Bellhouse Care Home Limited

Bell House Care Home Limited

Inspection report

61 Wilshaw Road
Meltham
Huddersfield
West Yorkshire
HD9 4DX

Tel: 01484850207

Date of inspection visit:
25 January 2017

Date of publication:
06 April 2017

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

This inspection took place on 25 January 2017. The service had been inspected in June 2016 and had been in breach of several of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our previous inspection we had concerns about how risks to people living at the home were managed and the lack of robust governance arrangements. Staff had not received appropriate induction, supervision and training and they had not had their competence checked to demonstrate they could put this learning into practice. At this inspection we checked to see whether improvements had been made and sustained.

Bell House is registered to provide personal care and accommodation for up to 24 older people. The accommodation is single storey and all bedrooms are single rooms some with en-suite toilet facilities. There were 22 people living at the service at the time of our inspection.

There was a registered manager in post who had been in post since 2014. 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 2008 and associated Regulations about how the service is run.

We found the registered provider had initiated many improvements at the service. This included the regular supervision of staff, and an improvement in training and competency checks particularly around moving and handling and medication administration. The environment had been further enhanced and a programme of refurbishment was on-going. The registered manager and registered provider undertook regular audits at the home, and these had improved from our last inspection, although we still found some of these audits lacked robustness as they had not picked up isolated issues we found when reviewing care plans, which had the potential to cause harm, such as one fall had not been analysed to ensure risk reduction measures could be implemented, and one person had not been assessed for suitable shower equipment. Record keeping and the detail in people's care plan on the whole had improved and reflected people's care needs. Staff were more accurately recording when care had been provided.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents. The home had a training programme in place to ensure staff had the knowledge and skills to perform in their role and this included specific areas of learning such as oral health. Staff had received practical moving and handling training and had their competencies checked.

There had been occasions when staffing numbers were not in line with the registered provider's assessment of staffing levels derived from the dependency tool in use. The home was actively trying to recruit more staff but was struggling to recruit staff with the required values and behaviours.

Standardised risk assessments had been undertaken for those people at risk of malnutrition and pressure sores. The home completed risk assessments when other risks such as choking, medication, fire and falls

had been identified. Moving and handling risk assessments and care plans had improved from the previous inspection although further improvements were needed in the amount of detail required to guide staff.

We reviewed accidents and incidents at the home and noted the analysis of accidents and incidents had improved since the last inspection and there had been management overview to determine the root cause of accidents and some measures put in place to prevent further accidents. However, we found one accident where staff had completed the form but not passed it to the manager to ensure all preventative measures had been considered or recorded.

Medicines were stored and administered safely and we observed medicines being administered appropriately during our inspection.

We found the environment was still in the process of refurbishment and to a high standard in most areas. However, one of the corridors leading to the bedrooms was narrow and not ideal for wheelchair users. The communal lounge lacked space to manoeuvre and when everyone was seated there was no space for visitors or staff to sit and chat with people. The home was extremely clean with good infection control practices in place.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice Staff had received training on the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards, but we still found the registered manager's understanding on how to assess mental capacity, and the best interest process was lacking. This was not having a major impact on the people living there who all but one had mild cognitive impairment and could consent to their daily care requirements.

People told us they enjoyed their meals. The home had been awarded the Kirklees Healthy Choice Gold Award for being committed to good standards of food hygiene and healthy options.

We found all the staff to be caring in their approach to the people who lived at Bell House and observed they treated people with dignity and respect and they clearly knew the people they supported. The home had received compliments from relatives who praised the care provided at Bell House.

People were provided with care which met their choices and preferences such as what time they got up, went to bed, what they ate and they were encouraged to share their views on how they wanted the service to be run. We found handover records and night check information had improved and was reflective of people's needs.

The management involved staff, people using the service and their relatives to inform developments at the service and staff spoke highly of the management team who they described as supportive.

There was no activities coordinator in post although one had been interviewed and was awaiting employment checks to be completed. This meant the home was not consistently ensuring meaningful activities for people at the service at the time of our inspection.

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 always safe

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents.

Risk assessments had improved and were detailed to reduce some risks but there were still areas which required improvement, such as the identification of assistive equipment and more detail in a moving and handling care plan.

There were not always adequate staff at the home in line with the registered provider's assessed dependency levels.

We found medicines were stored and administered safely and we observed medicines being given appropriately

Is the service effective?

Requires Improvement

The service was not always effective

People told us they enjoyed their meals. The home had been awarded the Kirklees Healthy Choice Gold Award for being committed to good standards of food hygiene and healthy options.

Staff had received training to ensure they had the knowledge and skills to perform in their role.

Staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. There was a lack of awareness amongst some staff in relation to the process to be followed to assess capacity and best interest decision making.

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy and

dignity were protected at all times.

People were encouraged to maintain their independence around activities of daily living and with their mobility.

People were supported to maintain cultural and religious preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in their care planning when appropriate and families consulted with to ensure preferences and views were considered when devising support plans.

Handover records and night check records had improved since the last inspection and accurately reflected each person's needs.

Activities on offer were limited in the absence of an activities coordinator

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some documentation such as moving and handling care plans had not been completed thoroughly although there had been an improvement since the last inspection.

All audits in relation to the environment were accurate and up to date, although care plan audits lacked rigour.

The service held regular meetings with staff, people using the service and their relatives to inform developments at the home. They regularly involved health and social care professionals to ensure people at the home were supported appropriately. .

Bell House Care Home Limited

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 25 January 2017 and was unannounced.

There were two adult social care inspectors, 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 care service.

We had not asked the registered provider to complete Provider Information Return (PIR) for this inspection. 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. They had provided us with contact information for professionals who had been involved at the home.

Before the inspection we reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

We spoke with 11 people living at Bell House and three relatives and visitors. We spoke with the registered provider, the registered manager, the head of care, two care assistants and the chef during our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the

home. We observed the lunch time meal experience in the communal dining area and observed care interventions throughout the inspection process. We reviewed five care files and daily records for people living there. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the service. One person said, "It is the willingness of the staff to help. Nothing is too big for them. Let's say they are going to the other end (of the room) and we needed a walking frame and you put your hand up and they get it straight away." Another person said, "It's lovely here."

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They could describe the signs of abuse which might be present in a care home such as physical, sexual and financial abuse. One member of staff told us they would report any concerns immediately to the registered manager who we were told was contactable 24 hours in a day.

The registered provider showed us the dependency tool they used to determine staffing levels. This categorised people into four areas, whether they were self-caring, low, medium or high dependency. The tool had been completed on 23 January 2017 and showed 53 hours of direct care interventions were required. The registered provider had calculated they required four staff during the day to support people and two during the night, although we could see from the staff rota that on occasions there were only three care staff in attendance during the day. Our observations during our inspection and from our review of people's needs indicated on the day of our inspection the home did have the right number of staff to people using the service. The registered manager was acting as a carer at the start of our inspection, but an additional carer was asked to support the service to free the registered manager from this role to assist us with our inspection in relation to management checks

We were told by staff on the day prior to our inspection there had only been three care staff during the day, which meant they had been under pressure, particularly around meal times and supporting people to access the toilet. This was lower than the number of staff the registered manager and registered provider had assessed they required at the home. The registered manager explained to us they were actively recruiting but they were struggling to attract staff to work at the home. They had used agency staff on nights with a permanent member of staff to cover shortfalls during the night.

The home employed cleaning staff with one cleaner for four hours each day and care staff were required to clean outside these hours which had a potential to impact on their caring duties. We observed the home was very clean. The home did not employ a dedicated laundry person and care staff completed laundry in and amongst their caring duties. Night staff ironed people's clothes and we observed clothes were neatly ironed and stored tidily in people's bedrooms. The registered provider told us these ancillary tasks had been factored into their staffing requirement calculations although we were not provided with the information to evidence how this had been calculated.

We asked people whether there were enough staff to ensure they were cared for safely and had their needs met in a timely way. We received the following comments, "There is. There are only two on at night and that this is a little bit understaffed." Another person told us, "I never have a problems finding them; there's

enough for me."

We found standardised risk assessments such a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition.

At our previous inspection we found risks identified in the risk assessment section of the care records had not been transferred into the care plans. At this inspection we found improvement in this area as risk assessments now underpinned care plans and were no longer in separate sections which meant staff were directed to consider risk reduction measures when providing support to people. However, we observed not all people were supported in line with their care plan. For example, one person at risk of choking whose directions from the Speech and Language Therapist had been transferred to their care plan for 'staff to monitor [name] to ensure [they] do not over fill [their] mouth before swallowing', was not supervised at tea time during our inspection. We discussed this with the head of care who confirmed staff were aware that this person supervision whilst eating but they were not doing it on this occasion.

We found at the last inspection there was a lack of recorded risk assessment around the use of assistive equipment such as bath hoist, wheelchairs and commodes in all the files we looked at. At this inspection we found risk assessments had been put in place for specific items of equipment, although they contained mostly generic risk reduction advice rather than specific to the person. For one person who had complex needs, there had been a lack of risk assessment in relation to bathing and showering to ensure suitable equipment had been used to shower this person. There was no suitable shower chair for this person and we were told they had been showered whilst in their wheelchair. They said they had been advised to do this by a professional but there was no evidence to support this. Assisting a person to shower using equipment not designed or tested by the manufacturer for this purpose, poses a risk to health and safety. We raised this issue with the registered manager and the registered provider who agreed to seek professional advice to ensure that this was addressed immediately.

One person at the home required mechanical assistance to move from bed to chair and had been assessed by the local authority moving and handling team following our last inspection and they had completed a detailed risk assessment. They also made the following recommendation for the home: 'A detailed handling plan that guides care practice should be developed by the service provider and made accessible to all relevant staff.' This had not been done at the time of our inspection. Although they had transferred some of the information provided to the care plan, they had not detailed the method required for each task completed with this person such as transfers between bed and wheelchair and transfers between wheelchair and bath.

At this inspection we saw there was a new risk assessment in place around falls which was an improvement from our last inspection. The registered provider told us they were in the process of improving this, as there were still shortfalls with the new form. They were working with the Care Home Liaison Team on a generic falls risk assessment. We found people had appropriately been referred to a falls prevention practitioner for guidance to prevent further falls.

We asked staff how they would respond in an emergency, for example if they found a person on the floor. The registered manager told us they had changed the procedure for this from their last inspection and if a person could not get themselves up from the floor they would call the emergency services. Each person had a personal emergency evacuation plan (PEEP) and the service regularly undertook fire evacuation tests which ensured they would be prepared in the event of a fire at the service. We found one person's PEEP had not been updated to reflect the equipment they required to be moved but other plans were up to date.

We looked at the accident and incident file for the service. The recording of accidents had been an issue at our last inspection and there had been no detailed analysis of each event. At this inspection we found incidents such as falls had been analysed to determine their root cause and to consider preventative measures. However, we found one accident form for a fall out of bed in one of the care files we reviewed which had not been passed to the manager to be analysed, although the person had required hospital treatment for a cut to their head. Therefore there was no record of what actions had been considered to prevent a further fall out of bed such as bed rails, a crash mat or a bed which lowered to the floor.

We found the examples above demonstrated a continued breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We looked at one staff file as only one member of staff had been recruited since our last inspection. We found the necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) checks, reviews of people's employment history and two references had been received. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. There had been gaps in this person's work history which had been explored by the registered provider.

We checked whether the ordering, storing and administering of medicines was safe. We observed the morning medicine round undertaken by the head of care, who put on a red tabard to show they should not be disturbed. They dispensed medicines from a medication trolley which was stored in the dining room during the round as there was insufficient space in the communal lounge area to dispense from the trolley where people were seated. We observed the trolley was locked during the time it was left unattended. We noted a 'Good Practice Guidance for Care Homes (PRN)' in the file on the trolley and a staff signature file to ensure the home could determine which staff had administered the medication.

Each person's medication administration record (MAR) contained a photograph of the person and the name of their GP. Staff signed the record after administration to confirm the medicines had been taken by the person. Administering staff had access to protocols with regard to the administration of PRN (as and when) medicines. People who required the application of creams and ointments had a body map to direct staff to where this should be applied and staff recorded this administration. Most medication was dispensed in a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

The medication room in which the medicines were stored were checked twice each day to ensure medicines were stored at the correct temperature and the medication fridge temperature was checked once daily. Medication such as eye drops which were stored in the fridge were dated upon opening to ensure they were not used past the manufacturer's expiry upon opening date.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation called controlled medicines. No one at the service was on this type of medicine and we checked the controlled drugs book which confirmed there were no controlled drugs in use at the service.

We inspected records of the two hoists, bath lift, gas safety, electrical installations, water quality, fire appliances and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out. A new boiler had been fitted in October 2016 which had initially caused issues with hot water temperatures, but which were regularly checked and recordings were found to be within an acceptable range.

We observed the home was well maintained and all areas were clean. Hand washing facilities, sanitizers and waste disposal bins were readily available throughout the home. The home had been inspected by the infection control team and no issues had been found. As a result of this they were to complete an internal infection control self-assessment audit for the 2017-18 year.

Requires Improvement

Is the service effective?

Our findings

When we arrived at our inspection people were eating breakfast in the communal lounge seated on high seat chairs with over chair tables for their crockery. One person who was eating muesli told us "It's lovely." And another person said of their breakfast, "It's nice." People told us they enjoyed their meals and our observations at meal times confirmed this.

The chef told us there was a four week rotating menu which they could amend to cater for the preference of the people at the home. They told us people were offered a choice at breakfast including a cooked breakfast, or bacon sandwiches and we observed people eating toast and porridge. The lunch menu on the day of inspection included chicken, mashed potatoes and vegetables, omelettes or jacket potato and beans. We observed the chef asking people what they would like for their lunch. At tea time people were given soup, a choice of sandwiches and cheesecake and yoghurt. They were offered a choice of drinks. The home catered for people requiring a pureed diet, a gluten free diet and a diabetic diet and the chef was able to describe how they supported they supported these dietary requirements. The registered manager told us no one at the home was on a fortified diet, although there were people on prescribed food supplements. There was a list of people's preference for tea and coffee and a record of people's birthdays so if family did not bring a birthday cake, the chef would make one. The home had been awarded the Kirklees Healthy Choice Gold Award in 2016 for being committed to good standards of food hygiene and healthy options.

We observed the lunchtime and tea time experience in the main dining area. The tables were nicely laid out with table cloths, napkins and glasses. On one table people were drinking wine with their lunch. Other people were offered a choice of blackcurrant or orange juice to drink. Staff offered people a refill of juice regularly throughout their meal.

Care staff served the tea time meals. The chef prepared some of the menu, but staff heated up soup and made people light meals, such as poached eggs. As there was no chef at tea time and the role was undertaken by care staff, this meant fewer staff were available to support people to meet their care needs. In addition we saw one person's care records stated they should be supervised at meal times, which did not happen and had they been supported, this would have left one member of staff supporting other people in the dining room. One person needed support to eat and they ate in their bedroom.

Staff we spoke with told us they had received an induction when they started in their employment at Bell House and they had shadowed more experienced members of staff before undertaking shifts. There was only one new member of staff since we last inspected. They had received training in the management of medicines and had their competency checked. We also reviewed their training record to evidence they had received online training in the following areas; safeguarding, moving and handling, food hygiene, health and safety. The service utilised the Care Certificate (the minimum standards that should be covered as part of induction training of new care workers) and every member of staff were completing the certificate whether they were new in care or were experienced care staff to ensure they were all working to the same standards.

The registered manager told us they utilised a mixture of on line distance learning and session based

learning. We reviewed the training matrix which evidenced staff were provided with opportunities to develop their knowledge and skills in the care field. They also had monthly training sessions and had undertaken training around maintaining oral hygiene as a topic in October 2016.

At our previous inspection we found staff had not had practical moving and handling training and the service could not evidence staff had received this training or were assessed as competent. At this inspection they evidenced staff had received training and competency checks in this area.

One member of staff told us they had done additional training in diabetes care and epilepsy. They had also volunteered to become a nutrition champion and were to receive additional training in relation to assessing people's nutritional risk.

The registered manager told us staff supervision took place every two months. We were shown records of recent supervisions and found the content of supervision had improved since our last inspection. Appraisals were on-going with six completed at the time of our inspection. Effective supervision and appraisal of staff enables a culture of learning and development, identifies gaps and enables the registered provider to develop a competent workforce.

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

People can only be deprived of their liberty so that they can 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 saw one person had a DoLS in place with one further authorisation about to be submitted to the supervisory body. There were no conditions in place for the one person who had an authorisation in place.

.

We found one person had a mental capacity assessment in their care records in relation to consent to a pressure mat. However, this was not completed in line with the requirements of the legislation. For example, the assessment followed the four key questions in the second part of the two stage capacity assessment and recorded the person could not retain the information which meant the person should have been deemed to lack capacity, although according to their assessment they had the capacity to consent.

We discussed the MCA and DoLS with the registered manager to gauge their understanding of the legislation. At our last inspection, the registered manager's understanding of the MCA was limited and at this inspection (although they had further training) our discussions demonstrated they still did not understand the principles of the Act or the processes required if a person lacked capacity to consent to care and treatment. Most of the people the home supported had the capacity to consent so the impact of the failure was not widespread. But there were at least three people who could not consent to all aspects of their care, where the process had not been followed in accordance with the legislation. However, one member of staff we spoke with had a very clear understanding of the MCA and their role in assessing people's capacity on a daily basis and supporting people to make decisions. The home was in the process of confirming which people had a Lasting Power of Attorney in place (a legal document that lets a person appoint one or more people known as 'attorneys' to help make decisions or to make decisions on their behalf) and whether this was for property and finance decisions, and/or health and welfare decisions.

For those people who had the capacity to consent to their care, we saw evidence in their care files that they had consented to care, photographs and consented to a physical examination.

Bed rails were in use at the home and our review of care files and discussions with staff evidenced where these were in use they were to prevent falls from beds rather than to restrain people whilst in bed. The registered manager told us they did not use restraint at the home.

We saw people using the service had access to other health care professionals for example, GPs, district nurses, chiropody, dentist and optician. The Care Home Support Team also regularly attended the home. This is a team which aims to work with care homes in the Kirklees area improving education and confidence for care home staff, patients and their families to be able to better manage and have knowledge of their condition.

The service had undergone planned refurbishment at the time of our inspection with accessible adaptations such as a level access shower, a bath with assisted bath lift and a separate accessible toilet. Consideration had been given to the toilet areas to ensure the toilet seat and grab rails were a contrasting blue colour to improve recognition for those with cognitive and visual impairment. The second phase of renovation on the bedroom doors was in process during our inspection and the quality of the work was to a high standard. The new bathroom had been designed to be wheelchair accessible, and one corridor leading to bedrooms was sufficiently wide to accommodate wheelchair use although the second corridor leading to further bedrooms was narrow with a slight slope. The communal lounge lacked space to manoeuvre and when everyone was seated we found there was no space to sit and chat with people. The entrance to the home doubled up as a conservatory where people and their visitors could sit if they preferred and provided additional communal space.

Good

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring. One person told us staff were 'Sweet peas'.

We found the interactions between people and staff were positive and staff spoke respectively and nicely to people and offered assistance appropriately. We observed one member of staff appropriately distract a person who was showing signs of distress, by chatting with them about their visitors, the weather and showed them paintings done by people at the service. The person had been tearful but this resolved with staff intervention.

The registered manager and the registered provider regularly observed how staff interacted with people to ensure this was appropriate and staff were respectful. The registered manager said, "I work the floor, I observe, I speak to the clients. If it's not how I expect my parents to be treated, I would reprimand them straightaway. They are very good, very caring, they use their initiative and their approach is very nice."

We asked staff how they maximised people's independence and they told us they encouraged people to undertake activities of daily living they could manage and they would support with the rest. The registered manager told us they had been praised by the relative of a person who had recently come to live at the home as "They were bedbound and we got them walking within a week." We saw examples of what people had undertaken independently referenced in their daily records such as during the day "[Person] independently going to the toilet." And "Independent with oral care."

The staff we spoke with told us they always ensured privacy and dignity was maintained. We observed staff knocking on people's doors before entering. One member of staff told us, "I would treat people how I wanted my mum and dad treated. I would knock even if no one was in. I would make sure I covered them with a towel. Some people are more embarrassed than others and I would always ask people if it is alright to do things for them." We observed the registered manager brought the mobile phone to one person who had received a phone call and asked if they wanted a private conversation. This person was supported to take the call in their room which assured their privacy to speak in private. Another person had a visit from the community nurse and the care assistant supported them to a more private location to receive support.

We asked how the home ensured people's religious and cultural needs were met. The registered manager told us they catered for people's religious needs. The vicar of the local church held a service at the home the first Tuesday of every month which we were told was well attended. The chef advised us they were able to cater for people who required their meals prepared to ensure they met the person's cultural requirements. For example, they had one person staying for a short period from a West Indian heritage and they spent an hour with the person to understand their preferences.

There was no dedicated area for staff to complete confidential paperwork which they undertook in a section of the communal dining room. The registered manager told us there were no plans to make a dedicated area for staff to hold confidential discussions such as handover, and for staff to update care files. This meant

there was the potential for confidential information to be accessible to or overhead by others in this area, although we did not observe this during our inspection.

In one of the care files we reviewed we found a record that a person had an advocate An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves, However, on discussions with the registered manager they told us the advocate had recently stopped as there were no more decisions to be made at the current time.

We asked the registered manager about end of life care. We were told no one in the home was at end of life at the current time but where this had been the situation they involved the district nursing staff and sought advice from the local hospice. They told us they discussed end of life preferences with people to ensure their wishes were recorded. We saw evidence of this in the care files we reviewed including information about funeral arrangements and the person's preference in relation to where they wanted to be cared for when they reached this point in their life. The head of care told us all apart from one person had been assessed by their GP for "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) and we found these records in the care files we reviewed.

Requires Improvement

Is the service responsive?

Our findings

We reviewed care records at the home ensure the service was assessing people appropriately to live at Bell House and to ensure people's needs were accurately reflected. The registered manager told us they, the head of care or the registered provider undertook pre-admission assessments to ensure they could meet the needs of people before they came to live at the home. They said people contributed to the compilation of their care and support plans and they sat with people and chatted with them to find out their likes and dislikes.

Staff we spoke with demonstrated they were aware of the needs and preferences of the people they were supporting. They told us how they supported people to make choices in their everyday lives taking into account their views and preferences, which demonstrated they were providing person centred care. We saw evidence throughout the day that people were offered choice from what time they wanted to get up to what time they wanted to go to bed, what they wanted to eat and where they wanted to sit. We saw information on whether people preferred a male or female carer to undertake personal care, whether they liked the light on during the night, and the bedroom door unlocked. We found bedrooms were personalised and people had photographs, personal items and personal effects to make their bedrooms individual to their preferred layout. Bedrooms were clean and tidy and care had been taken to be respectful of people's personal effects.

We reviewed the care files for five people living at Bell House. Each care plan was split into sections of people's support requirements such as personal hygiene, mobility, social activity, continence, dementia, nutrition and hydration. Each care plan was underpinned by a risk assessment relevant to that area of support. We found care plans were person centred and reflected people's preferences as to how they would like their support to be provided. For example, in one file in the medication section, the following information was recorded, "[Name] needs [their] medication administered by staff. Staff to place tablets in [their] hand and [name] will put them in [their] mouth, then have a drink of water." Care records contained a section to record professional visits such as GP, speech and language therapy, and chiropodist.

Each care file contained a separate book for staff to record the support a person had been provided with each day. Some entries had improved from our last inspection and were person centred and referenced choice. One entry recorded, "[Person] had enjoyed having their hair done today and attended the residents' meeting. [Person] had got [them]self ready for bed and is listening to music in their room".

The care files we looked at evidenced care plans were reviewed each month and the registered manager told us a review was triggered where there had been a change in the person's needs.
People on short term stays or those whose needs had changed due to illness had an emergency care plan to detail how they were to be supported until the full care plan was completed or until they returned to their previous abilities.

We reviewed night check records which were undertaken at specified intervals depending on the needs of the person. At our previous inspection we found they did not provide a record of interventions during the

night, but recorded whether a person was asleep or awake. At this inspection we found a significant improvement and staff were recording what interventions they had supported people with during the night to give a more accurate account of how people's care needs were met. We saw positional charts were used for people at risk of skin breakdown. One person who was cared for in bed had an hourly record of interventions which had been completed apart from the day before our inspection where there was a gap between 3.30 pm and 8.30 pm which coincided with the time the home was short of staff. The registered manager told us they had personally completed these checks during this time, they had just not recorded them. However, the lack of recording meant they could not evidence this care had taken place as prescribed in the person's care plan.

The staff we spoke with told us they had an effective handover for all staff at each shift change. At our last inspection we found the documentation at handover did not fully identify people's needs. The registered provider had changed this form and we found it contained details such as what time people arose in the morning and what time they went to bed in addition to a more detailed account of their experience during the shift.

At our previous inspection there was a new activities coordinator in post. However, they had since left the service and the home was reliant on an activities coordinator who only came in one afternoon a week. The registered provider told us they had arranged for a private company to come in to do arm chair exercises and a pantomime at Christmas. People spoke highly of the person that provided activities once a week and looked forward to their visits. The chef told us they were paid to undertake baking sessions with people at the service two to three times each month for a few hours. The registered manager told us they had advertised and interviewed for a replacement activities coordinator and they were awaiting their references before confirming the appointment. The registered manager told us one person had employed a care agency to take them out into the community for lunch and this had been a success.

We found there was a lack of evidence of activities at the home and this was an area which required improvement but the register provider confirmed plans were in place to ensure compliance in this area.

We reviewed the compliments and complaints file at the home. There had been no complaints and two compliments since our last inspection. One compliment recorded, "It was so great to know that [they] was so well looked after in a home with such a lovely atmosphere. The home had a lovely homely feel." People knew how to make a complaint and told us they would not hesitate to raise any concerns with the staff at the home.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had been at the service since October 2014 and registered with the Care Quality Commission since May 2015. At our previous inspection we found a breach in the regulation around governance arrangements. The registered provider and the registered manager had failed to ensure staff were adequately supervised, appraised and trained to enable them to develop in their roles. In addition audits had failed to identify where improvements were required. At this inspection we checked to see whether improvements had been made and sustained. We found the registered provider had initiated many improvements at the service and record keeping and audits on the whole had improved although they recognised further improvements were required. The registered provider told us they were on site at least once a week to support the registered manager and they were involved in the day to day running of the home. Staff had been trained and supervised and we noted the content of supervision sessions had improved since our last inspection. Appraisals were on-going and further training had been planned. In addition staff competencies were checked in the management of medicines and to ensure they moved and handled people safely.

The registered provider had undertaken a quality survey in December 2016. As part of this survey the registered provider spoke with one member of staff, and one person living at the home. They checked ten care records and one staff file, compliments and complaints and any CQC notifications. They spot checked rooms, and communal areas and also attended the staff meeting. We saw evidence they acted on any shortfalls identified. They also reviewed the registered manager audits to see whether any actions were required. However, the value of this check was dependent on the accuracy of the management checks. For example, the survey concluded all accidents had been recorded and analysed, which was not accurate as we found one fall which although had been recorded on an accident form had not been passed to the registered manager for analysis and to consider further falls prevention strategies.

We saw evidence to confirm the registered provider was ensuring the safety of people at the service in relation to the risk of a fire such as a weekly fire alarm test and a monthly fire drill. There was a plan in the office containing individual personal evacuation plans (PEEPS) with people's mobility requirements in the event an evacuation was required, although we noted one person's moving and handling equipment needs had not been updated. The home was well maintained and all safety and maintenance checks had been undertaken and refurbishments were to a high standard.

The registered manager completed a management audit each month which they shared with the registered provider. This included information such as staffing issues and levels, accidents and incidents, staff training, medication audits, catering, laundry and the environment. They also completed an antibiotic audit for one of the GP surgeries that was monitoring the use of antibiotics in the care home. The management team completed regular audits in areas such as pressure care, dining room experience, staff training audit, complaints, safeguarding, hand hygiene, health and safety, dignity, and infection control audits. They undertook a care plan audit of each file every month. However we noted their audits confirmed all accidents and incidents had been recorded and analysed, and all moving and handling risk assessments and care plans were up to date. This demonstrated a lack of robustness remained with some audits as they had not

found the issues we had picked up as part of inspection in relation to showering equipment and a detailed moving and handling plan.

The head of care was the key moving and handling trainer for the home which meant they had additional training to enable them to cascade this learning to their staff. At our previous inspection we found their 'train the trainer' qualifications were out of date. They were also unable to provide evidence they had assessed staff competence. At this inspection records showed this person had retrained to be able to train staff and assess competencies, and we saw evidence staff had been trained and were competent to carry out moving and handling tasks.

The registered manager shared their vision for the service which was "To finish off all the refurbishments, all bedrooms done, new carpets for the bottom end and look at refurbishing the conservatory." They told us their biggest challenge was staffing. They had three regular night staff but were carrying vacancies which meant day staff were covering night shifts which put a strain on the day staff. They told us this was not having an impact on people using the service although acknowledged "we are getting tired." They had used agency staff to cover night shifts but they were always paired up with a permanent member of staff. They were actively advertising for two night staff and two day staff.

Staff described the culture at the home as "Open, honest, friendly. I think there is a good team. People help each other out." They told us they enjoyed working as a carer. They described the atmosphere at the home as, 'homely and relaxed' " and told us they would not be afraid to go to management if they had a problem. One staff member told us management worked well together and were always looking at what was best for people living at the home.

The registered provider told us their biggest challenge was in recruiting staff to get the right mix of staff in relation to their roles and a balanced work load. They told us they were considering changing the 12 hours shift pattern as they recognised staff got tired with long shifts and a mixture of shift patterns might help this and with recruitment. Not all records were available on site during the inspection in relation to the management of the home and staff, but these were provided by email following the inspection.

The registered manager told us they had kept up to date with best practice by attending two of the local authority 'Good Practice Events'. They were wearing a 'hello my name is' badge following one session which introduced them to the campaign for health and social care staff to make a pledge to introduce themselves to the person they are supporting to enable a more compassionate and personalised approach care with people.

We reviewed the minutes of relatives' and residents' meetings and staff meetings which demonstrated involvement from both staff and people using the service with the aim of improving the quality of the service in line with people's wishes and preferences. The registered manager told us the meetings were poorly attended by relatives and only two families attended the latest meetings. We saw a list of forthcoming residents' and relatives' meetings on the notice board at the entrance to the home for the coming year to alert people. They told us in addition they tried to speak with families and visitors at the home to gauge their views about the service to ensure that those not attending formal meetings were also consulted about the service provided at the home. The registered provider recounted a discussion the day before our inspection when a person requested more vegetables, which they immediately fed back to the kitchen and previously one person had requested tea cakes instead of bread for sandwiches and another person wanted pickled

beetroot as an option, all of which the home facilitated.

The registered provider told us they were not using volunteers at the home but they continued to be part of the local community including the local church. The home worked in partnership with professionals in the area such as the Care Home Support Team, and utilised the local authority registered manager and training sessions for care home staff.

The service routinely sent statutory notifications to the Care Quality Commission in line with their registration requirements, apart from one DoLS which had been re-authorised and the registered manager was not aware they needed to notify us about this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Although improvements had been made around the management of risk we found a continuing breach in this regulation as one accident had not been analysed to ensure preventative measures were put in place. One person had not been assessed for suitable shower equipment and they had not had their moving and handling care plan updated to include all tasks to be undertaken