Bethany House Care Home

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Inspection report

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Date of inspection visit:
25 February 2016
26 February 2016

Date of publication:
13 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bethany House Care Home is a purpose built service. It provides accommodation, nursing and personal care for up to 15 people who need care and support with their multiple and complex needs; the service was full at the time of inspection. People had a variety of physical disabilities including: acquired brain injury, congenital disorder and degenerative illnesses. The age range of people varied from young adults to people who were older. There are trained registered nurses working at the service 24 hours a day with a team of care workers.

There was a registered manager working at Bethany House. 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.

We last inspected this service on 15 October 2014. At that inspection we found some improvements were needed in respect of the understanding and implementation of the Mental Capacity Act 2005 by the provider, registered manager and staff and obtaining of consent. Accurate records of peoples care and support were not being maintained and some important health information had been overlooked. We asked the provider to send us a report of how they would address these issues and within what timescale, which they had done. At this inspection we found the provider had addressed most of the outstanding requirements but further shortfalls had been highlighted in regard to some operational and service user records.

People could be placed at risk because the provider could not assure their self through the records they maintained that all staff had received the recommended number of fire drills or that visual checks of fire equipment and some equipment used to support peoples care were taking place.

Staff said that they felt supported and the registered manager monitored their practice when she worked on shift with them but formal recorded staff supervision was irregular, with none recorded since August 2015; this meant there was no mechanism in place for recording staff performance and development throughout the year to inform their annual work appraisal or to monitor actions that have been highlighted for improvement.

Management of medicines required improvements. Staff showed that they had a good understanding of people's individual styles and range of communication, but this information was not recorded to inform newer staff. Similarly, some people expressed their emotions from time to time through behaviour, staff understood this and how to de-escalate situations in the least restrictive way, their practice however, was not recorded in care and support plan guidance for all staff to ensure they responded in a consistent manner.

A service development plan was in place and relatives were asked to share their views about the service;

there was however, no system in place to analyse their comments, and use these to inform the service development plan, nor a mechanism to provide feedback so people surveyed knew their views were listened to. Audits to assess and monitor service quality were largely undeveloped so the provider and registered manager could not assure their selves that all aspects of service delivery were operating to a good standard and any shortfalls were highlighted and dealt with.

People were given individual support with their interests and hobbies but we have recommended this be reviewed to ensure the range quality and frequency of activities is discussed with people and their relatives.

Relatives and staff referred to this as a 'happy home' and we saw that people were content, relaxed and comfortable in the presence of staff. Staff interacted well and showed they understood people's individual needs.

Relatives told us they were kept informed and had been consulted about their family members care and treatment plans. They said they were invited to and attended care reviews annually where possible, they felt able to contribute to these meetings and felt listened to.

Staff monitored people's health and wellbeing and ensured health professionals were contacted in a timely manner if health needs changed they supported people to attend routine and specialist health appointments when this was needed. Staff understood people's nutritional needs and provided them with a varied diet that was suitable for them; the cook was aware of people's personal food preferences and ensured these were incorporated into the menus provided. Weights were recorded and monitored to highlight any emerging problems. Staff sought advice and guidance from health professionals around supporting people who may have need of assistance with eating or having their nutritional needs met appropriately.

Risks were appropriately assessed and measures implemented to reduce the likelihood of harm occurring. There was a low level of accidents and incidents and these were monitored by the provider and registered manager.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Since the last inspection staff had received appropriate training to understand their responsibilities and applications for DoLS authorisations had been made for everyone in the service who met the criteria. The provider and registered manager now understood when an application should be made and the service was now meeting the requirements of the Deprivation of Liberty Safeguards.

Staff had been trained to recognise abuse and knew how to protect people from harm. There were enough staff to meet people's needs. Staff recruitment procedures ensured that all the necessary checks were made to protect people from unsuitable staff. Staff were provided with a wide range of essential and specialist training to help them understand and meet people's needs. They received support through staff meetings.

People lived in a clean, well maintained environment. The premises were well maintained. People were supported to personalise their bedrooms to their own taste. Equipment checks and servicing were regularly carried out to ensure the premises and equipment used was safe. Fire detection and alarm systems were maintained; Guidance was available to staff in the event of emergency events so they knew who to contact and what action to take to protect people.

We recommend that a record be made of the temperature of all hot food served to ensure this meets the requirements of food standards monitored by Environmental Health.

We would recommend that a review of the range, quality and frequency of activities on offer be undertaken in consultation with people and their relatives.

We found a number of breaches 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 this 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

Arrangements to ensure all staff participated in fire drills and that visual checks of fire equipment were carried out needed improvement. Some areas of medicine management needed improvement.

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Recruitment procedures ensured new staff were suitable to undertake their role. People were protected from harm because staff understood how to identify and respond to abuse. There were always enough staff available to support people.

The premises were well maintained. Staff understood the action to take in an emergency to protect people from harm and evacuate them safely. Risks were appropriately assessed.

Is the service effective?

Requires Improvement

Improvements were needed to ensure staff had opportunities to meet with their supervisor on a regular basis. Recording of food temperatures was inconsistent.

Staff received induction to their role; they received essential and specialist training to give them the right skills. People were supported in line with the principles of the Mental Capacity Act 2005.

People ate a healthy and varied diet, and their health and wellbeing was monitored by staff.

Is the service caring?

Good

People's privacy and dignity was respected. Staff showed kindness and patience in their contacts and engagement with people.

Staff helped people to maintain the independence they had and to make choices for themselves.

Staff supported people to maintain links with their relatives. Relatives said they were always made welcome, were consulted with by staff and felt they were kept well informed.

Is the service responsive?

Requires Improvement

People were assessed prior to coming to live in the service to ensure their needs could be met. Detailed care and support plans guided staff in delivering continuity of care, people and their relatives were consulted about care and treatment. Staff understood how to support people's communication and behavioural needs but their practice was not recorded in care and support plans.

Activities were tailored to people's needs, interests and abilities but their range, and frequency needed to be reviewed with people.

A complaints procedure was available. Staff knew people well and gave them time to try and understand issues that affected their mood or made them unhappy. Relatives felt confident of approaching staff with any concerns.

Is the service well-led?

Requires Improvement

A limited range of audits to assess and monitor service quality were in place. Audits had not been effective in identifying shortfalls highlighted at inspection. Relatives were asked to give their views about the service but did not receive feedback about how their views influenced the service.

There was a registered manager who staff, people and their relatives found approachable and supportive. The providers were a visible presence and staff said they felt listened to, and able to express their views at staff meetings.

Staff practice was informed by policies and procedures that were kept updated.

Bethany House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 February 2016, was unannounced and was undertaken by two inspectors. We last inspected the service on 15 October 2014 when we identified some areas for improvements and issued three requirement actions.

Before the inspection the provider had not been requested to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information we held about the service this included previous inspection reports, complaints and notifications received by the Care Quality Commission. Notifications are information we receive from the service when a significant events happened at the service, like a death or a serious injury.

We met nearly all of the 15 people using the service and had conversations with three of them. We spoke with five members of staff, the registered manager and the provider. We also spoke with four relatives and received feedback from a health professional who visited the service.

Not everyone was able to verbally share with us their experiences of life at this service. This was because of their complex needs. We therefore spent time observing how staff spoke and engaged with people, with each other and with a visiting relative. 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 how people were supported throughout the day with their daily routines and activities. We reviewed four care plans, and associated risk, health and medicine records. We looked at a range of other operational records, including: staff recruitment, training and supervision records, staff rotas, accident and incident reports, safety checks, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People were relaxed, calm and comfortable in the presence of staff who understood their needs well. Relatives told us that they were confident in the care offered to their relatives and that this was to a good standard, they thought the service was safe and said they never felt concerned at leaving their relative in the service. Relatives commented that the service was always kept clean and tidy with no unpleasant odours. Two staff told us that it was a lovely house to work for. They took pride in their role of keeping the service clean and maintaining good hygiene.

Staff knew how to protect people in the event of fire as they had undertaken fire training. Fire drills for them to practice evacuation were held, but these were not recorded this meant that the provider and registered manager were unable to assure themselves that all staff had received the minimum number of fire drills they should receive in accordance with the Fire Safety (Reform) Order 2005. Additionally, there was no system in place for the routine recording of visual checks of fire extinguishers to ensure these remained in working order.

Servicing of the fire alarm system and fire equipment were made annually, checks and tests of the fire alarm system were made on a weekly basis. Equipment checks and servicing were regularly carried out to ensure this was safe and in good working order. A number of people used an air mattress to minimise any risk to the integrity of their skin, room checks were made to ensure people's health and safety was protected but there was no recording system for this or to ensure mattress settings were routinely checked; we found one inaccurate setting out of three checked, over time if not addressed this may have led to the development of a pressure area for the person concerned.

The failure to ensure that operational records related to some fire safety procedures or the establishment of monitoring systems for the safe use of equipment is a breach of Regulation 15 (1) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Only qualified nurses were able to administer medicines. Medicines were managed safely but some improvements were needed. An administering staff member told us that all boxed and bottled medicines not in blister packs were dated upon opening in accordance with home policy and good practice guidance. When we opened the medicine trolley however, we found only one or two medicines dated in this way. Medicine administration records were supported by individual photographs of each person, and details about their allergies and the medicines they received, this ensured right medicine for the right person, when we checked medicine records we found that staff used a range of codes for when medicines were not administered, for example refusal, but these codes were not recorded anywhere as a key to ensure staff used all used the same codes for the same reason, this could provide an inconsistent picture of the reasons for people not having medicines administered. There was a failure to ensure that systems in place for the safe management of medicines were fully effective and this is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The ordering receipt and disposal of medicines was the sole responsibility of the registered manager at this

time but she recognised the need to delegate this responsibility so that other staff became skilled at this and assured that the registered manager's absence never impacted on the availability of medicines to people.

People were unable to administer their own medicines and this was made clear in their care records. Medicines were stored securely and appropriately. Temperatures were checked to ensure these did not exceed recommended levels. The medicine trolley was kept secure when not in use and locked when unattended during medicine administration. Medicine Administration Records (MAR) charts were completed with any hand written changes signed for. Staff talked to people before giving them their medicines and explained what they were doing and asked if they were happy to take their medicines.

The provider operated safe recruitment procedures. All required checks were undertaken before staff commenced work; these included proof of identity, satisfactory written conduct in previous employment and character references, a Disclosure and Barring Service (DBS) criminal record check, a statement as to the health and fitness of the prospective staff member. These processes helped the provider make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Staff rotas showed there were sufficient staff on shift at all times during the day to meet the needs of people. Staff told us that there were always enough staff and rotas were followed. Rotas showed that agency staff were used on occasion at times of staff shortage, although there was a preference for gaps in shift to be covered from within the staff team by people familiar with the needs of the people in the service and their routines. This helped to ensure continuity in their care and support.

Staff were able to tell us about the signs of abuse, and how they would report their concerns and to whom; including those agencies outside of the organisation, such as the local authority safeguarding team. Staff received regular training in protecting people from abuse so their knowledge of how to keep people safe was up to date. Staff demonstrated an understanding of their responsibilities under whistle blowing to report concerns about the conduct of other staff and to raise these concerns with the provider, registered manager or outside agencies if this was needed.

Risk assessments were completed for each person; these were individualised and took account of each person's specific needs and their personal awareness and understanding of danger and risk. Measures were implemented to reduce the level of risk so that people were protected from harm when undertaking activities outside and inside of the service. Risk assessments were kept updated and reviewed on a regular basis. Environment risk assessments were reviewed and guidance made available to staff in the event of emergency situations that required evacuation. A business continuity plan was in place at corporate level, separate specific guidance was made available to staff about the actions they needed to take in the event of emergencies that could impact on the running of the service and who or what agencies they should contact. Personal evacuation plans took account of people's individual needs to ensure a safe evacuation.

The premises, décor and furnishings were maintained to a high standard. They provided people with a clean, tidy and comfortable home. Repairs were carried out in a timely way, and maintenance issues noted at inspection for example, the tiling surround for the Hydrotherapy pool, the need for replacement liners for shower trolleys had already been highlighted for repair and had been included in the forthcoming programme of maintenance. There was a secure accessible garden for people's use. The provider arranged for an external health and safety inspection of the service every year which included checks of the environment and equipment used by staff to support people.

Requires Improvement

Is the service effective?

Our findings

Several relatives commented on how proactive the staff had been in improving the quality of life for their family members, researching ways to help resolve some health issues and providing support and input that had led to a catheter no longer being required and medicines reduced to low levels all positive outcomes for the people concerned. A health professional said they had no concerns about this service.

Staff told us that they felt supported and listened to, they said that they did have one to one meetings with the registered manager; these had been held on a regular basis until August 2015 when recorded supervisions had stopped, but the registered manager said she continued to work alongside staff and was available to talk with staff when on shift with them, staff said they felt well supported and able to approach the registered manager at any time. These meetings provided opportunities for staff to discuss their performance, development and training needs, Staff said the registered manager was always available, and observed their practice as she worked alongside them on shift, they said that the registered manager commented on their practice if they did something good or if they needed to be reminded to improve their practice, but these observations of staff practice were not recorded. The failure to provide regular formal opportunities to discuss with staff their work life, training and development needs is a breach of Regulation 18 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014.

Food temperatures were recorded for lunchtime meals but not for hot food served at suppertime, we asked the chef about this and she said these should be recorded also by care staff providing the food at supper. She said she would follow this up with staff and is an area for improvement.

Some people had very specific requirements around how their nutritional and hydration needs were met. Staff had been guided by health professionals and relatives to ensure an appropriate level of support was given and staff were vigilant about how much people ate and drank.

People's dietary needs and preferences were discussed with them or with people who knew them well before admission. Guidance for staff in regard to people's specific nutritional support was recorded in the kitchen and informed the chefs preparing their meals. We looked at menus and discussed with the chef how these were developed and what input people had into them. The chef said menus were flexible they were based on an awareness of peoples likes and dislikes, there were no formal meetings to decide what the menu should be but if someone asked for something in particular this was included. Meals offered were varied and took into account how meals needed to be presented. Two choices were made available to people for the main meal of the day. Breakfast provided a range of cold and or cooked options if people requested this. Supper was a lighter meal but also consisted of a variety of cold or hot choices. People's weights were regularly recorded and any significant changes reported to the registered manager.

The provider valued the need to embed good practice and ensured staff received support to acquire the right skills and knowledge. Newly appointed staff were required to complete an induction programme that included the new care certificate if they had no previous experience in care. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care

workers complete during their induction and adhere to in their daily working life. Induction also prepared new staff by giving them an understanding of the routines within the service and the needs of the people being supported. All new staff completed a probationary period of three months but their progress during this period was not routinely recorded unless issues arose. All new staff completed the basic essential skills training they needed for example safeguarding, first aid, food hygiene, fire, moving and handling and health and safety, to help them to understand how to carry out their role safely and protect people from harm. For established members of the staff team this programme of training was routinely updated, with additional specialist training relevant to the needs of people in the service was also provided for example pressure care, diabetes, epilepsy.

Six staff including the registered manager were qualified registered general nurses and 11 out of 13 of the care staff had achieved or were working towards a vocational qualification at level two or higher. These are work based awards that are achieved through assessment and training. Annual appraisals of staff performance were carried out these identified individual staff development and training needs and set personal objectives for them. A staff member told us that the support they had received from the provider and manager to develop their skills and knowledge had enabled them to register to study for a professional qualification and eventually to move into a professional health career.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the previous inspection it had been identified that the principles of the Mental Capacity Act 2005 had not been followed in regard to seeking peoples consent and staff knowledge and awareness in this area needed improvement. Since then staff have all attended training. We found that the registered manager understood when an application should be made and how to submit one and had done for the majority of people in the service. Staff supported people when making everyday decisions about what they wore, where they ate, what they ate, what they wanted to do. Where people lacked the capacity to make some more important decisions for themselves around their care and treatment staff understood the processes for helping people with decision making including the use of Independent mental capacity advocates (IMCA's) and they were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests, and by people who knew them well.

People were supported by staff to maintain their health and wellbeing. People who required physiotherapy support had these needs assessed upon admission and an exercise program developed. A set of exercises were devised for each person and a physiotherapy aide supported people every day with their exercises. A hydrotherapy pool was also available on site that enabled people who enjoyed this form of exercise to have a hydrotherapy session at least once every two weeks. Where necessary referrals were made to other health professionals for support and guidance for example the epilepsy nursing service. Individual guidance was provided to staff in respect of health needs around specific conditions, such as epilepsy with monitoring of seizures and protocols in place for administration of rescue medicines when major seizures occurred. A record was kept of all health appointments and contacts people had with health professionals to ensure all aspects of their healthcare needs were kept under review. Each person had a hospital passport so hospital staff had a quick reference to what their individual needs were and how these should be supported when in hospital.

We recommend that a record be made of the temperature of all hot food served to ensure this meets the requirements of food standards monitored by Environmental Health.

Good

Is the service caring?

Our findings

One person told us "I absolutely adore it here. The people are so kind and whatever I want I get. I am more than happy here. I couldn't be anywhere else. Everyone makes me feel so at home, I feel so lucky, Nothing is too much trouble. Take X (staff member) for example, one of my plants died and she just went straight out and bought me another one." Several relatives told us that they felt confident in the care delivered to their family member and the positive and kind attitudes of staff, "I feel I can walk away without worrying X will be cared for properly." "I was never able to relax until X came here, I have been able to get my life back, the care provided is fantastic, I cannot fault them". A person told us that if he did not like what was on the menu he would speak to staff so they would make him something different for lunch. He was planning on purchasing some microwaveable meals as alternatives just in case he wanted something different, he said he liked to have his lunch a bit later and the Chef confirmed this was the case. She said that this person usually said when he wanted his lunch and they ensured that it was kept warm for him.

We observed that people were comfortable with staff and were happy to be around them and be involved in activities with them. Staff were friendly and kind in their support and responses to people, their attitude was respectful and they showed that they understood people's individual characters and needs. There was a relaxed atmosphere in the service and we observed many examples of positive gentle patient and supportive interactions between staff and the people they were supporting. There were a number of people who were nonverbal but staff showed that they understood people's individual styles of communication well enough to know their preferences and wishes, a relative commented " staff are completely switched on to how she expresses her emotions and how she is feeling, another said that staff understood how their relative communicated and took time to enable them to make choices about their support for example if they were happy with their personal support and what they wanted to wear. Relatives said this was a happy home and that staff who left often returned, staff spoken with said they enjoyed working at the service.

Relatives told us that they were made to feel welcome when they visited and some said they visited unannounced. Some parents had requested a diary be kept for their relative so that they were able to read about what had happened in their family member's life since they last visited them. Relative's told us that communication from the registered manager and staff was good and they were always contacted about matters relating to the health and wellbeing of their family member, and any changes in care and treatment before these were implemented. They said they were included in regular reviews and were consulted about care and support decisions, they said that they were asked to contribute their thoughts and felt listened to. They said they felt confident of raising concerns if they had any, and always found the registered manager and staff approachable.

Relatives told us that staff were supportive of people having home visits and although they did not facilitate these by transporting people to and from home, they ensured that people going home were always ready and everything they needed for their home visit was packed away for them.

Staff supported people where possible to make choices and decisions for themselves in their everyday lives and how they spent their time, when they went to bed, what they wore, or did, where they ate and what they

ate. Staff respected people's choices. Staff protected people's dignity and privacy by providing personal care support discreetly and respecting confidentiality, for example speaking in private with them or with their relatives.

When at home people were able to choose where they spent their time, for example, in their bedroom or the communal areas. Bedrooms had been personalised with personal possessions and family photographs.

People were supported to maintain relationships with the people who were important to them, and were supported to make regular contacts or visits. Some activities people participated in were interlinked with a sister home for example musical events and this enabled people to enhance their social circle and make relationships with people outside of their own service.

Although relatively rare staff were experienced in providing end of life support to people; good links had been made with the hospice team who the registered manager liaised with and who provided support and guidance and assured that good practice was maintained.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found that records regarding important information about specific health matters relating to two people failed to make clear whether appropriate support was being offered. Since then the registered manager has implemented a programme of review of all the care plans, at inspection this was part way through. Whilst there had been improvements in the level of detail contained within the care & support plans viewed, we found that whilst staff showed they had a lot of knowledge and understanding of people's individual styles and methods of communication, this was not recorded in a communication section of people's care and support plans; this would ensure that all staff understood how the person communicated and responded in the same way. Similarly, staff showed they understood how to de-escalate situations where some people expressed behaviour that could be seen as challenging, but how they did this was not recorded in peoples plans to ensure people were supported in a consistent way. The use of agency staff by the service meant there was a risk that not all staff would have the same understanding of what support was required and this could be provided inconsistently. The failure to ensure that staff practice is accurately reflected in people's care and support records is a breach of Regulation 9 (1) (a-c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Activities were suited to the needs of individuals and provided at a pace to suit them. Two people went out unaccompanied by staff; another person said they were happy staying indoors occupying themselves with activities that interested them. There was an activities co-ordinator who worked four days each week between this service and the sister home. The activities co-coordinator worked with any of the people who were interested in craft work and she tailored the artwork they did to each person's specific needs. She told us that she sought advice from other professionals who came into the home and had spoken with a speech and language therapist to ensure that she was able to communicate with individuals in the best way. She also explained that where individuals were having additional input from physiotherapists or occupational therapists she incorporated that into her sessions. For example one person was working on their grip and she ensured that he was able to practice this when using a paintbrush. The co-ordinator said she tried to ensure that working in groups helped strengthen relationships between people so those who liked working together were able to do so.

In addition to craft work some people had regular hydrotherapy sessions every two weeks, there was a musical entertainment every two weeks. Physiotherapy exercises were provided Monday to Friday for everyone by the physiotherapy aide. Staff played games with people who were unable to go out, and we observed a staff member working with someone with sensory equipment. There was no structured activity planner because the registered manager said this allowed a more flexible arrangement that could respond to people's individual health and responsiveness on the day. The service diary showed that people were going out with staff support either individually or in small groups; this was staff intensive and provided on a one to one basis, time was also set aside for people to do activities of their own choice, such as listening to music, or watching favourite DVD's. Daily reports recorded activities people were undertaking each day.

Three out of four relatives although positive about the quality of care provided said they would like to see more activities provided to people particularly at weekends, they said they thought that sometimes people

were left in the lounge in front of the television for too long when staff could have taken opportunities to play games or to read to them. This is an area for further improvement.

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. Initial meetings with the providers, registered manager, relatives, representatives and previous care providers enabled reports to be gathered. An assessment of needs was usually undertaken at a pace to suit the person, with opportunities for visits and trial stays. A relative confirmed that they had looked around a number of services before this became a suitable option; they said they could have chosen a service nearer to their home but this was the best they had seen.

Following initial assessment people's everyday care and support was designed around their specific individual assessed needs. This included an understanding of their background history, interests, preferences around daily routines including for example washing dressing , nutritional needs, mobility pain management sleep and night time support mental capacity, personal care, social activities and interaction, night time support including continence management, and a recognition of the people who are important in their lives.

Care records did provide a holistic picture of each person and guided staff in delivering support consistent with what the person needed and wanted. There was also recognition of what people could do for themselves. Each person had an allocated care worker who took responsibility for ensuring the person's needs were met through meeting with them and or reviewing and updating their care plan to reflect any changes in needs or support. The registered manager had oversight of care plans to ensure these were kept updated. Relatives said that they were consulted and involved through reviews of their family member care needs and placement with relevant social and healthcare professionals.

Staff showed that they were able to respond appropriately to people's needs in a way that was consistent with their plan of care. Changes in people's care and treatment was discussed with their relatives and representatives before these were put into place. People and their relatives were included in the regular assessments and reviews of their individual needs.

A complaints procedure was in place. The complaints record recorded concerns and formal complaints; we noted three recorded concerns and the actions taken to address these with those concerned. Relatives told us they found the registered providers, registered manager and staff approachable and would not hesitate in raising concerns with them if they felt this was necessary but would not complain about trivial matters. We observed several examples at inspection where concerns were taken seriously and action taken to address these, for example, relative expressed concerns about the health and wellbeing of their family member to the registered manager who immediately instigated four hourly observations, the relative was happy with these interventions. In another example a person expressed a dislike of the dishes offered on the menu that day the chef said the person did not have to eat either of these and offered an alternative that the person was happy with.

We would recommend that a review of the range, quality and frequency of activities on offer be undertaken in consultation with people and their relatives.

Requires Improvement

Is the service well-led?

Our findings

Relatives said they found the registered manager approachable and always willing to listen. One commented "The manager is great, one of the best". A person using the service said "You don't always see the bosses, but when you do they're nice too. X (the provider) has taken me out on the bus before, and we can have a joke." A staff member told us that "the management" were very responsive and reacted quickly when items needed to be replaced or repaired for example assessment of equipment was undertaken and replacements ordered. In response to a requirement to replace an item of laundry equipment a staff member told us "there was no questioning it, they just wanted it replaced there and then".

There was good oversight by the provider and registered manager. In response to requirements issued at the previous inspection action had been taken to ensure suitable arrangements were in place for the assessment of people's capacity to consent to care. Care and support plans that had lacked some important health information had been updated but improvements in recording were still needed in respect of some operational and care records for example fire drills, visual checks of equipment, guidance in respect of peoples communication and behaviour to reflect staff practice and ensure consistency on the way staff delivered support in these areas.

A weekly meeting was held by the provider with the registered manager where ongoing developments, operational issues, and issues in regard to individual people using the service were discussed. These were informal; no systems had been established for some of these meetings to be identified as supervision meetings or recorded for reference purposes, clinical supervision for the registered manager had not been established.

There were a limited number of quality audits to provide assurance to the provider and registered manager that all aspects of the service were operating as they should. At inspection we were informed that the audits conducted were: a monthly medicines audit, an annual external medicines audit by the pharmacist, a health and safety audit conducted twice annually by an external consultant, an audit by environmental Health officers checking food safety standards and systems and processes used in the kitchen had resulted in the service being awarded the highest rating of five stars. The other internal and external audits in place however had not been effective or wide ranging enough to identify the shortfalls we have identified at inspection for example, recording issues in respect of some fire procedures, shortfalls in medicines management.

Relatives told us that they were asked to give their views about the service in annual surveys. There was no evidence however, of analysis of survey information or a mechanism in place for providing feedback to those who had contributed their views and how these would inform future service development. Relatives said they would like information about how their comments were used or influenced the service.

There was a failure to ensure that there were appropriate effective systems in place to assess and monitor service quality; to seek and act on the views of people using the service, their relatives and or other professionals and to provide feedback. This is a breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a range of policies and procedures governing how the service needed to be run; the provider and registered manager confirmed that these were all reviewed annually and updated where necessary in line with changes to policies and current best practice.

Communication was facilitated through the registered manager who when on duty met with staff at shift changes to ensure they were kept informed of important changes, and to listen to any emerging concerns or issues staff might have or had become aware of. The registered manager worked alongside staff on shift and made observations of their practice. Regular staff meetings were held every three months. Staff said they felt confident of raising issues within these and felt listened to. They said they were also able to raise issues on a daily basis, either with the registered manager who was on shift with them regularly or to record in individual daily reports. One staff member we spoke to was a nurse who confirmed that the staff worked very much as a team and team meetings were held for the whole staff team and nurses were included in this.

The provider of the service was based most of the time at the sister home down the road 'Bethany Lodge', they did however visit Bethany House a minimum of weekly and sometimes more; they were easily accessible by telephone to the registered manager or staff when needed.

There were clear lines of accountability within the service and staff knew their particular roles and responsibilities. The registered manager was supported by a team of registered nurses, care assistants and domestic staff. There was no deputy manager but in the registered managers absence the registered nurse on duty each shift took responsibility for providing support to staff and any important issues were escalated to the provider or registered manager at the sister service.

The registered manager was a visible presence within the service, and we observed her acknowledging and chatting to people and staff when she moved among them. Her office was centrally located near to the entrance to the service and people and relatives could locate her easily. Staff said she was a good manager and they felt supported by her and found her approachable if they wanted to talk about something, they said they felt listened to and that their views and opinions were valued.

The registered manager demonstrated that she had a good understanding of people's individual needs and kept herself updated with how everyone was on a day to day basis; in this way she was able to respond to relatives enquiries. People and relatives told us that they found her easy to talk with.

A development plan for the service was in place and was updated to take account of maintenance projects and equipment replacements that were needed. A business continuity plan had also been developed to look particularly at financial impact of events that could affect the running of the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to ensure that staff practice in regard to their support of people's communication and behavioural needs was accurately recorded in people's care records. Regulation 9 (1) (a-c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure that systems in place for the safe management of medicines were fully effective. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was a failure to ensure that operational records were kept in regard to staff participation in fire safety drills, and visual monitoring of some fire and care equipment. Regulation 15 (1) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure that: There were appropriate and effective systems

	in place to assess and monitor service quality; to seek and act on the views of people using the service, their relatives and or other professionals and to provide feedback;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to provide staff with regular formal opportunities to discuss their work life, training and development needs. Regulation 18 (2) (a).