Bentley House Limited

Bentley House Care Centre

Inspection report

Twenty One Oaks
Bentley
Atherstone
Warwickshire
CV9 2HQ

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

Date of inspection visit:
05 January 2017
11 January 2017

Date of publication:
16 February 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Bentley House on 5 & 11 January 2017. The first day of our inspection visit was unannounced. We returned to the home on the second day to continue our discussions with the manager. Bentley House provides personal and nursing care for up to 50 older people, including people living with dementia. There were 43 people living at the home when we visited the service.

The home was divided into a number of units. One section of the home was named 'The Lawns' and provided accommodation and support for people living with dementia. This area had a separate lounge/diner and conservatory area. Another unit of the home provided accommodation and support for people receiving physiotherapy. This unit had a separate area for physiotherapy sessions. People with nursing needs were provided with accommodation and support over the ground and first floors of the home. There was a large lounge, dining room, and conservatory on the ground floor of the home for all to use.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was not a registered manager in post at the time of our inspection visit. However, a manager was running the home and had applied to be the registered manager. They had been in post since October 2016, and were employed at the service immediately following the previous manager's departure.

At our previous inspection in January 2016 we found medicines management required improvement to ensure people received their prescribed medicines safely and that medicines were stored in accordance with manufacturer's guidelines. At this inspection we found that the provider had made some improvements to the way medicines were managed, but improvements still needed to be made to ensure people received their prescribed medicines safely.

Staff received training in safeguarding adults and understood the correct procedure to follow if they had any concerns about people's safety. All necessary checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there.

There were enough staff employed at the service to care for people safely, although some people told us they waited longer than they would like to receive care during busy times. The manager was reviewing staffing levels to ensure staff were deployed effectively around the home.

Care records were not always kept up to date, however, people were supported by a staff team that knew them well. New staff completed an induction programme when they started work to ensure they had the skills they needed to support people effectively. Staff received refresher training and had their practice observed to check they had the necessary skills to support people. However, some staff practice required

improvement around the administration of medicines.

People were supported with their health needs and had access to a range of healthcare professionals where a need had been identified. People were encouraged to eat a balanced diet that took account of their preferences and nutritional needs. This assisted people to maintain their health.

The manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made some applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA.

People's care was planned with them and the support of their relatives and staff. This helped to ensure care matched people's individual needs, abilities and preferences. A new format of care records was being introduced which were personalised and reflected people's care and support needs. The manager was in the process of improving care records and was incorporating end of life care plans for people.

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

People knew how to make a complaint if they needed to. However, no-one had a made a written complaint in the last twelve months. People who used the service and their relatives were not always given the opportunity to share their views about how the service was run. The manager was implementing feedback systems to encourage more involvement with stakeholders in the running of the service.

Quality assurance procedures were in place to identify where the service needed to make improvements, these included checks of people's care records, medicines administration and staff's practice. Accidents and incidents were also monitored and investigated, to see where actions needed to be taken to improve the service, and to minimise the risk of re-occurrence. However, quality assurance procedures did not always identify where improvements needed to be made. For example, the manager had not identified where medicines administration procedures needed to be changed.

We found there was 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 consistently safe.

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

Is the service effective?

Good

The service was effective.

Staff completed an induction programme when they started work at the home so they had the skills to meet the needs of people there. The manager and staff knew how to support people in line with the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) so that people's rights were protected. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

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

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in

accordance with their interests and hobbies. New versions of care records described the care people needed and how staff should support them, in accordance with their wishes. People were able to raise complaints about the service, and the provider had procedures in place to respond to complaints in the timely way.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

There was not a registered manager in post at the time of our visit, however, the manager had applied to become the registered manager of the home. The management team were approachable and there was a clear management structure to support staff. The manager was accessible to people who used the service, their relatives, and members of staff.

People, their relatives and staff were not always asked for their feedback on how the service was run. Quality assurance procedures did not always identify areas where the service could improve. Where issues had been identified the manager took action to improve the service.

Bentley House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 5 & 11 January 2017. The first day of our inspection was unannounced. This inspection was conducted by two inspectors, a pharmacy inspector and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported this inspection had experience and knowledge in nursing care. The pharmacy inspector looked at how medicines were managed at the service.

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

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

We spoke with six people who lived at the home and three people's visitors or relatives. We spoke with two nurses (one of which was the clinical lead), two care staff, a care supervisor and an activities coordinator. We also spoke with the chef, the manager, the deputy manager and the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records about people's care including ten care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had

consumed. This was to assess whether the care people needed was being provided.

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

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2016, we found medicines management required improvement to ensure people received their prescribed medicines safely and that medicines were stored in accordance with manufacturer's guidelines. At this inspection we found improvements still needed to be made to ensure people received their prescribed medicines safely. A member of the CQC medicines team reviewed the management of medicines, including the Medicine Administration Record (MAR) charts for 11 people during first day of our inspection visit.

Most people told us staff supported them to take medicines if they needed them to. Comments included, "I have to have tablets. Staff help and will ask me, 'Do you want to do this yourself?', but I would rather they [staff] do it", "Staff help me with tablets and eye drops." However, one person said medicines were not always available when they needed them. They said, "This morning I should have had pain relief half an hour before I get out of bed. But the night nurse said it was locked away and they didn't know what time the day nurse would be in so I had to wait." This meant the person was left in pain and were unable to get up, whilst they waited for staff to give them their medicine.

Accurate records of medicines administration were not always kept. Two people were taking medicine that required careful monitoring. It was not possible to tell from the records what dose they received as different doses were recorded for the same administration on the MAR chart and on a separate medicine specific chart. In addition, we found a gap on one person's MAR chart for their antibiotic. There was no staff signature to record the administration of the medicine, or a reason documented to explain why the medicine had not been given. On further investigation we found that the person had not received their medicine.

There was a risk of errors where medicine was prescribed to be taken "when required". There was no information available to staff on why the medicine would be needed, how much to give and when. This meant there was a risk staff did not have enough information about what medicines were prescribed for, or how to give them consistently and safely.

One person had run out of their pain relief medicine and had not received any for twenty days. On 5 January 2017 a prescription had been received for the medicine but the nurse could not tell us why it hadn't been ordered from the GP sooner to ensure the person had their medicine on time.

The service did not ensure that medicines were stored at safe or recommended room temperatures. We found the temperature of the medicines room had reached 31.5 degrees centigrade on the first day of our inspection, exceeding the recommended upper limit of 25 degrees centigrade. A nurse showed us how temperatures were measured and how the thermometer was reset. We found temperatures were not recorded correctly. The measurements being recorded did not include maximum and minimum temperatures of the refrigerator in line with good practice. We were particularly concerned because on the day of the inspection the temperature reading was above the maximum recommended limit for the refrigeration of medicines, and the fridge was being used to store temperature sensitive medicine. In

addition, it was unclear how long the temperature had been out of range for because the thermometer was not being reset daily.

Medicine that had a short expiry date once opened was sometimes dated to ensure that staff knew how long the medicine could be used for. However, we found some medicine that can be kept out of the fridge for 28 days was in a tray in the medicines room and not in the fridge. The medicine had no record of when it was removed from the fridge and so it was not possible to tell if this medicine was still safe to use. We also found some eye drops for another person in another tray that should have been kept in the fridge. We asked a nurse to ensure the medicine was not used and a replacement sought.

There were no body maps or additional information available where care staff applied prescribed creams to people's skin, to show where and how often the creams should be applied to each person. We saw there were no records of when and where creams were applied, which meant we could not be sure people always got their cream as prescribed or as needed. A person's skin condition may not be treated effectively if creams are not applied as the doctor intended. In addition, members of staff that were applying creams, did not have any training or competency checks to administer medicines or apply creams.

Some records for people using medicinal patches showed where the patches were being applied to the body but others were not being filled in. Where the records were filled in, we saw the patches were not being applied and removed in line with the manufacturer's guidance, which could result in unnecessary side effects.

The provider was able to assure us that all nurses administering medicines had completed medicines training within the last year. However, we saw that there was no recent evidence of reporting, shared learning or meaningful action plans in response to medicine errors to help prevent similar errors occurring again.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

All the people we spoke with told us they felt safe at the home. One person said, "Before I came here I was on my own, here I like it because I feel safe."

Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. They explained they would not hesitate to report things to the nurse or manager, who they were confident would act appropriately to protect people. Staff were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. One staff member commented, "One person might be shouting at another, we might notice suspicious marks or bruises for example. I would report that straight away to the nurse in charge."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken.

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff prior to them working at Bentley House. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for so that any disruption to people's care and support was reduced. Staff were given clear information about how each person should be evacuated in the event of fire.

At the time of our inspection visit a re-decoration and refurbishment programme was underway. Several areas of the home were being decorated. Where this was the case, people had been moved temporarily to safe areas of the home to minimise the risks to people's safety.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce those risks. Risk assessments we reviewed in the newest format of care records were detailed, up to date and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. Staff we spoke with had a good understanding of the risks related to each person's care. One member of staff told us, "We know about the risks to people from talking to each other and getting to know people."

In one of the older care records we found the person's risk assessments were not up to date. For example, we saw the person needed to be moved using two members of staff and specialist equipment, however their risk assessments did not reflect the person needed this level of support with their mobility. The manager stated all care records would be reviewed and transferred to the new format by the end of February 2017, we saw on the second day of our inspection visit, this person's care records had been updated.

People gave us mixed feedback about whether there were enough staff available to meet people's care and support needs. People told us there were times when there were not enough staff, and that they had to wait longer than they should to be supported. Comments included, "No [there are not always enough staff]. We could do with more as people have left and haven't been replaced quickly. Some people have to wait a bit to go to the toilet. Not long though", "They could do with more staff. You have to wait a long time to get to the toilet. About half an hour to an hour", "The trouble is, there aren't enough staff. You hang around waiting a lot, especially for the toilet. I sometimes have to wait up to an hour."

Some relatives we spoke with told us there were enough staff. One relative said, "There are always enough staff when we are here." Others did not feel there were always enough staff, with one commenting, "I am not sure there are always enough staff, especially in the morning when everyone is getting up. It can be difficult I think."

We asked staff whether they felt there were enough staff at the home to meet people's needs safely. All the staff told us they felt there were enough care staff. Staff told us they worked together to ensure people did not have to wait for support too long. One staff member said, "Yes, there are enough staff. One day is different to another, but we all muck in so no-one is left." The manager confirmed in the Lawns area where people had a diagnosis of dementia, there was always one member of staff in the area to ensure people were safe.

We observed there were enough staff during our inspection visit to care for people safely. Staff were available to respond to people's requests for assistance. We saw that in addition to the nurses and care staff on shift, there was the manager (who was also a registered nurse) available to cover care duties at the home when needed.

There were a number of different staff roles. Some staff were trained nurses who supported people with nursing needs and assisted people with their medicines. Care staff were assigned to each unit of the home

to provide care and support. In addition to these staffing levels, other staff members worked alongside care staff, such as activities co-ordinators, cleaners and kitchen assistants so that care staff could concentrate on care tasks.

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their needs and their dependency level. The manager had introduced a new tool for each person to establish their dependency levels, which was being implemented at the time of our inspection visit. The tool would assess how much care and support each person required. The provider and manager intended to use this information to ensure staffing numbers were adequate at the home. The manager had already identified that there were specific times of the day where staff were busier than they would like. The deployment of staff was being reviewed, to introduce new shift patterns. This would allow for extra staff to be available at certain times of the day, for example, when people were getting up or going to bed.

We asked the manager about the number of staff vacancies at the home, they told us they currently only had one vacancy on their night shift which they were recruiting to. They added, "We have recently employed several new staff, including staff for team leader positions, the new deputy manager, and the new chef." Where they were short of staff to fill all the rotas at the home the manager used agency staff, who worked alongside experienced members of staff. The provider and manager acknowledged there had been a recent period of time, over the Christmas holidays, where staff were on holiday or had been off due to sickness, which had impacted on the number of agency staff used.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One person said, "Oh yes, there are a few new ones [staff] getting trained today. I think they know what they are doing." A relative told us, "They [staff] know what they are doing. You know [Name] is in good hands."

Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. We spoke with one recently recruited member of care staff. They explained new staff had the opportunity to work with experienced staff who knew people well. They commented, "It's a nice, friendly place. I've had a lot of support."

The provider was introducing a new induction process at the time of our inspection visit. The new induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was following the latest guidance on the standard of induction.

Staff told us the manager encouraged them to keep their training and skills up to date following their induction programme. The manager maintained a record of the training staff attended, so they could identify when staff needed to refresh their skills. Each member of staff received an individual training programme tailored to their specific job role. For example, nurses received specific training in wound management and medicine administration. Nurses were also supported with attaining re-validation with their professional regulator. Although the provider was able to assure us that all nurses administering medicines had completed medicines training within the last year, we found procedures around the administration of medicines still needed to be improved. We have asked the provider to review their training techniques, procedures and auditing around the administration of medicines.

Care staff used their skills effectively to assist people at the home. For example, we saw people being supported to move from wheelchairs to easy chairs in a communal area of the home. Staff used equipment competently to assist people, and used techniques which ensured this was done safely. Staff communicated with people throughout to help them understand what was happening and to prevent people from becoming anxious.

Staff told us they were supported with regular meetings with their manager to discuss their role and any training or development needs. Staff spoke about how they had been supported to undertake nationally recognised qualifications in health and social care so they could be more effective in their roles. One senior staff member told us, "We get lots of training. I have just done 'Train the Trainer' so can now train others in all sorts of things like health and safety, moving and handling."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had reviewed each person's care needs to assess whether people were being deprived of their liberties. Several people had a DoLS in place at the time of our visit which demonstrated the manager had made appropriate assessments in accordance with the MCA. They told us additional applications had been made to the local authority, which were awaiting their authorisation.

People we spoke with told us staff respected their rights to make decisions about their care. People told us staff sought their consent before supporting them to ensure they were happy. Staff told us they had received training in MCA and DoLS so they knew how they should respect people's decisions. One staff member said, "It is partly about giving choices and seeking consent so we don't take over."

We reviewed people's care records to see whether they had a mental capacity assessment and where a person lacked the capacity to make all their own decisions, any decisions made in their 'best interests' had been recorded. We saw people had this paperwork in their care records. The manager was undertaking mental capacity assessments where people could not always make their own decisions. Where people lacked the capacity to make all of their own decisions, the manager was consulting with relevant health professionals and people's representatives to make decisions in people's 'best interests'.

There were a number of dining areas available for people to use. Dining tables were laid with table clothes and cutlery to make the mealtime experience enjoyable. The dining rooms were calm, and there was a relaxed atmosphere. When people arrived in the dining area, they were given a choice of where they wanted to sit, and staff respected this.

People were offered a choice of meal each day. There was a daily menu on display in the dining room, and people were asked before their meal was prepared what they would like to eat. Staff responded quickly where people changed their minds about what they wanted. For example, one person changed their mind about what they wanted to eat once they saw their plated up meal. Staff fetched the person the alternative meal as requested. People told us the food was good, and they could choose what they wanted to eat. One person commented, "The food is excellent. I don't eat poultry, never have. So I ask for something else. At Christmas I asked for something else so they cooked me what I asked for."

Where people needed specialised equipment such as cups, plates and cutlery to help them eat and drink, this was available so people could eat and drink independently. Where people needed support from staff, we saw this was available and that there were enough staff on hand to assist people as required as well as ensure everyone had food and drink in a timely manner.

Food looked and smelt appetising and was well presented. Each person had their own gravy jug for example, with staff supporting people with this where they needed it. Staff ensured everyone had the opportunity to eat at their own pace, and persevered where people did not seem to want their food. For example, one person was tired and sleepy. Staff sat with them and said, "I'll take your dinner back and keep it warm while you wake up a little." Staff ensured they went back to check with the person when they wanted to eat, and found the person was more awake and now wanted to eat.

There was more food available if people wanted it. For example, when one person had finished their meal, a staff member said, "Would you like some more?" When the person said they did, the staff member commented, "Right, let's get you some more then."

People were offered food that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes. The chef told us, "Soft or pureed food is always served in portions, and is not mixed all together, so that it is appetising and people are able to taste each individual element." They added, "We are kept informed of any specialist dietary requirements for people." One person who was on a specialist gluten free diet said, "I get what I would normally get in a café, the food is good."

Over lunchtime, we observed people were offered a verbal choice of drink. Where people did not want any of the choices offered, others were available. For example, one person said they wanted apple juice. A member of staff went to a nearby fridge and found some apple juice which they poured for the person. People were offered drinks and snacks throughout the day in accordance with their needs. We saw people had access to drinks in their bedrooms, in the dining areas and in the lounge areas. This supported people with maintaining their hydration.

Most people told us they were supported to access medical professionals when they needed to. One person said, "The physiotherapist is coming in to see me later today, so I am making a list of the things I want to ask about." However, one person commented, "I can't get to see the Doctor when I want. The nurse always says, 'you're alright as you are'. I am supposed to be seeing the Doctor today. If I do it is a bonus." We brought this to the attention of the manager during our visit who explained the doctor visited the home each week, visiting people as required according to their healthcare needs.

Nursing staff told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, physiotherapist, dietician and dentist where a need had been identified. We found people were referred to see health professionals to address their healthcare needs. People's GP visited the home each Thursday and other health professionals such as the physiotherapist team visited the home daily. We found advice given by health professionals was being followed.

Good

Is the service caring?

Our findings

People told us staff were kind, caring and respectful. Comments included; "The staff are alright. They are really good to us", "They are good staff all round. They are all caring. You get well looked after", "They are wonderful. They really are brilliant. They want to help so much."

Relatives agreed. One told us, "We are very pleased. It is lovely here. The staff are very attentive." Another relative said, "Staff go out of their way. It is a job I could not do but the staff go out of their way to help."

Throughout our inspection we observed positive interactions between people and staff. People appeared comfortable with staff, and we saw staff speaking with people with kindness and respect. A member of staff said, "It [the home] is caring, supportive. Visitors come in and you get to know one another. It is a real family environment."

People told us they were supported to maintain relationships that were important to them. One person said, "My family come to see me often. It is no problem." Relatives told us, "There is never any problem with visiting. We have our own fobs [to get in] so it is fine. The staff are always so welcoming."

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. We saw people and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome.

People told us staff understood the importance of respecting and ensuring people's privacy was maintained. For example, one person commented, "They [staff] knock on the door before they come in." We observed care staff respected people's privacy when entering their rooms. Staff knocked on people's doors and announced themselves before entering. People's care records were kept securely at the home, to protect people's privacy.

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

People told us, and we saw, people's bedrooms were their own personal space, and each one was different. There were ornaments and photographs of family and friends, personal furniture and people had their own pictures on the walls according to their choice. Relatives told us people could make choices about what they wanted. One relative commented, "[Name] has brought their cat in once in a while. They brought all their belongings to their room when they moved in."

People's religious needs were met. One person said, "We have people coming in for prayer on a Sunday." Relatives also commented on this, one saying, "The local vicar comes in. [Relative's name] has had communion too. They cater for Methodist and also Church of England too."

People told us they were supported to do things for themselves. One person commented, "Staff keep an eye on you but they let you get on with it if you can. I can get all the way to the dining room and back with my frame now so I have improved while I've been here."

Some people at the home were nearing the end of their life. The manager had introduced a procedure to consult people about their wishes at this time. In addition, the manager had reviewed end of life care planning and had new care documents in place which were ready to be implemented. The manager planned to have these introduced by the end of February 2017.

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

Good

Is the service responsive?

Our findings

Throughout our inspection visits we saw staff had a friendly approach to people and were responsive. Most people told us staff responded if they asked for something. One person said, "You can ask for things and they get them for you straight away. Like a drink for example." However, other people told us staff's responsiveness depended on the levels of staff available. For example, when people wanted to go to the toilet they sometimes had to wait until staff were available.

We observed staff responded quickly and effectively to support people. For example, one person was calling out to staff and was becoming anxious. Staff were on hand quickly to sit with the person and spoke with them about the day and other things to distract them and help them remain calm. On another occasion we observed one person tell staff their arms were feeling cold. A staff member reassured the person and told them they would fetch them a cardigan. They did so quickly and helped the person put the cardigan on.

People were supported to take part in activities according to their own personal preferences. People spoke positively about activities on offer at the home. One person commented, "We have games, jigsaws, newspapers. I like the old fashioned type of music. Sometimes people come in and perform it for us." We observed one person being assisted to plant bulbs in pots. That person had told us earlier in the day they liked gardening. Others were involved in a game of skittles in the communal area. Some people were enjoying taking part, others were watching. People were not always aware what activities were on offer. One person said, "I don't know what activities are happening today." We raised this with the activities co-ordinator, who told us part of the home was due to be made into an 'activities hub' where group activities on offer could be advertised so people knew what was planned each day. We noted on the day of our inspection several areas of the home were undergoing re-decoration. Display boards and noticeboards were also planned for other areas of the home, after the redecoration programme had been completed.

Relatives told us they were also invited to take part in activities and entertainment that was on offer. One relative said, "There is lots of entertainment. We get invited to come in. For example, there was a really good 'Elvis' impersonator recently. One day they brought in a load of animals for people to stroke too."

We spoke with the activities co-ordinator, who told us there had recently been recruitment which now meant there was 7 day activities cover. They also told us part of the home was being decorated and would become an 'activities hub'. They told us this would give them somewhere to keep things they used in activities, and would mean smaller groups with shared interests could be catered for in a dedicated space. They explained, "We know inactivity breeds inactivity, so it is important to keep people as occupied as we can." We were shown a list of recent events held at the home to demonstrate the type of activity people enjoyed, this included flower arranging, Christmas events and seasonal activities.

The manager told us they intended to introduce a 'resident of the day' programme at the home. The programme would involve one person being identified each day, and that person would be consulted about all aspects of their care and support. This would include what activities they would like and would also identify individual activities people might prefer. Information would also be gathered on their previous life

history so that people could be encouraged to take part in activities which reminded them of their previous occupations or family life.

Relatives told us they had been involved in putting together people's care plans before they came to the home. One said, "[Relative's name] had a lot of falls before coming here. We were involved in putting together the care plan to help prevent that." Relatives also told us they were kept informed of what was happening. One relative commented, "Everything that happens is recorded. You only have to ask to read it. Nothing is hidden; they tell us what is happening."

Care records were available for each person who lived at the home. Records gave staff information about how people wanted their care and support to be delivered. For example, care records included information on maintaining the person's health, their support needs and their personal preferences where these were known. However, we saw that not all care records were kept up to date at the home. This had been identified at a recent care record audit, and a new format for care records had been drawn up to improve recording. A review of each person's records was planned and all records were being updated. We saw some records had already been transferred to the new format, the manager estimated these would all be completed before the end of February 2017.

However, where people's records remained in the 'old' format, staff were not always keeping these up to date. For example, in one person's care records it showed they had breathing difficulties and their care plans should be reviewed every three months to ensure their health was being monitored appropriately. However, we saw the person's records had not been reviewed since May 2016. In another person's records it showed they needed to be moved or repositioned every two hours to prevent them from developing damage to their skin. Charts were in place for staff to record each time the person was moved. The nursing and care staff we spoke with knew the person's needs well. However, when we reviewed the care records we saw the charts were not always filled in and did not show the person had been moved every two hours. Staff told us the person was being moved as they should be, but sometimes the records were not always completed accurately.

In another person's records we saw staff were not keeping a full and accurate record of their nutritional intake, such as the amount of fluid they consumed each day. This had been identified as a requirement for the person, so that their hydration levels could be monitored. The manager told us they were currently conducting a check on each person's weight at the service, this information would then be used to accurately assess the amount of fluid and nutrition each person may require to maintain their health. Fluid and food charts would then be updated where necessary. A check had been introduced to ensure that nursing staff reviewed the charts for each person on a weekly basis.

Another person had recently been admitted to the home, and their care records had not all been written so that staff knew the person's needs. We asked the manager how long care records took to be in place when someone came to the home, the manager explained each person had some records in place on admission, for example, to manage the risks relating to their health. Within seven days a full record of the person's needs would be in place.

Although we found these issues with the records, we found no impact on the care people received as staff knew people's needs well. Staff were able to respond to how people were feeling and to their changing health or care needs because they had a verbal and written handover at the start of their shift. One member of staff told us, "The nurses update the care staff about changes in people's needs daily. Care staff in turn have a daily report sheet to communicate to nurses any changes." The handover records and communication logs showed each person at the home was discussed daily, including any changes to their

care or their health needs. A staff member said, "Information can be communicated to nurses on a daily basis and this record has been seen to have had a positive impact on care."

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. People told us they had not made any complaints, but were confident to do so. One person said, "I would talk to [manager] if I had any complaints."

Staff told us they would support people to make complaints. Speaking with us about what they would do if someone told them they wanted to make a complaint, one staff member said, "I would ask the person what was wrong, and I would reassure them. I would tell them I'd have to speak to someone and would make sure I explained that as you have to make sure people trust what you say."

The provider had acted on the feedback they received in complaints to improve the quality of their service. They had responded to verbal complaints by discussing the issues with the complainant and reaching a resolution that suited all concerned. However, there were no written complaints received at the home during the previous twelve months.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager at the service. The previous home manager had vacated their position prior to applying for registration to become the registered manager. The current manager had originally been appointed as the deputy manager, and had quickly been promoted to the manager's position following the home manager's departure. They had already applied to become the registered manager with CQC at the time of our inspection visit.

The manager operated an 'open door policy' and encouraged staff and visitors to approach them. People knew who the manager was, and told us they were approachable and visible in the home. One person said, "They come and talk to you. If you have any problems you can talk to them." Relatives told us the manager was approachable and effective. One said, "Staff and management are very helpful. You only have to ask and they respond." Relatives also said the manager was visible in the home which they found reassuring.

One staff member said, "More than ever, this home is geared up for the people. They come first. If you don't think that way, you are not needed here. Staff would not last very long if they didn't. We are like a big family."

Another staff member told us, "If I have any concerns, they have been dealt with. They [manager and senior staff] do not stand any nonsense." Another staff member told us, "We get lots of support. If we have a problem or a concern we go to the manager or supervisor and they will help." They added that they thought management of the home had improved since the current manager took over managing the home. They said, "I love it here. It has improved since [manager's name] took over. We are much more organised now. It is all coming together, which is good."

There was a clear management structure within Bentley House to support staff. The registered manager was part of a management team which included a clinical lead who was a trained nurse, and a deputy manager. Nurses were available to support care staff on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. The deputy manager also worked alongside staff several shifts each week to keep staff and themselves up to date with what was happening in the home. In addition, the manager and deputy manager conducted 'spot checks' on staff performance, day and night. A new management structure was being planned at the home to include team leaders; this was to ensure supervision for staff was available on each shift.

The manager told us the provider was supportive to them and offered them guidance in their new role. They added, "The provider is here daily, so they are always accessible to me." They also discussed issues around quality assurance procedures and areas for improvement at the home. The manager said, "The provider is supportive and will listen to my ideas about any improvements." They added, "We are implementing some refurbishment plans to improve some areas of the home at the moment. This includes some redecoration and also the development of storage areas for equipment, and replacement flooring in some parts of the home."

The provider completed regular checks on the quality of the service they provided. The provider visited the home daily and conducted a regular 'walk around' as part of their quality checks. The provider directed the manager, the deputy manager and clinical lead to conduct regular quality checks on different aspects of the service. Regular checks included health and safety checks, infection control audits, medicines checks and checks on people's care records. Where these had highlighted any areas of improvement, action plans were drawn up to make changes. For example, a recent care records review had highlighted the need to amalgamate and improve some record keeping at the home. The manager had introduced new care records for some people at the home, which were being developed for everyone there. A recent infection control audit had highlighted the need for additional equipment at the home which was being purchased.

However, we found that some quality checks had not identified where improvements needed to be made. For example, although new care records were being developed for everyone at the home, some of the older type care records that were still in use were not being kept up to date by staff during the transition. This meant records did not show a complete and contemporaneous records of the care people needed, or received.

Audits that the provider had completed around medicines were not effective as they did not pick up on the issues we found during our inspection. We spoke to the manager about how the audits could be improved to ensure medicines processes were in line with the homes policy and good practice.

Auditing procedures required development so that issues could be more easily identified in the future. For example, daily recording of fluid and food monitoring needed to be updated to ensure people's nutritional intakes were monitored, and people received enough to eat and drink. Daily checks done by the nursing team had not identified where people might need additional support to maintain their health.

The provider did not regularly gather feedback from people who used their services or their relatives. For example, the provider had not completed a recent quality assurance survey so that people could comment on the service they received. Relatives told us, "I don't think the surveys are a regular thing." In addition, relatives told us they could not recall being invited to any relatives meetings. We brought this to the attention of the manager during our inspection visit. They said they were currently compiling a survey to be sent to people. They intended to complete a quality assurance survey each year.

The manager told us they encouraged verbal feedback from people, visitors and relatives. They added that quarterly relatives and residents meetings were being arranged. The first meeting was due to be held at the end of January 2017, and they planned to hold these meetings every three months. Manager's surgery dates were already arranged, the manager intended to have an 'open door' evening the last Friday of each month, so that visitors and relatives could speak with them if they only came into the home outside standard working hours.

The manager had gathered feedback from people as part of a consultation where improvements to the home were planned. They gave us an example of when people had been asked for their feedback on the naming of some parts of the home, people had been asked to provide suggestions in a suggestion box, and suggestions had been reviewed. The majority of people's views had been to name areas after flowers, which was being implemented.

Staff had regular team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were held within teams. For example, nursing staff met to discuss clinical information. An agenda was drawn up before each meeting and staff were able to contribute their suggestions for discussion. One staff member said, "We are alerted to the date of the meeting in

advance. If we can't attend we get a summary of the meeting left for us that we must read." A recent meeting record showed staff had discussed the needs of people in their care and were reminded to complete paperwork in people's care records.

The provider made plans for improvement at the home, based on quality assurance audits and feedback. Some improvement plans were in place for the redecoration of the home, which were already being done. Other improvement plans included the purchase of additional infection control equipment, the re-fitting of sluice rooms, and new carpeting and flooring in certain areas. Hoist and equipment stores were being arranged so that equipment was moved away from corridors and communal areas. This demonstrated the provider invested in improvements at the home following feedback.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) (2g) HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care and treatment was provided in a safe way to all service users. The provider had not ensured the proper and safe management of medicines.