# Signature of Hertford (Operations) Limited

# Bentley House

## Inspection report

Bentley House
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Hertford
Hertfordshire
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Tel: 01992515600

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14 December 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Bentley House is registered to provide accommodation, nursing and personal care to a maximum of 90 people. At the time of the inspection 43 people were using the service.

We carried out an unannounced comprehensive inspection of this service on 18 July 2016 where two breaches of legal requirements were found. These were in relation to shortfalls in medicine management, incident management and record keeping. The provider wrote to us on 08 September 2016 to say what they would do to meet legal requirements in relation to the identified shortfalls.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bentley House on our website at www.cqc.org.uk.

The registered manager had left their post since our previous inspection and the home was being managed on an interim basis by a member of the provider's senior management team. The interim manager had submitted an application to register with CQC whilst a suitable candidate was recruited for the post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe living at Bentley House. Staff understood how to keep people safe and risks to people's safety and well-being were identified and managed. The home was calm and people's needs were met in a timely manner by sufficient numbers of skilled and experienced staff. The provider operated robust recruitment processes which helped to ensure that staff employed to provide care and support for people were fit to do so. People's medicines were managed safely.

The provider had arrangements to receive feedback from people who used the service, their relatives, external stakeholders and staff members about the services provided. People were confident to raise anything that concerned them with staff or management and were satisfied that they would be listened to.

People's records were kept up to date and reflected their current care needs. There was an open and respectful culture in the home and relatives and staff were comfortable to speak with the manager if they had a concern. The provider had arrangements to regularly monitor health and safety and the quality of the care and support provided for people who used the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

We found that action had been taken to improve safety.

People's medicines were managed safely.

Accidents and incidents were responded to in a timely manner and were promptly investigated to help keep people safe.

People told us they felt safe living at Bentley House and staff were aware of how to identify and report any suspicion of abuse.

People's care was provided by sufficient numbers of safely recruited skilled and experienced staff.

### Is the service well-led?

Good

The service was well-led.

We found that action had been taken to improve management and governance systems.

Systems were effective in assessing and reviewing the quality of care people received and mitigating identified risks to people's safety and welfare.

Records relating to people's care were accurately maintained and updated on a live electronic system.

People praised the provider and management team for the significant improvements that had been made in terms of recruitment and management systems.

The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

# Bentley House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was done to check that improvements had been made to meet legal requirements planned by the provider following our comprehensive inspection on 18 July 2016. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? This is because the service had not met some legal requirements.

We undertook an unannounced focused inspection of Bentley House on 14 December 2016. The inspection was undertaken by one inspector.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We reviewed the provider information return (PIR) submitted to us in August 2016. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make. We also reviewed the provider's action plan that had been sent to us on 08 September 2016 to say what they would do to meet legal requirements in relation to the identified shortfalls.

During our inspection we spoke with three people who used the service, six staff members, the interim manager and a representative of the provider.

We reviewed care records on the electronic monitoring system and other documents central to people's health and well-being. These included staff training records, medicine administration records and quality audits.

Good

# Is the service safe?

## Our findings

At our previous inspection at Bentley House in July 2016 we had found that the service was not always safe and that some improvements had been required in relation to medicines management and incident reporting. We had found that staff had not followed best practice guidance when medicines were opened as they had not always recorded dates on boxes and reconciled medicines regularly. We had found gaps in the medicine administration records (MAR) and discrepancies with the remaining stocks held.

At this inspection we checked a random sample of boxed medicines for five people who lived at Bentley House. We noted that staff had recorded the date when boxed medicines were opened which helped them to reconcile the medicines held at the home. We found that people had received their medicines in accordance with the prescriber's instructions however; we saw one example where a person's tablets did not tally with the records.

The manager conducted an immediate investigation which identified that a recording error had been made the day before the inspection by an agency staff member and an incident form was raised. The error had not been identified by the permanent staff member who was the signatory for the day of this inspection because they had failed to reconcile the box of tablets. The manager confirmed to us the following day that this error had been managed in line with the organisation's standard procedure which meant that they had informed the agency of this medicine administration error as well as having arranged to have a conversation with the staff member when they were next on duty. The manager also confirmed that the permanent staff member had this error noted within their medical competency file in order to monitor trends regarding errors across the staff team to help identify who may need further support and training going forward.

The medicine administration records (MAR) had been completed to reflect when people had been given their medicines. We also noted that staff members had recorded the number of tablets administered for people when they had been prescribed a variable dose so that it was clear how much medicine had been administered. People's medicines were stored safely in lockable cabinets within their rooms. Staff had received training to give them the skills and knowledge to administer medicines safely and this was refreshed regularly and also in the event that an error was identified.

People told us that they felt safe living at Bentley House. A person who used the service told us, "Oh yes I feel safe, they look after us well." A relative of a person who received care and support from the staff team said, "I used to be so anxious when I left my [relative] here. However I now feel that they are safe and loved."

Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Staff described to us how they would report any concerns to their line management and said that they were confident that they would always listen to their concerns and do the right thing. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike. When prompted staff told us that they were aware that they could report externally to CQC but we found that the staff we spoke with lacked awareness that the local authority safeguarding team were the lead in adult safeguarding matters.

We discussed this with the manager who undertook to refresh this area of knowledge with the staff team. This showed us that the provider had taken the necessary steps to help ensure that people were protected from abuse and avoidable harm.

We saw that potential risks to people's health and well-being had been assessed and reviewed regularly to take account of their changing needs and circumstances and were clearly flagged on the electronic care planning system. Detail of the risks also appeared on the healthcare assistant handheld devices so that they were always aware of people's risks and how to mitigate them. Risk assessments were in place for such areas as allergies, falls, moving and handling and choking. These assessments were detailed and identified potential risks to people's safety and detailed the controls in place to mitigate risk.

Staff had a good knowledge of the people they supported which meant that risks to their safety were known and understood by staff. For example one staff member told us, "[Person] is prone to falls especially at night time so they have a pressure mat by their bed which alerts us if they get out of bed. This means we can be there to support them safely and help prevent them from falling and injuring themselves."

The care manager told us that if people experienced frequent falls, this was reported to the care manager and further explored to see if there was a pattern identified for example in relation to medicines, the time of day or the location of the fall. The falls clinic and the person's GP were then contacted as a matter of routine.

People, their relatives and staff all told us that there were enough staff members available to meet people's needs. Throughout the course of the inspection we noted that there was a calm atmosphere in all areas of the home and that people received their care and support when they needed it and wanted it. Staff were observed to go about their duties in a calm and organised way. They told us that permanently recruited staff numbers had been increased which had reduced the need for agency staff cover which had a positive impact on the standard of care delivered.

Safe and effective recruitment practices were followed to help ensure that all staff were of good character and suitable for the roles they performed at the service. A recently recruited staff member confirmed that they had a face to face interview and had not been able to start to work at the home until satisfactory references and criminal record checks had been received. This showed us that the provider had the correct processes in place to help ensure that people were supported by staff who were safe to work with vulnerable adults.

A person who used the service visited the care manager's office to tell them that they had seen the head of recruitment and told them that they done such a good job in recruiting some lovely staff. The person told us, "The staff are loving and caring, they are an exceptional crew of people."

Good

# Is the service well-led?

## Our findings

The registered manager had resigned their post since our previous inspection and the home was being managed on an interim basis by a member of the provider's senior management team. The interim manager had submitted an application to register with CQC whilst a suitable candidate was recruited for the post.

At our previous inspection at Bentley House in July 2016 we had found that improvements were needed to ensure that people's records were accurately maintained and that incidents were fully investigated and reported to the Care Quality Commission when required.

The manager told us of an 'incident reporting day' that had been held with the managers to support them to understand the importance of reporting incidents. The manager said this had involved a culture change within the staff team because they had previously been wary to fill in incident reports as they felt blame would be apportioned. The manager reported that there had been an increase in incident reports and said, "Every incident is a learning opportunity for the team". For example, when a person had a fall the process was to investigate the cause and explore what actions may be needed to be put in place to help prevent recurrence. The manager said that staff then reviewed the incident at an agreed later date to check that the right action had been taken and had been effective.

Incidents were reported to the provider monthly in a governance report. For example, in the October 2016 report we noted that a person had been administered an incorrect supplement. The staff member was suspended from administering medicines pending a competency check and a safeguarding alert had been completed. This showed that the management team had clear processes in place to manage incidents.

We were given an example where a relative had reported to a healthcare assistant that they had witnessed some inappropriate moving and handling practice. The healthcare assistant escalated this concern to the management team by means of an incident form. The outcome of this was that the moving and handling lead provided additional training for the staff member within a couple of days of this incident and feedback was provided to the relative who had initially raised the concern.
Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The service had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.
This showed us that incidents were managed effectively for the safety and wellbeing of people who used the service.

The manager told us that a large piece of work had been done on care planning. The service used an electronic system of care planning which was updated by the healthcare assistants at the point of care delivery. Each staff member carried a handheld device which enabled them to access people's care records wherever they were in the home and to update the system to reflect when people's needs had been met. Previously the management of these processes had not always been robust. The manager explained that now the residential care manager or nursing care manager were responsible for ensuring that any red flags showing on the system were explored. For example, a person had refused assistance from staff with cleaning

their teeth in the morning. The red flag reminded care staff to revisit the person later in the day to see if they were open to being supported to clean their teeth. The care manager had a continuous overview of the system so they were able to see if anybody's care needs were overdue.

Food and fluid charts were identified by an icon on the handset. When a person was identified as being at risk of poor nutrition or hydration it was flagged up on the handsets and the front sheet of the person's care plan. Care staff were prompted by the electronic system to update when food or fluids were consumed and any recording shortfalls were flagged up electronically and explored by the care manager. This meant that people's care records had been maintained accurately and when their needs changed.

The provider's monitoring visits had become more robust since the previous inspection. For example, we reviewed the report from a provider visit undertaken in October 2016. The quality of the service provision was assessed in line with CQC key lines of enquiry and the October report focused on the responsive and well-led domains. We noted that people who used the service were asked their views and various documents and systems were reviewed. A number of action points were identified and passed to the home manager for completion to be reviewed at the next provider visit.

The manager maintained a calendar that indicated a schedule of audits to be undertaken at regular intervals throughout the year. These included audits of such areas as activities, staff training, supervision and appraisals, health and safety, infection control and the environment. The manager reported that daily random checks were undertaken looking for gaps in medicine administration records and checking the numbers of tablets tallied with the medicine administration records. The manager reported that there was a monthly random care plan check undertaken for five people to confirm that the care plans continued to meet people's needs in terms of such areas as religion, nutrition, hydration and general care needs. The manager said that this was a positive process because it helped to pick up trends and gave them an overview of how people's care was being managed. This showed us that the provider and management team had taken the necessary steps to help ensure that people's care needs were kept up to date by use of the live system.

The manager was supported by a large management team which included a care services manager, nursing manager, residential manager, dementia manager, HR manager and restaurant manager who all provided additional managerial oversight in their area of responsibility. The manager reported that a number of lead roles had been created since they had been in post; these included such areas as infection control, electronic system, moving and handling, environmental cleaning and safeguarding. This meant that named people had the responsibility for providing support and cascading learning and knowledge in these areas as well as keeping an overview of the home's performance in these areas and reporting to the manager. For example an infection control audit of the home had been undertaken in November 2016 by an external organisation, the service had achieved a compliance score of 97 %.

The manager was visible within the service and people told us they were approachable and listened to them. A person who used the service told us that there had been a meeting with the directors, some people who used the service and their relatives subsequent to our previous inspection. They told that this had been a difficult meeting, but that people were a great deal happier now. The person told us, "There have been massive improvements since the previous inspection. It is a really, really good place now, the group should be proud."

Staff were also very positive about the manager and told us they felt well supported by the management team. Staff members told us that many improvements have been made since the previous inspection in July 2016. These were in such areas as the recruitment of more staff which meant that less agency staff were

being used and ensuring that documentation was up to date and accurately reflected life in the home.

The manager reported that there was a '10 at 10' meeting held every day where they met with heads of departments and care managers. This meeting pulled forward all aspects of care and support, including restaurant service, housekeeping, activities and care. This helped to ensure that all aspects of people's care and support could be reviewed and any important information could be disseminated to all departments and discussed as needed.

The senior management team were responsive to advice and guidance from external agencies. For example, we mentioned to the quality assurance director that the provider's website did not accurately reflect the management arrangements currently in place in the home. This point was acknowledged and immediately rectified.

The manager promoted a culture of listening to people and looking for ways to improve. They actively encouraged and sought input from people so that they were included in the running of the service. People's feedback was sought in a number of ways including through residents' forum meetings monthly and the distribution of satisfaction surveys. The manager told us of a residents' forum meeting where a person had said, "I never get any meat here." The manager told us that daily meal options had always been provided, however in response to this feedback they had implemented the practice of showing the person plated options to choose from. The manager reported that the person still opted for the non-meat option but that they were now confident that the person was supported to make effective choices. We were also told of feedback from the residents' forum meeting that people wanted the shop to be open for longer hours. This had been arranged and some people had volunteered to assist with running the shop. This showed that the management team listened to people's opinions and encouraged them and supported them to influence how the home was run.

The manager had adopted a robust and positive approach to the management of complaints, concerns and allegations. They told us, "A concern is an opportunity to drive forward improvements." A culture shift had been created within the team so that they could pause to consider why the concern had arisen, what could be done to address the issue and how they could make sure that people would be satisfied with the outcome. All issues were logged with the dates of an acknowledgement being sent, the investigation, the dates of completion and the date that the outcome was given or the letter sent. This showed us that the management team acted responsibly to investigate people's concerns.

The activity manager and client liaison manager were key staff in raising the profile of the home in the local community. The manager reported that there were links with the local theatre and local bridge club and there were plans afoot to create opportunities to draw people from outside the home into Bentley House to be involved in various activities and past times. Children from the local school were due to come into the home to sing carols for the residents.