Five Focal Point Limited

Beech Court Care Home

Inspection report

52 Church Lane
Selston
Nottingham
Nottinghamshire
NG16 6EW

Tel: 01773581450
Website: www.careffp.co.uk

Date of inspection visit:
04 December 2017
06 December 2017

Date of publication:
13 February 2018

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 4 and 6 December 2017. Beech Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beech Court Care Home accommodates up to 23 people in one adapted building. On the day of our inspection 14 people were using the service.

The service had a registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
Risks to people's health and safety were identified and assessed although further improvements were required to ensure that good practice was followed and people remained safe. We have made a recommendation about the use and review of bed rails. People were supported by staff who knew how to recognise abuse and who were confident to act to keep people safe from harm.

People were generally supported by enough staff. People received their medicines as prescribed, although some additional information and checks were required. People lived in a clean environment although improvements were required to ensure the risk of spread of infection was reduced.

People were not always provided with timely support to eat and drink well. People were supported by staff who received training, although some gaps in staff training and knowledge were evident. People who lacked capacity to make certain decisions could not always be assured their rights would be upheld in accordance with legislation.

People lived in a service which met their needs in relation to the premises and adaptations had been made when required. Information was available in the event that people needed to leave the service and staff monitored and responded to people's changing health conditions.

People lived in a service where staff knew them well. Staff spoke about people warmly and were knowledgeable about their needs and backgrounds. People were supported to maintain their privacy and dignity although it was observed that further improvements could be made.

People's needs were assessed before they started using the service and people and their relatives were involved in producing and reviewing care plans. People were offered opportunities to take part in social activities. People were given opportunities to make a complaint or raise concerns about the service they received.

Systems were in place to monitor and improve the quality of the service, however, these were not fully effective. People, their relatives and staff were complimentary of the management of the service. The provider sought people's feedback in relation to the service they received and staff told us there was an open working culture which supported them in their role.

This is the first time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's health and safety were identified and assessed, although improvements were required to ensure that good practice was followed and people remained safe.

People were supported by staff who knew how to recognise abuse and who were confident to act to keep people safe from harm.

People were generally supported by enough staff.

People received their medicines as prescribed, although some additional information and checks were required.

People lived in a clean environment although improvements were required to ensure the risk of spread of infection was reduced.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always provided with timely support to eat and drink well.

Staff had not always received training and some staff had gaps in knowledge.

People who lacked capacity to make certain decisions could not always be assured their rights would be upheld in accordance with legislation.

People lived in a service which met their needs in relation to the premises and adaptations had been made when required.

Information was available in the event that people needed to leave the service and staff monitored and responded to people's changing health conditions.

Is the service caring?

Good

The service was caring.

People lived in a service where staff knew them well.

Staff spoke about people warmly and were knowledgeable about their needs and backgrounds.

People were supported to maintain their privacy and dignity although it was observed that further improvements could be made.

Is the service responsive?

Good

The service was responsive

People's needs were assessed before they started using the service and people and their relatives were involved in producing and reviewing care plans.

People were offered opportunities to take part in social activities.

People were given opportunities to make a complaint or raise concerns about the service they received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to monitor and improve the quality of the service, however, these were not fully effective.

People, their relatives and staff were complimentary of the management of the service.

The provider sought people's feedback in relation to the service they received and staff told us there was an open working culture which supported them in their role.

Beech Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 6 December 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider.

During the inspection, we spoke with 11 people who lived at the service and four relatives either face to face during our visit or over the telephone. We also spoke with the registered manager, two care workers, a domestic worker, cook, two representatives of the provider and two visiting healthcare professionals.

We looked at all or part of the care records of three people who used the service, medicines administration records, staff training records and the recruitment records of three members of staff. We also looked at a range of records relating to the running of the service, such as audits and maintenance records.

We observed care and support in communal areas of the service and 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.

Requires Improvement

Our findings

All of the people and relatives we spoke with told us they felt the service was safe. One person told us, "I feel very safe as the staff look after me really well," whilst another person said, "This is a very safe place."

The staff we spoke with told us they had received training in safeguarding adults from abuse. They were able to describe some of the different types of abuse, the signs and symptoms of abuse and confirmed they would report any allegation or suspicion of abuse to the registered manager. Whilst staff were confident that the registered manager would act appropriately in response to any safeguarding concerns, staff were not aware of the role of the local authority safeguarding team in investigating allegations of abuse. However, the registered manager was aware of their responsibility to refer to the local authority safeguarding team when required and we saw that contact details were available in the service.

Records showed that not all staff had completed the required training in safeguarding adults. We raised this with the registered manager who provided confirmation following our inspection that all staff were in the process of completing safeguarding training.

People could not always be assured they were supported safely when being assisted to change their position (for example, moving from a chair to a wheelchair). We observed two examples of staff members supporting people to change their position which could have posed a risk to their safety. The equipment used was not appropriate for the needs of the people and on one of these occasions we saw the interaction resulted in the person's discomfort. Training in moving and handling was being provided to staff by an external trainer during our visit and on the second day of our inspection, the registered manager confirmed that all staff had been required to demonstrate their competency with equipment. The registered manager also took action to ensure that information about the equipment people required was available to staff. Whilst this action reduced the risk to people, the risk to people of the improper use of equipment had not been fully addressed prior to our visit.

Some of the people living at the service used bed rails. Bed rails are used to reduce the risk of a fall from bed. It is important that consideration is given to whether the use of bed rails is suitable for the person. We viewed one person's care records which included a bed rails risk assessment and stated that the person's family had requested the use of bed rails at Beech Court Care Home. Whilst this request should be considered, the person's risk assessment had not been reviewed to ensure the use of bed rails remained safe for the person. This is despite the person experiencing a fall from their bed whilst bed rails were in place.

We recommend that the provider considers current guidance on the use of bed rails and that bed rail risk assessments are reviewed regularly to ensure they are suitable for the people using them.

We found that other equipment was used to reduce the risk of harm to people, such as pressure relieving mattresses which reduce the risk of people developing pressure ulcers. We found that one person's mattress was not at the correct setting for the person's weight which would reduce the effectiveness of the equipment. The registered manager took immediate action to correct this. They showed us new checks which were in the process of being introduced to the home to ensure that equipment was safe and working. The registered manager confirmed that checks on bed rails would also be included to ensure they remained safe.

People were protected from risks associated with fire and legionella bacteria. We saw that regular fire safety checks had been carried out and recorded and that the advice of the local fire service had been acted upon following a routine visit. Information was available to staff about the support people would require to leave the service in the event of an emergency, such as a fire.

People told us they did not feel unnecessary restrictions were placed on them. We observed that people who required support to mobilise were asked where they wished to eat their meal and assisted to move if they wished to. The staff we spoke with were aware of people's anxieties or frustrations and how this could impact on behaviour. For example one staff member told us about a person's frustration in relation to their limited mobility and the strategies they used to alleviate their frustration. However, we also observed two people sat next to each other who were arguing and swearing at each other. Whilst staff were aware that the two people argued, it was not clear whether either of them had been consulted about where they wished to sit or how staff responded to their arguing.

People and their relatives told us there were generally enough staff to meet people's needs in a timely way. One person said, "Mostly there's enough around to help," whilst a relative commented, "When I'm here I see people's needs being met. If people need help it is responded to." However, another relative told us, "I do think they can be short staffed. Particularly when there is only two on and they are both having to deal with one person. That means there is nobody to help anyone else. Having said that, I've never seen any worrying incidents." The staff we spoke with told us that staffing levels were sufficient and records showed that the amount of staff which the provider had identified as being required was generally provided.

During the first day of our inspection, the amount of staff available was reduced due to a training session taking place and the registered manager supported the staff in responding to people's needs. However, we observed that at busy times, such as mealtimes, staff were not always effectively deployed to ensure that people were supported to eat and drink well. For example, during a mealtime we saw that some people were not prompted or encouraged to eat their meals. One member of staff was assisting a person to eat their meal in a communal area whilst other people sat with their meal untouched for up to 25 minutes. This meant that either staff were not effectively deployed or there was not a sufficient amount of staff available during the mealtime to ensure people received the support they needed. The registered manager told us they would monitor mealtimes at the service to ensure people got the support they needed.

People could be assured that staff were safely recruited however, improvements were required to records kept by the service. Criminal record checks were carried out through the Disclosure and Barring Service (DBS) prior to staff commencing employment. Two references were required before people commenced working at the service. However, it was not always clearly documented that copies of photographic identification had been seen and gaps in employment history had been accounted for. This is good practice to ensure the recruitment process is robust and identifies any risks.

People were supported to take the medicines they required. One person confirmed that staff followed good practice when administering medicines. They said, "They (staff) watch me while I take the tablets and bring me some water." The registered manager told us that all staff who administered medicines had their competency to do so assessed annually. We observed a staff member administering medicines and saw they followed good practice when doing so including recording when medicines had been given.

Records showed that information was available to help the safe administration of records such as a photo of the person, a record of any allergies and information about how people liked to take their medicines. However, we saw that some people had medicines prescribed as and when required (known as PRN) and a protocol was not always in place for staff providing them with details about when and why the medicines should be given. The registered manager confirmed these were completed following our inspection. Medicines were stored safely and securely.

People lived in a clean environment however, improvements were required to ensure that sufficient action was taken to prevent the risk of infection. The staff we spoke with were aware of the action they would take to prevent and control infection. This included the use of hand wash, personal protective clothing (PPE) and ensuring areas of the home were cleaned. We observed that staff used protective aprons and gloves when providing people with drinks and snacks but then continued to wear them for a significant part of the morning which would impact on their effectiveness. Staff told us they had plenty of PPE and hand wash available to them and that sufficient amounts were stored in people's bedrooms so they could be used when they were supporting people with personal care. However, we checked one person's room and found there was no apron, paper towels or hand wash available. The registered manager confirmed that they were in process of devising an action plan in response to a visit from an external organisation which had raised concerns about hand washing. They shared their plan with us which included actions to address this issue.

The registered manager carried out monthly reviews of the accidents and incidents that occurred at the home. We checked recommendations which had been made by external agencies following incidents which had occurred at the service and found these had been implemented. However, we also reviewed details of an accident which had occurred at the service and whilst action had been taken in response, a relevant risk assessment had not been reviewed to check that the measures in place remained safe and appropriate for the person. This is important to ensure that risks to people are accurately assessed. The registered manager told us they would review the risk assessment.

Requires Improvement

Our findings

People were not always provided with timely support to eat and drink well. A menu was available in pictorial format which showed a choice of two meals. On the first day of our inspection this did not reflect the food choices for people, however we saw that a member of staff asked people what they wanted to eat. We saw that meals were of a sufficient portion size, however people were not always provided with the support they needed to eat sufficient amounts.

We viewed the care records of one person who had previously experienced weight loss. Their care plan stated that the person should be prompted to eat their dinner and if the person was not able to do this they were assisted by staff. We observed the person was provided with a meal which was untouched for approximately 25 minutes before they were prompted to eat. Once prompted, the person began to eat but their meal would have been cold. Another person's care plan stated the person needed substantial support at mealtimes. We saw that the person was not provided with support until 25 minutes after the food was served. A third person's meal had been on a plate in the dining room for approximately 15 minutes before it was taken to them in the lounge. When we asked the person if they were enjoying their meal, they told us it was cold. They did not eat all of their meal. This meant that people could not be assured they would be provided with the support they needed to eat well.

We observed people asking for a drink with their meal. We saw that a staff member provided people with a drink but did not offer them a choice. In addition, people were not always provided with support and encouragement to drink. One person refused their meal but agreed to have a cup of tea. Whilst this was provided the person was not provided with support or encouragement and did not drink their tea. We observed another person whose care plan stated they drank fluid through a straw, was not provided with a straw and they did not drink during the mealtime.

Limited information was available to kitchen staff about people's likes and dislikes. Some people's care plans contained this information but it was not clear how this was used to plan the menu. In addition, people's food allergies were not sufficiently recorded to reduce the risk of harm. We saw in one person's care plan they had an allergy to a certain food. There was no record of this available in the kitchen and the cook told us that no one living at the service had any food allergies. This meant there was a risk that the person may be provided with a food item they were allergic to.

The above information was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above people were mostly complimentary about the quality of the food available at the service. One person told us, "I like the food. It's very good," whilst a relative commented, "I think the food here is really good and (relation) has put on some weight since they have been here." However, another person told us they were not enjoying their meal and said, "I wouldn't advise having the dinner." Records showed that people's weight was monitored and referrals had been made to external healthcare professionals for advice when required.

Before people started using the service, an assessment of their needs was carried out. The records we saw showed this to be the case and that individual plans of care had been completed to provide guidance to staff as to how people's care needs should be met. The service used an electronic care planning system and the registered manager explained they could request alterations to the system to ensure that the tools used reflected best practice.

People spoke positively about the skills and knowledge of staff. One person told us, "They (staff) are very good. They help me get dressed and they are very gentle." Another person's relative commented, "The staff here are really good."

The staff we spoke with told us they received training and support which enabled them to carry out their roles effectively. One staff member told us, "It is really good training and we get feedback on our performance." The staff member provided an example where they had received feedback from the registered manager on their performance and described this as constructive. Records identified a number of different training areas. These records showed a number of gaps, for example, not all staff had received training in the mental capacity act or equality and diversity. The registered manager acknowledged there were some gaps in training and confirmed that staff were in the process of completing these.

The registered manager told us that staff received supervision every two months and that they monitored staff performance. The staff we spoke with were knowledgeable about different aspects of care, although we observed that staff did not always support people to change their position in accordance with good practice guidance. The registered manager confirmed on the second day of our visit that all staff had received practical instruction and been required to demonstrate their competency.

People told us they had access to healthcare professionals when needed, such as the doctor. People's relatives also told us that staff sought medical attention when required and that they were kept updated of any changes to their relations health. One relative told us, "They (Staff) are really good in that respect. They will always get in touch if [relation] isn't well or they are worried at all." Another relative commented, "Staff go with (relative) to the doctor or they get health professionals in(to the home)."

People's records showed that people had access to a range of healthcare professionals such as the GP, falls and bone team, dietician and community nurses. The visiting healthcare professionals we spoke with told us that they were contacted appropriately for support when people's needs changed. They commented that staff followed advice given to them. One healthcare professional commented that staff were good at taking up any training offered whilst the other stated that staff ring to update them of people's health conditions.

Information was available in the event that people needed to leave the service and go to hospital. This included of a record of the person's medicines, any allergies the person had, the support they required to eat and drink and any medical conditions. This ensured that important information about the person would be available when needed if they moved to a different health or social care setting.

The premises that people lived in met their needs. People had access to a garden with a large patio area

which staff told us was used by people when the weather was good. Adaptations had been made to the environment to suit the needs of the people using it, for example grab rails had been installed and a specialist bath was provided for people with reduced mobility. We saw that people had made their own decisions about the information they chose to display on the door of their bedrooms and the registered manager told us that people were able to bring their own furniture in order to personalise their rooms and provide familiarity.

People told us that staff asked for their consent before they provided support to people. One person told us, "They (staff) are always asking me. Everything they do, they say, 'is it ok?" whilst another person said, "They don't take anything for granted." Our observations supported what people told us with the exception of one person being moved from the dining room into the lounge without any explanation or choice. We saw that a staff member moved the person's wheelchair without talking to the person who caused them to startle and reach for the table in front of them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with showed an understanding of the principles of the MCA and told us how they would act in the best interests of people who lacked capacity to consent. For example, one staff member told us, "There are people we have to make decisions for. We use information in care plans and their past history and if families come in we can speak to them." The staff member gave us the example of holding up different choices of clothes to help people make as many decisions as they could for themselves.

However, people's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. Whilst care plans contained some assessments of people's capacity, mental capacity assessments and best interest decisions were not always in place as required. For example, one person was only supported to have a cigarette at certain times of the day. When we spoke with the registered manager they told us that the person had previously agreed to this when they had capacity, however, this was not clearly documented and the person had since lost the capacity to make this decision. The registered manager completed a mental capacity assessment and best interest decision following our feedback.

People's care records showed that their relatives had given their consent for aspects of care. For example, one person's relative had signed their consent for photographs to be taken of their relative. Another person's family had provided consent for their relative to receive care and support. In both of these examples, there was no evidence that the relative held power of attorney which would give them the legal authority to make health and welfare decisions on behalf of their relative.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us that applications had been made if required. However, the system used to identify if people required an application for authorisation and to alert staff if the authorisation had expired

was not effective. We found that one person's DoLS had expired at the end of 2016 and an application for reauthorisation had not been made as required. The application was submitted by the registered manager following our feedback.

Good

Our findings

People told us they were happy living at Beech Court Care Home and were complimentary of the staff. One person told us, "They're all lovely with us. They are really super lasses," whilst another person commented, "They're all nice to us. I tell it how it is and I would say the staff are marvellous. They're very nice staff."

Staff spoke about people respectfully and described them warmly. People told us they were comfortable with staff and the way they spoke with them. We observed the registered manager taking time to speak to people and providing support when required. On person's relative commented, "[Relative] really likes the manager. [Relative] thinks she is great."

The interactions we observed from staff were conducted in a kind and respectful way. We observed that staff responded to people's requests for support with patience and understanding. For example, as a consequence of one person's dementia they made repeated requests of staff members. We saw that staff responded to the person's requests and provided information to reassure the person. On another occasion we saw that a staff member was patient and encouraging whilst supporting a person to have a drink.

The care plans we looked at contained information about people's life history and information about how to support the person to communicate and maintain a sense of self awareness. However, information about people's preferences were variable. For example, although care plans contained information about people's preferred bedtime routine, not all of the care plans contained information about people's likes and dislikes in relation to food. The registered manager told us that due to the small size of the service they felt that staff had developed meaningful relationships with people and knew people well. We observed this to be the case during our inspection.

The staff we spoke with were knowledgeable about people's family relationships, backgrounds and what was important to them. For example, one staff member spoke about a person who was frustrated due to a recent change in their physical health and described the support staff provided with physical exercises to help the person regain their independence. Another staff member told us they had the time to sit and talk with people to find about their past lives and their preferences. A relative confirmed that staff knew their relation well, they told us, "My relative is really well looked after. [Relative] does get very depressed sometimes if left on their own. The manager and staff know that and make sure [relative] is being engaged with all the time."

People had access to independent advocacy to help them express their views. The registered manager was fully aware of the different types of advocacy available to people and under what circumstances they would request the use of an advocate. They confirmed that a person living at the service had previously used an advocate. Advocates are trained professionals who support, enable and empower people to speak up. Information was on display within the service which informed people about local advocacy services available to them.

People told us that staff respected their privacy and dignity. Our observations mostly supported people's views however, we saw that on occasion people's privacy and dignity were not appropriately supported. For example two members of staff were supporting a person to change their position using a piece of equipment and we saw that staff did not ensure that the person's dignity was appropriately supported. The person's lower back and upper buttocks were exposed during the manoeuvre which took place in a communal area of the service. In addition, on another occasion we observed that a person was not offered clothes protection during a mealtime and they spilt a considerable amount of food onto their clothing. We brought this to the attention of the registered manager who ensured the person was provided with support to be clean.

People told us they were supported to maintain their independence. The people we spoke with told us they got to make choices such as what to wear and when they wanted to go to bed. One person said, "I go to bed when I'm ready and I choose my clothes." People were also supported to maintain their independence. One person told us, "I can undress myself when I am ready" whilst another person's relative commented, "[Relative] tries to manage things on their own and staff let them do it but keep an eye on them. Simple things like putting their cardigan on."

Good

Our findings

Staff told us they had time to get to know people and learn about their preferences as to how they wished support to be delivered. Consideration had been given as to how people could be involved in care planning and review. For example, people's care plans contained details of the support they needed to understand and contribute to their care plan. In most cases, this was through discussions with their relatives. People's relatives confirmed they were kept up to date of any changes to their relatives support and had the opportunity to contribute to care planning and review. One person's relative told us, "If there is anything serious they (staff) let us know. I think they know [relation] very well. (Registered manager) keeps in touch." Another person's relative told us, "We were involved in the care plan and every time any of us come in, the manager will always take time to give us an update on [relative] and if anything has changed at all."

Our observations confirmed what people and relatives told us. During our inspection we saw the registered manager met with a relative to discuss their relations care and support. People's care plans also contained evidence of people's relatives being invited to attend care plan reviews. The care plans we saw had been regularly reviewed and we found these had mostly been updated when changes had occurred. For example, one person's mobility care plan had been updated following a fall. However, another person's care plan did not reflect improvements in their mobility. We spoke to the registered manager who told us that the person's mobility could be variable, however this was not clear in the person's care plan.

People were supported by staff who were given information about their support needs. The registered manager told us they carried out a pre admission assessment prior to a person being admitted to the service. They told us this included information about the person's spiritual needs, any cultural considerations or needs in relation to people's sexuality. We saw that people's care plans provided guidance for staff as to how people should be supported and risks reduced. For example, one person was at risk of skin breakdown and their care plan contained information for staff about how the risk could be reduced. The staff we spoke with were knowledgeable about people's health conditions and how these should be managed. For example, one member of staff described the signs of skin breakdown and what areas of skin were most at risk, they also described how another person's medical condition was managed in line with their care plan.

The provider was aware of the need to identify accessible information needs during the assessment of people's care and some information was available in people's care plans about how they should be supported to understand information. The provider showed us easy read complaints information and people's care plans contained some information about how people should be supported to understand

information, for example, with the assistance of their relative or advocate.

People were offered opportunities to take part in activities. People's relatives told us that people were provided with the opportunity to take part in activities, such as singing. During our inspection, we saw that people were offered hand manicures and the opportunity to access a local community group. Those people who wished to partake in these activities were offered the support to do so. Information was available in the service about past activities, upcoming events planned and asking for people's ideas. We also saw that activities were discussed at residents meetings.

People had the opportunity to access the local community via regular opportunities to attend a community group and trips to Matlock illuminations and Carsington water. People's care plans contained information about their spiritual needs, although from documentation it was not clear how these were met, however records showed people were given opportunities to attend a carol service and have bible readings.

None of the people we spoke with could recall having the need to raise a complaint. The relatives we spoke with were confident in approaching the registered manager if they had any concerns or complaints about the service and told us that their concerns were responded to. One person's relative said, "When we have raised issues it is sorted."

No formal complaints had been received since our last inspection therefore it was not possible to assess whether formal complaints were responded to appropriately. The registered manager told us they spoke with people on a daily basis to ensure they were happy and provide the opportunity to raise issues. We observed this to be the case during our inspection. Information was available about the process of making a complaint and what people could expect in response. This included information about the action the person could take if they were not happy with the outcome of their complaint.

People's care plans contained limited information about how people wished to be supported towards the end of their life. For example, some people's care plans contained information about whether they wished to have input from a member of the church and where they wished to be cared for at the end of their life. In most cases this information was limited. The registered manager was aware of the need for additional information and we saw they had contacted people's relatives to discuss people's end of life wishes. However, we reviewed the care plans of a person who had recently been receiving care at the end of their life. We found this to be much more comprehensive and included information about medicines which should be made available to the person and how they should be supported with mouth care. We were told that the person spent their last days in an area of the service they wished to spend time in, with extra staff support and listening to the music they enjoyed.

Requires Improvement

Our findings

People could not be assured that the monitoring of the service was robust. Both the registered manager and the provider carried out a series of audits and checks within the service, including medicines audits, infection control audits and health and safety checks. Whilst these had identified some areas which required improvement, they had not identified some of the issues we found during inspection. For example, a medicines audit was carried out every three months, however, the last audit did not identify whether ointments and creams were dated on opening or whether protocols were in place for medicines which were prescribed to be given when required. In addition, although forms were completed following accident and incidents in the service, investigations were not sufficiently robust in ensuring that all required actions had been completed, for example, ensuring that risk assessments had been updated.

Systems and processes were not always fully effective. For example, it had not been identified prior to our inspection that one person's DoLS authorisation had expired and that they required a further application to be made. In addition, whilst care plans had been routinely reviewed, changes had not always been acted upon, for example by ensuring that mental capacity assessments were completed if required. Despite the registered manager informing us they observed staff practice and provided feedback, the system to ensure staff received training and were competent in their roles was not fully effective. We observed that people's safety and dignity had been compromised when they were assisted to move their position and people experienced a lack of support at mealtimes. Combined with gaps in staff training this meant that people could not be assured they were always supported appropriately.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service promoted an open culture for staff. The staff we spoke with told us they enjoyed their work and felt supported. One staff member told us they "loved" their work and described a staff team that worked well together. They told us they would feel comfortable reporting any concerns or issues to the registered manager, including if they had made a mistake or were concerned about the treatment of people by a colleague. They felt that any issues raised would be dealt with fairly.

There was a registered manager in post who was clear about their responsibilities and had notified us of significant events in the service. The registered manager was visible and actively engaged with people who lived at the service. They told us they spoke with people who lived at the home on a daily basis and was confident that people would voice any concerns they had. We observed this to be the case during our

inspection, the registered manager spent time taking to people, providing information and reassurance and supported the staff in providing care. It was clear from our observations that the registered manager maintained positive relationships with people who lived at the service.

People's comments supported our observations, one person's relative told us, "The manager is really good. She is all over the place and very accessible. She really listens to what we tell her and she does her very best. She puts her heart and soul into the home." Another person told her that the registered manager ensured that "if [relative] wants anything, they can have it."

The staff we spoke with told us they found the registered manager and the provider to be approachable and accessible. One staff member said, "I feel listened to. I enjoy working here. [Registered manager] is approachable. There is always someone available, you can always get hold of someone if you need them." Another staff member commented, "[Registered manager] is visible and approachable. There is always someone on call and they respond."

People were given opportunities to give feedback on the service they received. Although few of the people and relatives we spoke with could recall any opportunities to do so, one person's relative confirmed they had been asked their opinion of the service. Records also showed that meetings were held with people who lived at the service and that suggestions about activities people wished to participate in had been acted upon. We also saw that a survey had been carried out which had gathered the views of people and relatives in December 2016. The results showed that people and relatives were largely satisfied with the service received. The next quality assurance survey was due to be carried out shortly after our inspection. People's relatives told us they felt listened to and that any issues they raised were acted upon.

The registered manager made efforts to keep up to date with current research and had received training on the implementation of a new falls risk assessment aimed at reducing falls in care homes. They told us they would use this knowledge to assess falls risks more comprehensively. The feedback we received from visiting healthcare professionals about the management of the service was positive and described a collaborative approach to working with external professionals. The ratings from our last inspection at the service were displayed in the service as required.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive the support they required to eat sufficient amounts at mealtimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the services provided were not fully effective.