Kristal South Limited

Beaufort House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 24 and 29 August 2017 and was unannounced. This is the first inspection of the service as it was only registered in August 2016.

Beaufort House provides accommodation and support for up to six people, who have a learning disability or an autistic spectrum disorder. At the time of the inspection five people were living at the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

At the time of the inspection the service did not have a registered manager in place. A temporary management team had been put into place, which had taken over the overall running of the service. The current running of the home was being overseen by a temporary manager (who will be referred to as 'the manager' throughout this report) and a temporary head of care (who will be referred to as 'the head of care' throughout this report). The manager and head of care was from a neighbouring home also owned by the provider.

Quality assurance systems had failed to address shortfalls found at this inspection. The provider had asked for feedback from people's families but had failed to address their concerns. Families did not feel listened to or involved in the care of their relatives.

There were not effective systems in place to ensure that staff received training and supervision necessary to their roles.

Records relating to peoples' care and treatment were not fully completed and monitored to identify omissions and to analyse concerns. Family or professional contact had had not always been recorded.

Where accidents, incidents, and near misses had occurred there was not an effective system in place to ensure that appropriate action was taken to mitigate any risks or prevent reoccurrence.

The manager and provider had sought feedback from people and families using the service. However were issues and concerns were raised there was no process in place which demonstrated that concerns or issues had been addressed.

People were supported to have enough to eat and drink. However were not always encouraged or supported to have healthy diets. Staff supported people to eat and drink, when necessary in a patient and friendly manner.

People and their families told us they felt the home was safe. Staff had received safeguarding training and was able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

There was enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who could not communicate verbally and who used a variety of signs, noises and body language to express themselves. Staff were able to understand people and respond to what was being said.

We found two 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?

Good

The service was safe.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

Individual risks to people had been assessed and action had been taken to minimise the likelihood of harm.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

People received their medicines at the right time and in the right way to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction to support them to meet the needs of the people using the service. However not all staff had received the provider's mandatory training. Training was not always completed or updated as required. Staff did not receive regular supervision.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. However they were not always encouraged or supported to have healthy diets.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's privacy.

Staff understood the importance of respecting people's choice and wishes.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Family members did not feel involved or included in discussions about their relatives on going care.

Each person had a personalised activity timetable in place, however activities highlighted were not always provided.

People experienced care that was personalised and staff demonstrated a good awareness and understanding of people's individual needs.

Care plans were personalised and focused on individual needs and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place.

The systems in place for monitoring quality and safety were not effective in ensuring that shortfalls in the service were identified and addressed. The quality of peoples' care records were not monitored effectively.

Family members lacked confidence in the service and felt that it wasn't well led. Families did not feel listened to or involved in the care of their relatives.

The provider's values were clear and understood by staff. The manager adopted an open and inclusive style of leadership.

Beaufort House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 is the first inspection of the service as it was registered in August 2016. The inspection was unannounced and was carried out on 24 and 29 August 2017 by one inspector.

Before the inspection, the provider completed 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is legally required to send to us.

We spoke with five people using the service, six family members and a visiting professional.

We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with six members of the care staff, the manager, the head of care and the finance officer.

We looked at care plans and associated records for five people using the service, staff duty records, training records, three staff recruitment files, records of complaints, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

Family members told us they felt that their loved ones were safe at Beaufort House and people appeared to be at ease with the staff. One family member described their loved one as being, "Very safe." Another family member said, "I think [person's name] is safe, I have no concerns about their safety."

The staff and the management support team had the knowledge necessary to enable them to respond appropriately to concerns about safeguarding people. Staff had completed safeguarding training and were knowledgeable in recognising signs of potential abuse. Staff knew how to raise concerns and how to apply the provider's safeguarding policy. Staff said they would have no hesitation in reporting abuse. One staff member told us, "If I was concerned about the way someone was being cared for I would report it to the team leader or manager. If I needed to I would whistle blow." A second staff member said, "I would report concerns to the manager." They added, "I am confident that something would be done,). If I needed to I would go higher." A member of the management support team described the action they would take when they had safeguarding concerns about a person living at the home. The action taken was appropriate and ensured the safety of the person.

Staff understood the risks to people's health and well-being. Risk assessments were assessed, monitored and reviewed regularly. Risk assessments were personalised and written in sufficient detail to protect people from harm whilst promoting their independence. For example, some of the people living at Beaufort House experienced epileptic seizures and the risk assessments relating to their seizures were different for each person. There were also risk assessments relating to people helping in the kitchen, accessing the local community and participating in activities they enjoyed.

People were supported in accordance with their risk assessments. Staff were able to describe the risks relating to individual people in detail and the action they would take to help reduce the risks from occurring. The information provided by the staff corresponded with the information in their risk assessments. For example, where a person displayed behaviours that could place them or others at risk of significant harm or injury staff were able to describe the triggers for these behaviours. Staff described effective responses and actions they would take to reduce the risk of injury or harm.

There were sufficient staff to meet people's needs and keep them safe. Staffing levels were based on the needs of the people using the service. Most people living at the service received additional one to one hours throughout the week to keep them safe and support them to participate in activities. The staffing levels in the home provided an opportunity for staff to interact with people; staff supported people in a relaxed and unhurried manner. One staff member said, "We are short on staff at the moment but we are recruiting. The staff who are here have really pulled together as a team to make sure the shifts are covered, so people are getting the care they need." There was a duty roster system in place which detailed the planned cover for the home. The duty roster showed staff were available as required by people. Short term staff absences was managed through the use of overtime, agency staff and cover from staff who predominantly worked at another home owned by the provider.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited was suitable to work with the people they supported. Potential new staff completed an application form and underwent an interview before being offered employment at the home Appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

People received their medicines safely. People had medicine care plans in place which provided staff with individual guidance as to how people liked to take their medicines. For example, one person's medicine care plan stated, 'I like to take my medicine with milk or yogurt. If you are supporting me with my medicine in yoghurt please put the tablet on the spoon in front of me so I know what you are doing'. A second medicine care plan said, 'I have my medicine in a pot. I might refuse at first but this is because I need time to finish what I am doing, so come back in a bit'.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. We looked at a sample of MAR charts over a two week period; no gaps were identified, this indicated that people received their medicine appropriately.

Guidance was in place to help staff know when to administer 'as required' (PRN) medicines, such as medicine to be giving to support epileptic seizures and pain relief. Each person who needed PRN medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. One person told us they received pain relief when they required it. Systems were in place to ensure prescribed topical creams were used as prescribed and not used beyond their 'use by' date.

There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. Daily audits were completed to ensure that people had received their medicine as prescribed. Weekly stock checks of medicines were also completed by a senior member of staff to help ensure appropriate medicine were always available to people.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Environmental checks had been undertaken regularly to help ensure the premises were safe. These included water, building maintenance and equipment checks.

Requires Improvement

Is the service effective?

Our findings

The provider had a system to record the training that staff had completed and to identify when training needed to be updated. This included the provider's mandatory training, such as medicines training, safeguarding adults, moving and positioning and first aid. On reviewing this system, it was not robust in highlighting the training needs of the staff. Staff training had not always been received or updated as required. For example, the training record showed that six staff had not received moving and positioning training and staff that administered medication had not received updates within the required timeframe. This was discussed with the management team who were unable to confirm if this training had been received. A staff member said, "I have had some training, but we haven't always been given much notice about training and this can make it difficult to go to." At the time of the inspection the manager told us that they would review and update the system used to reflect where training had been received and highlight when training is required. They also provided us with written evidence that some additional training had been arranged for staff. However the provider had failed to ensure that staff were trained and competent for the role they were employed for.

There was an induction programme in place which aimed to enable staff to meet the needs of the people they were supporting. The induction programme included a two week period of shadowing a more experienced member of staff and completion of the provider's mandatory training. However as previously highlighted not all staff had received the provider's mandatory training as required. One staff member confirmed that they had received a period of shadowing and some training when they started at the home. They also said, "I found the induction hard so I asked the manager if I could do it again. They didn't mind so I repeated it."

We had mixed responses from staff in relation to them receiving regular supervisions. Supervision is dedicated time for staff to discuss their role, concerns and personal development needs with a senior member of staff. One staff member said, "I have had supervisions, the manager was approachable and their door was always open." Another staff member told us, "I feel supported, the manager supported us well and I still feel well supported by the [names of the management support team]." A third staff member said, "I haven't had supervision for a while."

The supervision record demonstrated an ad hoc approach to formalised supervision. For example it showed that three staff members had not received supervision since January 2017. The consistency of supervision was discussed with the manager who agreed to review the current supervision arrangements. The provider had failed to ensure they provided staff with opportunities to discuss their concerns, personal learning and development needs.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most family members felt that their loved ones personal care needs were met effectively by the staff. One family member said, "They [staff] do an excellent job with [person's name] personal hygiene, his oral

hygiene is so much better than it has ever been." Another family member told us, "[Person's name] does seem happy; I think they get the support they need from the staff." One person said, "It's alright here, they [staff] help me when I need it. They help me with bits and bobs."

Family members had mixed views on the staff's skills and knowledge to carry out their roles and responsibilities effectively. A person told us "The staff are alright, some are better than others." A family member said, "The staff seem to know what they are doing." Another family member told us, "Some of the staff are ok, although some need a bit more training I think." A third family member said, "They are brilliant."

Some staff had received other training which focused on the specific needs of people using the service. This included; Makaton, which is a language programme designed to provide a means of communication to people who cannot communicate efficiently by speaking, communication, epilepsy, autism and Non Abusive Psychological and Physical Intervention training. Staff understood the training they had received and told us how they applied it to their practice. For example, they explained how they would support a person to mobilise, be independent and manage behaviours that some people could find challenging.

People were supported to have enough to eat and drink. However, some people living a Beaufort House did not have the mental capacity to make decisions regarding healthy and unhealthy food choices and were therefore dependent on staff to support with this. Family members were concerned about the lack of healthy choices offered and significant weight gain of their loved ones. One family member said, "I had a meeting with the manager about [person's name] weight gain. We discussed arrangements being made for them to go to the gym. I don't think anything happened." Following a discussion with a staff member we were told that advice had been gained from the local GP and membership to the local sports centre had been obtained. Another family member said, "[Person's name] has put on a lot of weight, the foods not great." On viewing people's daily records we saw that people had received daily activities which were centred on food. For example, for one day a person went with a staff member to a well-known fast food chain during the morning and then went to a café in the afternoon. The daily records did not confirm if food had been consumed during these outings. People had food diaries in place, on viewing these it was noted that some people did not have healthy diets. For example, one person frequently had two main meals per day which often consisted of burgers, chips and takeaways. There was no evidence that healthy options had been offered or encouraged. When this was discussed with staff members we were told that unhealthy food choices were often provided at people's request and the refusal to provide unhealthy options would result in increased challenges in people's behaviour. However there was no evidence that discussions had taken place with mental health professionals or that the decision to provide unhealthy options were in the persons best interests.

There was a pre-arranged menu is place which highlighted the main meal offered for each day. We were told that this menu was arranged in advanced jointly with the people living at the home. When people declined the main meal offered they were supported by the staff to prepare an alternative of their choice or this was prepared on their behalf. Staff told us that they tried to encourage people to have healthy meals and snacks but these were often declined by the people living at the home. Staff were aware of people's needs and offered support when appropriate. For example one person needed extra support with their meal and a staff member sat with them providing them with encouragement to eat their meal independently.

Staff were aware of people's health care needs. A staff member said that if they thought a person was unwell they would, "inform the senior on shift, contact the GP and monitor them [person's name]." Another staff member said, "I would report my concerns to the manager or call 111 if I felt it was needed." Staff were able to describe the signs they looked for in individual people who were unable to communicate that they were feeling unwell. For example, a staff member said "When [name of person] is in pain they will become

withdrawn." Staff supported people to access additional healthcare services when required, such as chiropodists, opticians, GPs and dentists.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests.

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 service was working within the principles of the MCA, and whether DoLS applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLS applications had been made. At the time of the inspection two people living at the home were subject to a DoLS. However, documentation supporting this was not accessible to staff and staff were unsure if there were any additional conditions attached to the DoLS authorisation that needed to be adhered to. This was discussed with the manager and by the second day of the inspection appropriate documentation had been obtained and was available to staff.

Some people living at the home were unable to provide verbal consent, however family members told us that staff asked their loved ones for their consent when they were supporting them. One family member said, "Even though [person's name] is unable to tell the staff, he will make it very clear to staff if he doesn't want to do something." Another family member told us, "They [staff] know [person's name] well, they understand him." Staff explained that where people are unable to verbally consent to care they would look for facial expressions, body language and changes in the person's behaviour or mood. One staff member said, "[Person's name] will make it very clear to us if they don't like or don't want to do something." Staff encouraged people to make decisions and supported their choices. For example, during the inspection one person who was unable to verbally communicate made it very clear to a staff member that they wished to go out by taking them by the hand and leading them to the car. This resulted in the staff member taking them out for a drive.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. Family members described the staff that provided direct care to their loved ones as, "patient, kind, friendly and fantastic." One family member said "I would recommend the care and the staff." Another family member said "The quality of the care is brilliant; the staff are excellent with [person's name]." Staff members were clearly passionate about providing high quality care to the people they cared for and spoke fondly of and respectfully about the people living at Beaufort House. A staff member said "I want to help the people living here to get the best out of life." Another staff member said "It's very satisfying to see the people develop. I love coming to work." A third staff member said "We work where they [people] live; they don't live where we work. This is their home."

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and we saw positive and caring interactions. For example, one person enjoyed the company of a staff member who spent time singing and encouraged them to join in. When the staff member stopped singing the person indicated through body language and vocal sounds that they wanted this to continue. The staff member continued with this activity with good humour, which was clearly enjoyed by the person. Another person who was unable to verbally communicate would indicate to staff that they wanted to do something by pulling at staff or nudging them with their elbow, which at times could be quite forceful. Staff were seen to be very patient and responsive to this. The person's family member said "The staff are really giving, relaxed and can be a bit soft with [person's name]."

People's privacy and dignity was respected. People had the option to have their rooms locked and staff did not enter people's rooms without their permission. Where people required assistance with personal care this was done in a discreet and private way. A staff member told us that when supporting people, "I always close the door and make sure that they are covered as much as possible." Where people were able to shower or bath independently but required support to ensure their personal safety staff told us that they gave the person space to ensure their privacy and dignity. They offered verbal support and encouragement from outside the person's en-suite bathroom. Confidential information, such as care records were kept securely and could only be accessed by those authorised to view it.

Staff understood the importance of respecting people's choice and wishes. They spoke with us about how they cared for people and we observed that where people expressed the wish to do something this was responded to by the staff. People were offered choices in where they wanted to spend their time and what they wanted to eat. Choices were offered in line with people's care plans and preferred communication style. Where people verbally declined or indicated through behaviours or body language that they did not want to do something this was respected by staff. A staff member said "People have choice, they make their own decisions."

People were encouraged to be as independent as possible. One person told us, "I clean my room, staff help me sometimes." Another person liked to make cups of tea for staff and visitors and a third person enjoyed spending time making meals in the kitchen and was supported and encouraged to do this. Staff were heard to praise people's efforts and we saw their faces reflected a sense of achievement. Where appropriate

equipment had been provided such as specialist cutlery and kitchen equipment to support people to be independent with cutting vegetables and eating and drinking. Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, 'I like to wash my face myself' and another said 'Support staff need to put the toothpaste on the brush and put it in my hand.'

People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Requires Improvement

Is the service responsive?

Our findings

Most family members told us they were not confident that the service was responsive to their loved ones needs. One family member said "I have discussed a number of things with the manager that I believe will improve [person's name] quality of life. Nothing ever seems to happen; it's all just lip service." A second family member told us, "The manager doesn't do what they say they are going to do." One family member did say however, "I don't have any concerns; I think [person's name] gets the support they need."

One person told us they felt involved in their care and were able to tell the staff about what they did and didn't want. However, family members felt that they were not always involved or included in discussions about their loved ones on going care. One family member said "We do have meetings with the manager but these have only happened following a number of requests from us [family]." Another family member told us "I have asked for meetings but these have only happened when I have got the social worker or the advocate involved." A family member also told us that they had offered to visit the home to show staff how they managed their loved one needs and behaviours when they cared for them at home; this offer was never taken up. This family member told us that they felt "airbrushed from [person's name] life" as soon as they leave the home.

Staff told us that they completed assessments of people before they moved to the home to ensure their needs could be appropriately met. They also told us about how a number of the staff visited and spent time with a person in a residential home in another part of the country to enable them to understand the person's needs. This was done to ensure that when the person moved to Beaufort House staff were able to provide consistent care, had an understanding of the person's complex behaviours and also to provide the person with some familiarity when they moved to the home. A family member confirmed that their loved one was assessed by manager and staff before moving to the home. The family member said "They [manager] asked questions about everything in relation to [person's name] needs and their interests."

People experienced care that was personalised and staff demonstrated a good awareness and understanding of people's individual needs. Everyone living at Beaufort House had a care plan in place which was centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs, abilities and their likes and dislikes. One person said "They [staff] know what I like." Care plans also included specific individual information to ensure medical and psychological needs were responded to in a timely way. For example, for one person, who demonstrated behaviours that some people may find challenging, there was clear and informative guidance to staff. This included behavioural signs to look for, individualised distraction techniques to try and actions to take. Care plans and related risk assessments were reviewed regularly to ensure they reflected people's changing needs. Peoples care plans were 'easy read' and written information was supported by pictorial representations suitable for the needs of the person they related to. This helped to encourage people to become involved in developing their care plan.

Staff were kept up to date about people's needs through handover meetings, which were held at the start of every shift. Information was provided to staff during these meeting which included information about changes in people's emotional and physical health needs and where people had declined assistance with personal care. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

Where people were not able to verbally communicate, staff were able to demonstrate they understood people's communication needs and were able to describe how they supported people to express their views and wishes. For example, one person would communicate through body language and physical prompts to staff such as pulling on their hand. Staff told us that this indicated to them that the person wanted to move to another area of the home or go out in the car. Another person who was able to verbally communicate often felt more comfortable writing things down to communicate with staff. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication care plan' which provided information about their communication style. For example, one person's communication care plan stated, 'Do explain why you want to speak to me and ensure that you explain each step very clearly because I have autism' and 'Don't give me leading questions'.

Each person had a personalised activity timetable in place which included activities such as visiting outside organisations, creative arts and music and spending time with family members. Activities were also in place which supported personal fitness, such as swimming, bowling and walking however these activities were frequently replaced with less active past-times, such as driving in the car, visiting the local supermarket or spending time in the home. Daily records did not always provide the information as to why an alternative activity had been provided. Staff told us that it was possible that the activity had been declined although there was no written evidence to support this. During the inspection we saw someone being supported to play their games console, one person was cooking and some people visited the local supermarket.

The provider had a policy and arrangements in place to deal with complaints and there was a notice about this in the front entrance of the home. This provided detailed information on the action people could take if they were not satisfied with the service being provided. One formal complaint had been received in January 2017 and we saw that this has been investigated and a face to face meeting with the complainant offered. Staff told us that they would support people to raise any concerns or complaints if required or do this on their behalf. People were also supported to access independent advocacy services if they needed them. Family members said if they had any complaints they would tell the manager but some family members told us that they were not confident that the manager would act on complaints. This was discussed with the management team who were aware that families felt they were not always listened to. Both the manager and provider's representative had recently met with or contacted family members to discuss the future plans for the home and the care provided to individual people.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in place at Beaufort House. Plans had been in place to register the acting manager who had been in post since March 2017, however nine days prior to the inspection these plans had been put on hold. A temporary management team had been put in place, which had taken over the overall running of the service. The management structure at the time of the inspection consisted of the service manager, a manager, a head of care, team leaders and support staff. Staff understood the role each person played within this new structure. The temporary management team encouraged staff and people to raise issues of concern with them. One staff member told us that, "The manager seems nice, I think they will listen." Another staff member said, "I think I can approach them, they seem good." At the inspection we found staff worked well as a team and were working hard to ensure the current management arrangements were not impacting on the care provided to the people living at the home. Some staff members had taken on more managerial responsibilities to support the current manager.

The systems to monitor feedback from people and their relatives about the quality of service provision were ineffective. The provider and manager had sought formal feedback through the use of quality assurance survey questionnaires sent to people and their families. One quality assurance survey questionnaire had been sent to people and their families since the service opened in August 2016. We looked at the feedback from this survey, completed in May 2017, three responses had been received. All of the three responses were very satisfied with the care received; however two showed they were less satisfied with the environment. We saw that the completed surveys had been reviewed by the [prior] manager however we were unable to establish if any action had been taken to address the issues raised.

Five of the six family members we spoke to were not confident that the home was well led. A family member said, "We were made so many promises about things that would be done, but nothing ever happened." They added, "I'm still not confident now." Another family member told us, "I've never really seen the [prior] manager; they have never contacted me and when I have tried to make contact they are never around." A third family member said, "I don't feel listened to or feel involved in the care." They added "The communication is terrible." Family members were also concerned the effectiveness of the service had resulted in their loved ones not reaching their full potential. They attributed this to the lack of communication and lack of joint working between the provider's management, families and professionals. One family member said, "Since [person's name] has lived at the home their abilities have regressed." Another family member told us, "I don't think [person's name] has progressed in a way they should have." The provider had missed opportunities to ensure that concerns that were important to people and their relatives were addressed and that if they were not, an explanation was provided to them.

The quality assurance systems used by the provider and management staff were ineffective in assessing where the service required improvement. The systems had failed to identify the shortfalls found during this inspection such as missed staff training and supervision.

We also found that where accidents, incidents, and near misses had occurred there was not an effective system in place to ensure that appropriate action was taken to mitigate any risks or prevent reoccurrence.

There was not an effective system to monitor the quality of peoples' care records to identify omissions and to analyse concerns. Formal audits had not been completed in relation to daily records. The failure to analyse the records meant that when people had not receiving their planned activities or records of family or professional contact were not made no follow up action was taken. This meant that shared information may not always be remembered and actions highlighted may not always be taken as advised. This was reflected in that families did not feel listened to or involved in the care of their loved ones. Additionally information within people's daily records was not detailed and did not include relevant and important information in relation to the care that had been provided.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other quality assurance systems in place were effective. Regular audits had been completed in relation to, infection control, the cleanliness of the home, medicine and health and safety. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety.

The directors of the company were fully engaged in running the service and their vision and values were built around empowering people while promoting their life skills and independence. Staff were aware of the provider's vision and values and how they related to their work and all spoke positively about the home. The manager said "We want to empower people and help them achieve their goals." One member of staff told us "We what to help people get the best out of their life."
The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the manager had made appropriate notifications.

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 17 HSCA RA Regulations 2014 Good governance The lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure that staff had received appropriate and up to date training and on going or periodic supervision in their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. .