varied however. One person's records, where they were identified as end of life care did determine preferred place of death but there was no information as to wishes/preferences or practical details about their end of life care whilst receiving care. A relative told us the staff, "Have spoken to us about advance wishes". We did see that systems for monitoring levels of pain were in place for people that may not be able to clearly communicate how they were feeling, these were using recognised pain scales.

Inadequate

Is the service well-led?

Our findings

Our last inspection report for Bentley Court was published on 13 September 2018 at which point we rated this key question as 'requires improvement'. This was due to the provider, despite having quality systems in place, not being able to sustain and embed the improvements made. At this latest inspection we found the breach of the law had not been addressed and there were still areas of concern. This key question is now 'inadequate'

At this inspection we found the provider has been unable to implement sustainable improvements to the care and support people receive. Whilst the home had a registered manager they informed us they had given in their notice and were leaving the provider's employment the same week we completed our inspection. The provider shared their concerns in respect of the registered manager leaving and told us of contingency plans in place, which they have continued to update since the inspection. This has involved bringing a manager from another service to oversee the home with regular support from senior managers and quality improvement officers.

While we saw that the provider had a quality monitoring system in place due to management changes, lack of oversight and inconsistent leadership issues identified were not robustly addressed leading to repeats of concerns or on occasion not identified at all. This posed a risk to the quality of care people received. Not all improvements identified at the time of the last inspection had been actioned or maintained as demonstrated by the following examples.

The provider had identified improvements were needed to how agency staff were inducted as we saw in quality documentation which stated this matter had been addressed. We spoke with an agency nurse who was working at the home on the second day of inspection, this the first time they had worked at the home. They told us they had received no induction and had been, "Dropped in the deep end'. They said they had been asked to complete the medicines round on the dementia unit but were worried as they knew none of the people and were concerned about making a medicines error and the potential impact this may have for them as a registered nurse. They said they had asked for a member of staff to assist them to help ensure they identified the correct person and they said they were told by another nurse that this was not possible as they were short staffed. The nurse was seen asking other staff for help due to her concerns. We had to raise this issue so the nurse could be given an induction and receive support with medicines from a permanent staff member.

Three notifications we had received from the provider since June 2018 had told us about medicines errors agency nurses had made. On these occasions there was no harm to any person due to these errors and action was taken to ensure there were no repeat, for example asking the agency only to send nurses familiar with Bentley Court. This meant the provider was aware of the potential risks of agency nurses completing medicines administration when new to the service and without support and induction. The quality audit for November 2018 stated that 'agency inductions are not always completed, staff on duty are responsible for ensuring that the induction is fully complete before they start their shift' and 'agency nurse inductions to contain the extra medication induction sheet'. This was stated to have been addressed by 7 December. The

provider was made aware of these concerns and we were told the nurse should have received an induction at the point they commenced their shift.

On 17 December 2018 at 16.00 we identified that the call bells were not audible in the dining room on the dementia unit. We raised this with the provider on the same day and it was stated that this was due to the call bells been on a night setting which was lower so as not to wake people at night. We were assured at this time the calls bells would be switched to a louder day setting when communal rooms were in use in the day from that point on. On the 19 December 2019 we checked that the call bells were audible in the same dining room and found they were not. The call bells were checked and we were told they were on the night setting again. When checked later in the day they were found to be audible. Despite reassurances given to us on the 17 December 2018 by the provider these checks had not ensured risks of staff not responding to the call bell, due to it been inaudible had been addressed. This did mean that there was a risk of staff not hearing the call bell should they be in areas of the home where it was not audible with a potential delay in their response to people.

The provider's systems for oversight of how effective incident management was, and related training failed to identify concerns. Staff told us there were occasions where people received intervention from three to four staff when they were challenged by their behaviour. Staff told us they had received injuries and this number of staff was needed for some people due to concerns they had about their personal safety. This was not in line with the low arousal intervention approach that staff had been trained in. This showed the effectiveness of behaviour management training in actual practice situations, with staff involved in appropriate support and feedback was not in accordance with best practice guidance. The provider told us that they were looking to train some staff in behaviour management so they could train others in the work place and help develop systems to ensure appropriate intervention for people that challenged staff.

Systems were not always in place to identify risks to people living at the home. Staff at the home had failed to identify the early signs of sore skin from pressure for one-person. Staff should have had the time to detect redness of skin whilst providing personal care support for this person. The delay in identifying the early signs meant the person now had a pressure sore that needed treatment. We also found that records did not reflect people's current needs, for example, we found some people's fall records were not updated after falls and there was no clear directions as to how changes in risk to people would be mitigated.

Our previous inspection in July 2018 identified the provider was reviewing the layout of the units to improve the quality of care people received. The provider responded quickly at this previous inspection regarding our concerns regarding staffing levels and said they would also look to divide the two units in the home to four, to assist with staff deployment. At this latest inspection the provider had divided staff teams to work as four teams but due to no physical separation on the units this had limited the success of these changes. The provider told us these changes were to happen, but work had not progressed since our previous inspection and to date we have no confirmed timescales. We also found continued issues with staff deployment impacting on the quality and safety of care

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with and visitors knew who the registered manager was and felt they were approachable. One person said, "The [Registered manager] is lovely, she pops in for a chat sometimes". A visitor told us, "Relatives meeting are regular, 15-20 relatives, really good". We had mixed views from staff about management. Some said that staff morale was very low due to the high dependency of people, a lack of perceived support from managers, not feeling listened to or appreciated. Other staff told us the registered

manager, "Would listen, approachable, dedicated and committed and will work the floor". Another member of staff said, "I'm happy, I really rate [the registered manager].". Most staff were however positive about teamwork within their staff teams. We received positive comments from nursing staff regarding the visibility and presence of the registered manager on the floor and her empathy and approachability.

We spoke with the providers clinical training lead and they told us they were looking at working more with the nursing staff to develop their accountabilities and take on more responsibility for responding to areas that needed improvement. We saw that nurses were carrying out and taking part in 'Quality walk round' audits that look at a variety of care and management issues via a set audit form. Another senior manager also told us how they were looking at their employment terms and conditions for nursing staff to try to encourage recruitment so they could maintain a more stable nursing team.

The staff we spoke with said they felt able to raise any issues with the registered manager or seniors and were aware of how to 'whistle-blow'. A 'whistle-blower' is a person who informs on a person or organization who may be regarded as engaging in an unlawful or immoral activity.

The registered manager told us they looked to work with other agencies, this included for example, social workers, and agencies to build on partnership working to support best practice. We saw some improvements had been made following the involvement of other professionals and a visiting professional told us the management and staff were responsive to comments they raised. We also saw that there had been links with other organisations such as the King's fund who had completed an audit on the dementia unit.

The registered manager and provider were aware of their legal responsibilities, for example submitting notifications in respect of any incidents to CQC. They were also aware of their duty of candour. The registered manager and provider were open about areas where they felt the service needed to improve. The law requires the provider to display the previous rating for the service and we saw this was on clear display in the home and on the provider's website.