Wilton Rest Homes Limited

Beacon House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Beacon House on 18, 19 and 24 May 2017. The visit was unannounced on 18 May 2017 and we informed the assistant manager we would return on 19 May 2017. We gave feedback about the concerns we had identified to the director of the provider organisation on 24 May 2017.

Beacon House provides care for up to 23 people living with differing stages of dementia. There were 15 people living at the service on the days of our inspection. Accommodation was provided over three floors of a converted residential dwelling, with a passenger lift that provided access to the second floor and a stair lift to the top floor. The service also has six bungalows on site but at the time of our inspection no one living in the bungalows required personal care.

Beacon House did not have a registered manager in place on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The home manager's application to be registered was being considered at the time of the inspection.

When we previously inspected the service in September 2016 we found six of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service 'Inadequate' overall and the service was placed in special measures. To support the provider to make the necessary improvements we imposed three conditions on their registration in respect of the regulated activity, accommodation for persons who require nursing or personal care they carry on at Beacon House. The provider was required to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They had to send a monthly report to CQC detailing the audit dates, the outcomes of these and any actions taken or to be taken as a result.

At this inspection we found planned improvements had not been made or sustained. We found four ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one new breach. We found whilst the service had been in 'Special measures' not enough improvement was made within this timeframe and at this inspection there was still a rating of inadequate in the key questions; Is the service Safe? and Is the service Well-led? with an overall rating of 'Inadequate'. We will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found although the provider had taken some action and engaged an external consultant to drive improvements in the service this had not resulted in people always receiving safe care and the service still lacked the leadership to improve the quality of care provided to people.

We found an effective governance system to monitor the quality of the service and identify the risks to the health and safety of people was still not in place. A regular programme of effective audits had not been completed in relation to the management of people's medicines, infection control practices, health and safety, and quality of care records. The provider had not identified the areas of concern we had found. As a result, action had not been taken to improve the quality of care and ensure the safety of people.

We found people's safety was being compromised in a number of areas. Risks to people in relation to the use of medicines, and moving and positioning equipment had not always been assessed and risk management plans in place were not sufficient to enable staff to keep people safe.

People's care records did not include all the information staff would need to know about how to provide people's care and when people received care this was not always recorded. Staff and the managers could therefore not judge from people's records whether people had received their care as planned and their medicines as prescribed.

Recruitment arrangements were still not safe. All the information required to inform safe recruitment decisions was not available at the time the provider had determined applicants were suitable for their role.

Staffing levels were sufficient to meet people's needs but staff were not always supported through induction and training and there continued to be a lack of supervision and effective performance management.

People were not always protected from abuse as staff were not identifying safeguarding concerns. Some safeguarding issues had not been escalated and investigated by the management team and reported to relevant agencies.

Decisions about people's care had been guided by the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity. However, when decisions were made in people's best interests it was not always recorded how these decisions had been made in consultation with those who knew people well. The provider had requested appropriate authorisation when placing restrictions on people and had met the requirements of the Deprivation of Liberty Safeguards.

Some improvement was needed to ensure the arrangements in place for people and relatives to provide feedback about the service would be taken into consideration when making improvements to the service.

People were treated with dignity and respect. Some improvement was still needed to ensure people living with dementia were always communicated with in way that would support their understanding and enhance their daily decision making and participation in the service.

We identified four continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one new breach. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks of harm and injury to people were not always identified and when they were, actions to minimise those risks were not always in place or followed by staff.

Staff did not always have the skills to provide safe care and concerns about people's safety had not always been reported and investigated to protect people from potential harm.

The provider did not have a safe system of recruiting staff and checks were not always undertaken to make sure staff were of good character before they supported people who lived at the home.

People had their prescribed medicines available to them but a safe administration system of medicines was not consistently followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not all undertaken training to deliver care and support to people. Regular supervision had not taken place to assess staff's competencies to undertake their job role effectively.

Some improvement was needed to ensure where people lacked the mental capacity to make decisions about their care a record would be available of decisions made about people's care, involving families and other professionals.

People enjoyed their food and were given the support they needed to eat and drink.

People were supported to maintain their health and were referred to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated in a way that respected their dignity and supported them to feel valued.

Some improvement was still needed to ensure people living with dementia were always communicated with in way that would support their understanding and enhance their daily decision making and participation in the service.

People were supported to follow their faith and attend religious services.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff understood people's needs. However care plans were not always detailed to support staff in delivering safe care and support in accordance with people's individual needs.

People's feedback was sought and addressed on an individual basis. However, the provider did not always use individual feedback to learn and make improvements to the service to the benefit of all the people living in the home.

Some group social activities were offered and improvements were being made to ensure daily opportunities were available to support people's emotional and social well-being.

Is the service well-led?

Inadequate

The service was not well led.

The provider's systems and processes to monitor the quality and safety of the service were not effective in identifying where improvement was needed. This meant that people experienced a number of shortfalls in relation to the service they received.

There was a lack of management leadership and oversight which resulted in a culture that was task led and not focused on improving the home for the people who lived there.

The information in people's care plans was still not sufficiently detailed to ensure staff, that did not know people well, would know how to meet people's individual needs when referring to

their care plans for guidance.

Records relating to the care people received were not always completed.

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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 18, 19 and 24 May 2017. The visit was unannounced on 18 May 2017 and we informed the assistant manager we would return on 19 May 2017. We gave feedback about concerns we had identified to the director of the provider organisation on 24 May 2017. The inspection was carried out by one adult social care inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. Before the inspection, we did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during our inspection.

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

During our inspection we spoke with five people using the service and one person's relative. We also spoke with the director of the provider organisation, the assistant manager, head of care, four care workers, one agency care worker, the housekeeper, the cook, a kitchen assistant, the activities co-ordinator, the head of housekeeping and a visiting hairdresser. We spoke with the specialist nurse for residential homes who visited the home during our inspection.

We reviewed records relating to five people's care and support, such as their care plans and risk assessments, and the medicines administration records for 15 people. We also reviewed training records for all staff and personnel files for six staff, and other records relevant to the management of the service.

We previously inspected the home in September 2016 and identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our previous inspection in September 2016, the provider had sent us an action plan telling us about the improvements they will be making. During this inspection, we gave the director of the provider organisation an opportunity to supply us with information, which we then took into account during our inspection visit.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found risks associated with people's care had not always been assessed and actions were not always put into place to reduce the risk of harm. Staff did not always have the training, skills or information they needed to keep people safe. We found the provider to be in breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this domain as 'Inadequate' and asked the provider to send us an action plan with monthly updates on how improvements would be made, which they did. At this inspection we found planned improvements had either not taken place or had not been sustained. We identified ongoing and further concerns relating to the safe care and treatment of people and found ongoing shortfalls in people's care records.

We found improvements had been made following our inspection in September 2016 to ensure people's medicines were stored safely. However, at this inspection we found ongoing concerns in relation to medicine recording and a new concern that people had not always received their medicines as prescribed.

We found a number of staff signature omissions (identified as gaps) in people's medicine administration records (MAR) which had not been identified by the staff administering medicine. There was no explanation recorded on the MAR as to whether the medicines had been administered or not. The assistant manager assured us that they had checked the medicine stock and that people had received their medicines but it had not been recorded in their MAR. However, staff administering medicines would not know from people's MAR whether they had received their medicines as prescribed which increased the risk of medicine errors occurring. Handwritten MAR entries were not always double signed or dated. Staff would not be able to tell from people's MAR when and by whom new medicines had been authorised. People's creams and topical ointments were not dated when opened. Some were subject to environmental contamination and should be discarded after a period of use. Staff would not know when people's topical medicines had passed the safe period for use so that they could be discarded.

People's medicine administration records did not support the safe administration of medicines and people had not always received their medicines as prescribed. We found there had been a 24 hour delay in administering one person's antibiotic as it had not been recorded that the medicine was stored in the fridge and staff did not know where the medicine was. Another person had missed their medicine for 25 days as it had not been clear on their MAR that they still needed to continue taking this medicine. A third person required their medicine to be taken at specific times of the day. This had been noted on their MAR but staff told us they were not aware of this instruction and the person had received their medicine during the routine medicine rounds instead. Supporting information was not available to staff to explain the need to ensure timely administration of this medicine to reduce the risk of this person falling.

Three people could at times become anxious and agitated and their behaviour could then put themselves or others at risk of harm. They had been prescribed a sedative to be used 'when required' when they were upset or unsettled. Where sedatives were prescribed for occasional use, guidance was not always available to: inform staff when to use the sedative, when a second dose could be given; the maximum dose that could be administered and possible side-effects. Information about risks associated with the medicine and what

action to take if the medicine was not effective to ensure people would remain safe was not available to staff. Staff told us they were not aware of people needing this medicine and would not always feel confident to make the decision whether a sedative needed to be administered. There was a risk that staff might not follow a consistent approach when deciding when to administer the sedative and people might therefore not always receive the support they needed to remain safe when they became anxious or agitated.

Mobility plans were in place for people at risk of falls and we observed staff supporting people who were walking to remain safe. However, we found people still did not always receive the support they required to ensure the risks to their health and safety were mitigated following a fall. At our previous inspection in September 2016 we found staff had not always implemented the home's post-falls guidance appropriately. At this inspection we found staff did not always complete the required health observations, inform the GP or complete the post-falls paperwork correctly. This meant staff might not always have identified any falls related injuries that might require prompt treatment from healthcare professionals. People's falls care plans were still not always reviewed following a fall. This would be good practice to determine whether the risk management plans in place were still sufficient and whether additional safeguards or checks for people at high risk of falling were required. Staff might therefore not have up to date information to support people experiencing recurrent falls to mobilise safely. The specialist community nurse for care homes had identified that improvements were still needed in staff's post-falls management and was completing additional staff training at the time of our inspection.

At our inspection in September 2016 we found people were not protected from avoidable harm as staff used unsafe moving and positioning techniques which placed people at risk of bruising, skin tears and soft tissue injuries. During this inspection we observed staff supporting people to use the hoist and wheelchairs appropriately. However, staff told us they were still concerned that not all staff were following safe moving and positioning techniques. Records showed three concerns had been raised about staff not supporting people appropriately following our previous inspection. Staff had been instructed by the deputy manager and head of care to take extra care when using the hoists as they had found unexplained bruising on two people. We found the provider had not taken sufficient action to ensure all staff were competent to move people safely. Records showed only 10 of the 18 care staff had received moving and positioning training, two had receive hoist training and only one had their moving and handling competency checked despite this having been identified as a concern at our previous inspection in September 2016. We could not be assured that staff had the skills, competence and experience to undertake moving and positioning tasks safely.

Three people's mobility had declined significantly and they were at high risk of falling. Staff had made a referral to the community occupational therapist who assessed two people for hoisting equipment and slings. The assistant manager had assessed the third person as requiring a standing hoist to move from their bed to a chair. They had not received training to enable them to undertake a moving and positioning assessment and there was a risk that equipment used to move this person might therefore not be appropriate to keep them safe. The provider did not have a structured assessment process in place to ensure moving and positioning assessments were completed by a competent person. Staff did not have clear guidance for when and how they were to involve community occupational therapists to ensure safe moving and positioning arrangements for people.

The risk management plans for people who required the use of a hoist needed further development. They did not inform staff of all the person's moving and handling activities that required the use of a hoist or any physical characteristics and abilities of the person that needed to be taken into account when hoisting them. There was a risk that staff who did not know people well would not know how to hoist them safely.

At our previous inspection we found people's skin concerns were not always managed appropriately to

prevent pressure ulcers from developing. At this inspection we found some improvements had been made. Concerns relating to people's skin were identified and reported to the community nurse in a timely manner. In the past two weeks a system had been put in place to describe any skin concerns and note the action that was taken daily as directed by the community nurse. However improvements were still needed to ensure that the managers recorded the actions they took to review people's skin and check that staff were appropriately implementing the community nurse's guidance between their visits. There was a risk that staff would not identify when people's skin did not respond to the community nurse's treatment plan and action needed to be taken to keep them safe before their next visit.

People were assessed by staff monthly for the risk of them developing pressure ulcers. Care plans showed where people had been identified as at risk, arrangements had been made to prevent their skin from deteriorating. People were prescribed topical creams to hydrate and protect their skin in order to minimise their risk of developing pressure ulcers. New topical medicine recording charts had been introduced since our previous inspection. However, information about the frequency of use, thickness of application and areas of the body to which people's creams and topical ointments should be applied, was still not readily available to staff applying people's creams. This had resulted in people's topical medicines not always being administered correctly. One person required their topical medicine to be administered twice a day for a short period. However their topical medicine record did not inform staff of the frequency of administration. Records showed that they had received their topical medicine at times three times a day, at times twice a day and some days only once. There was a risk that this person's skin condition could deteriorate as they had not received their medicine as prescribed.

Some people who could not change their position independently to relieve the pressure on their skin were supported to reposition regularly to protect their skin from pressure damage. Following our previous inspection new turning charts had been introduced to demonstrate that staff had changed people's position at regular intervals throughout the day in accordance with good practice. However these turning charts had still not always been completed appropriately within the required frequency. Accurate repositioning and topical medicine charts were still not maintained for people to evidence they had not remained in the same position for too long and received support to keep their skin hydrated. This would ensure that the manager had all the information they needed, to evaluate whether the preventative action they had instructed care staff to take to protect people's skin, had been implemented appropriately.

The above information demonstrated that care and treatment was not provided to people in a safe way. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The above information also demonstrated that the provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our previous inspection in September 2016 we found the provider had not implemented safe recruitment practices as all the required pre-employment checks had not been completed before staff had been offered employment. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made in this area and the provider remained in breach of this regulation.

We looked at the recruitment records of staff that had been employed following our inspection in September 2016. Checks to ensure that staff were of suitable character and able to meet the requirements of the role for which they were employed had not always been completed. Pre-recruitment checks, such as confirmation of applicants' identity, full employment history, explanations of employment gaps, criminal

record checks, and declaration of fitness to work, had not been satisfactorily gathered, investigated and documented.

The provider had not recorded the reasons why they considered an applicant to be suitable when information obtained through recruitment checks did not provide satisfactory information. For example; where employer references only confirmed staff's employment dates and did not provide any information to support the recruiting manager to judge whether they were of good character, questions in relation to applicants' character and conduct had not been asked during their interview. Risk assessments had not been completed when staff had disclosed that additional adjustments might be required to ensure they would remain fit to undertake their role. In the absence of all the required pre-employment checks a record was not available to evidence how the provider had gathered, considered and mitigated any potential risks staff could pose to people prior to offering them employment.

The registered provider had failed to protect people by ensuring that staff were of good character and suitable to work with the people they were supporting. This was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were available and staff could describe the action they needed to take if they identified people were at risks of abuse or had been abused. However, when we asked staff if they had referred the medicine errors, the incidents relating to people not receiving safe moving and handling support and people's unexplained bruising to the local safeguarding team, they told us they had not identified it as potential abuse or neglect and had therefore not made the required referrals. Thirteen of the 24 staff had not received safeguarding training and staff we spoke with told us they had not read the provider's safeguarding policy. Improvements were needed to ensure staff would always identify potential abuse, including neglect, so that action could be taken to report and investigate these concerns to protect people from harm.

Systems were not operated effectively to investigate, immediately, any allegation or evidence that abuse might have occurred. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed there was sufficient staffing in the service to support people with routine tasks. For example, we did not notice any people left waiting to be attended to, and on the occasions when we heard the call alarms or people calling for assistance they were responded to quickly. The provider had installed a new call bell system and people we spoke with said that staff would always respond to any requests for attention but that some took a bit longer than others. When people were supported for example, to eat during lunch time, this was unrushed and provided at people's pace. The provider continued to recruit to staffing vacancies and absences and vacant posts were covered by existing staff or regular agency staff. The deputy manager and head of care were improving the use of staff and had started allocating specific tasks to staff during each shift. Some care staff worked both days and nights and this ensured people received care from staff that knew them.

There was some anxiety from staff about the future staffing levels if the needs of people increased or if an emergency was to occur. The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people and keep them safe at all times. The business continuity plan did not describe the procedures to follow in an emergency that made sure sufficient and suitable staff were deployed to cover both the emergency and the routine work of the service. Twelve of the 24 staff had still not received fire training, 14 had not received first aid training and 10 had not received infection control training. Staff also told us that they had not had sight of the emergency

procedures. There was a risk that sufficient competent, skilled and experienced staff might not be available if an emergency was to occur.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in September 2016 we found staff had not all received the supervision and appraisal necessary to enable them to carry out their duties. We found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this domain as 'Requires Improvement' and asked the provider to send us an action plan with monthly updates on how improvements would be made, which they did. However, at this inspection we found improvements had not always been made or sustained. All staff had still not received regular supervision and they had not received the required training and support to enable them to effectively meet people's needs.

Following our previous inspection the manager had completed appraisals during November and December 2016 for those staff who had worked for over a year. However, three staff still required an appraisal of their skills to ensure their development needs would be identified and action taken to address any shortfalls in their practice. Some staff had received some supervision as managers had assessed their competency to undertake specific care tasks,for example in relation to supporting people to eat and medicine management. However regular competency assessments or one to one supervisions had not taken place since December 2016 to give staff the ongoing opportunity to identify gaps in their knowledge, which could be supported if necessary by additional training. Where gaps in skills had been identified through competency assessments managers had not always monitored staff's performance over time to ensure their skills had improved and they continued to support people appropriately. Staff might therefore not have the skills and knowledge required to support people's needs effectively.

The induction provided to new staff was still not sufficient to prepare staff for their role. New staff told us the only induction they had received was working alongside experienced staff for two weeks. There was no comprehensive induction to ensure they would gain the necessary competencies or training required to perform a care worker's role. There was not a structured programme that showed how new staff would be supervised until they could demonstrate the required competencies and skills to carry out their role unsupervised. Records showed and new staff confirmed that they had not been instructed to read people's care plans, had not read the provider's policies or completed any of the mandatory training. The provider had still not introduced the Care Certificate standards to ensure new staff were supported, skilled and assessed as competent to carry out their roles. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. New staff had not received sufficient support to adequately prepare them for their role in accordance with national good practice guidance.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. However, training records showed all staff had not completed the provider's mandatory training in moving and positioning, dementia, safeguarding, infection control, fire training and the Mental Capacity Act. We found staff did not always have the skills to support people's needs. For example, some staff showed a lack of understanding in supporting people who lived with dementia. This was observed by some staff not always effectively communicating people and engaging them in their care tasks. Staff who had completed training did not always have their skills updated through regular refresher

training to ensure their practice remained up to date. Staff might therefore not always have the skills and knowledge to meet people's needs in accordance with current best practice.

Staff had not received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living with dementia did not have the mental capacity to independently make decisions about their care arrangements. 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.

Staff understood the importance of gaining people's consent before undertaking care tasks. They were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example, when asking a person if they wanted their medicines or if they wanted to see a doctor.

Some staff still needed to complete training to develop their understanding of the principles of the MCA. Senior staff told us they understood their responsibilities under the Act and when, for example, a 'best interests' meeting should take place. However, people's care records did not always reflect this; when decisions were made about people living in the home, records did not always show which less restrictive options had been considered. Time was needed for staff to embed learning into practice to ensure mental capacity assessments and associated best interests decisions would always be completed in accordance with current best practice guidance.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. At our previous inspection in September 2016 we found people who could not consent to restrictions being placed on them to keep them safe were being deprived of their liberty without appropriate safeguards being in place. We found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the requirements of the regulations had been met. Following our previous inspection the manager had appropriately submitted applications under the Safeguards for four people and was awaiting the outcome of these applications.

People spoke positively about the quality and quantity of food available to them at Beacon House. Their comments included: "I can't complain''; "I like the food'' and ''I choose what I want to eat''. We observed the dining room experience of people during a lunch-time. We found a calm pleasant atmosphere with most people sat at dining tables and it seemed a social and supportive event whilst other people preferred to eat in their rooms. People required different levels of support and those who required help with their food were supported in a dignified way. At our previous inspection in September 2016 we found people at risk of choking did not always receive the support they needed to eat and drink safely. At this inspection we found staff knew how to support people to reduce their risk of choking and we observed people being supported appropriately during lunch time.

People made their meal choices on the day and the cook told us that if someone did not like the menu options offered then they would offer them an alternative of their choosing and people's preferences were met. The kitchen staff were aware of people's food and portion preferences. At the time of our inspection no

one needed a specialised diet.

People were supported to maintain good health through access to a range of healthcare professionals. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, community nurses, mental health nurses, physiotherapists, diabetic nurses and podiatrists (foot specialists). A local GP visited the home when needed and people told us they were satisfied that their health needs were met. One person told us, "They make sure I see the GP if I am not feeling well."

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in September 2016 we found people were not always treated with dignity and respect and we found the provider in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this domain as 'Requires Improvement' and asked the provider to send us an action plan with monthly updates on how improvements would be made, which they did. At this inspection we found improvements had been made and the requirements of the regulation had been met. However some time was needed to ensure all people living with dementia would always be supported in manner that would enhance their daily decision making and participation in the service.

People and a relative we spoke with were full of praise for staff and the support they received. One person told us, "You can't fault them, they are always polite, friendly and helpful. I like them very much and appreciate their help." Another person said, "The staff are all very nice" and a relative told us that staff were always respectful and considerate towards their loved one.

We found staff had an increased understanding of promoting people's dignity and respect. We observed interactions between staff and people were appropriate and staff only used touch when it was clear that people found it reassuring and were comfortable with being touched. Doors were kept closed when personal care was delivered and we heard staff reminding people to keep their bathroom doors shut or doing so if people could not protect their own dignity. One person told us, "They always make sure my door is closed before I have my bath or get undressed." We observed staff calling people by their preferred names and ensured they crouched down so that they could maintain eye contact with people when they were seated to support effective communication.

We saw some improvement had been made to support people living with dementia to make sense of their world. For example, when people were sitting at the dining room table waiting for their lunch time meal, staff were present in the dining room while people waited, reassuring and explaining to them what was happening and distracting them with conversation so they would not get anxious and agitated.

However, some staff were more skilled than others at initiating conversation with people living with dementia and opportunities to have caring interactions with people might therefore be missed. For example, when supporting people to eat some staff sat in silence for up to 15 minutes without making eye contact or talking with the person they were supporting. Some staff did not take the opportunity to engage with people whilst for example pushing them in their wheelchairs whilst others chatted and commented on people's outfits or discussed their plans for the day. We saw people responded positively when staff made conversation; they smiled and answered their questions. Staff told us and we observed some staff gave the impression that they were focused on getting tasks done which could make people feel rushed and not understood. The head of care told us they were aware some staff required additional support to communicate with people who found it difficult to articulate their thoughts and they were supporting staff to understand people's behaviour and facial expressions. More time was needed for all staff to always engage people living with dementia when supporting them so that people would have the opportunity to fully partake in these care tasks.

People were encouraged to personalise their environment to make them feel at home and comfortable. We saw people were able to bring in personal items from their homes and we could see that a number of people had brought in their own bedding and pictures of their families and friends.

People were supported to follow their faith and attend religious services. Staff explained that religious beliefs were recognised and that leaders from people's own faith could visit the service as people wished. We saw two religious services were undertaken within the service every month.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in September 2016, we identified that improvements were needed to provide support to people that met their individual needs. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs and preferences. We found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this domain as 'Requires Improvement' and asked the provider to send us an action plan with monthly updates on how improvements would be made, which they did. However, at this inspection we found improvements had not always been made or sustained. The information in people's care plans were still not sufficiently detailed to ensure staff, that did not know people well, would know how to meet people's individual needs when referring to their care plans for guidance.

The provider had introduced a new care plan format following our previous inspection and people's care plans had been re-written. Staff we spoke with knew people well and could describe their preferences and individual routines. However this information was not always included in people's care plans. For example, one person had a pace maker but their care plan did not inform staff how often they needed to visit their specialist, how to identify if their pacemaker might not be working appropriately and any risks relating to this device. Another person lived with diabetes, however their care plan did not inform staff about how to identify if their blood sugar levels were to become unstable and what action to take if they were to become unwell.

Some people living with dementia had found it increasingly difficult to plan and execute tasks for example, when eating and drinking. Care plans did not show how these people were to be guided and assisted to enhance their independence and maintain their skills. For example by breaking down the task or providing practical support only when it was clear that people needed additional support on the day. We saw staff fully assisted one person to eat during mealtimes but it was not clear from this person's care plan how staff were to support them on the days they found it difficult to eat independently. When staff, who did not know people well, were to solely rely on people's care plans they would not know how to meet people's individual needs and people might therefore not always receive the support they needed.

Some people required support to complete their personal hygiene tasks to the level they wanted. People's daily personal care charts did not always show whether all the planned hygiene tasks had been completed for each person. Staff could not be assured from people's records that people had received a regular bath, mouth and nail care and that their personal hygiene needs had been met. Records completed by staff each day did not always demonstrate that care had been given as set out in their care plans.

The provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a planned programme of leisure and social based activities were provided by an activity

coordinator who visited the service three afternoons a week. During these sessions they provided gentle exercise, games, and arts and crafts for people to remain occupied. Trips were arranged monthly and people told us they enjoyed these social opportunities. One relative told us, ''There is enough for my mum to get involved in during the day." Additional staff were made available on the days the activity coordinator did not attend so that activities would be available for people seven days a week. However, the assistant manager and head of care told us staff did not always take the initiative to lead an activity session. They had started to allocate a specific member of staff at the start of a shift who would be responsible for activities on the days the activity coordinator was not working.

People and their relatives were given an opportunity to share their views about the service. Records showed the provider completed a satisfaction visit every month to speak with staff and gain feedback from people and their relatives. Improvements had been made to the quality of food following people's feedback during the provider visits. A satisfaction survey had been completed which showed overall people were satisfied with the service they received. Where issues had been raised they had been dealt with on an individual basis. The home manager still needed to collate the survey results to identify any patterns in relation to the feedback and ensure lessons were learnt and individual's feedback used to improve the service for everyone living in the home.

People we spoke with told us that they would raise any concerns they might have with staff and were confident that action would be taken to improve things. One relative told us, "I have never had to make a complaint but the few niggles I have had were sorted out immediately."

The provider had received nine complaints following our previous inspection. Records showed the manager had investigated these complaints and where appropriate, had written to complainants with the outcome of their investigation. However it was not clear how the provider had used the information from complaints to improve the service. For example; concerns raised in relation to people not being supported to walk and use hoists safely had not resulted in improvement and at this inspection we found concerns relating to moving and handling practice remained.

Improvements were needed to ensure the provider would always use people's and relatives' views as an opportunity to learn and improve the service for people.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in September 2016, we identified significant improvements needed to be made to the overall governance of the home and we found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this domain 'Inadequate' and asked the provider to send us an action plan with monthly updates on how improvements would be made, which they did. At this inspection we found planned improvements had either not taken place or had not been sustained. Systems and processes to audit the quality of the service provided were not operated effectively to ensure good governance of the home. There was still insufficient management oversight to check delegated duties were carried out effectively and to ensure quality concerns had been responded to.

During our inspection we found the systems in place for the provider and staff to assess, monitor and mitigate risks to people's health and safety, failed to identify issues that required improvement and where people may as a result be at increased risk. Planned improvements had not been implemented or sustained since our last inspection. For example, audits undertaken failed to correctly identify where improvements were needed and there was insufficient management oversight to check delegated duties were carried out effectively. For example, a 'Room Record' check was completed daily by the head of care to ensure all daily records including people's topical medicine administration charts and turning charts were completed accurately. The checks completed in May 2017 showed the concerns we found in relation people's cream and turning records had not been identified. No check had been completed by the home manager or provider to ensure the 'Room Record' check which they had delegated to the head of care had been completed correctly. Therefore the shortfalls in both the records and the record check had not been noticed and action had not been taken to address the quality concerns.

The medicines audit completed by the home manager and assistant manager on 5 and 6 May 2017 had not identified the issues we found. For example, the audit record had incorrectly noted that 'all medicines had been signed for immediately' when we identified several gaps in people's MAR. We found there was a trend in the home of staff administration medicines and not signing the MAR sheet as evident by the 'MAR gap sheet'. When these MAR gaps where identified by senior staff they were listed and staff signed the MAR gap when they were next on shift. The audit had not identified that this gap checking system carried some risks as it had not ensured that senior staff checked people's medicine stock and recorded that they had assured themselves that people had in fact received their medicines. The audit did not identify correctly that handwritten entries on the MAR had not always been double signed. Although a medicine audit had been completed it had not been effective in identifying shortfalls and driving improvement.

The medicines audit tool used by the provider was not always effective because it did not prompt checks on all aspects of the safe management of medicines. We found that for some people additional information about their 'when required' medicines were not available to staff. The audit tool did not prompt the home manager to check individual's records to see if care plans were available to staff for all their 'when required' medicines. Topical medicine administration charts were also not included in this audit. There was a risk that the medicines audit would not support the provider effectively to identify risks or quality concerns in how people's medicines were being managed.

Audits of staff employment files were not effective in driving improvements. The audit completed by the home manager in January 2017 identified some gaps in pre-employment checks for example in relation to full employment histories not always being available. However, we identified the same concerns continued to be present in the employment records of staff employed following this audit. The deputy manager was preparing to interview new applicants on the second day of our inspection and they were unaware of the concerns that we had found and what action they needed to take to ensure the same risks did not occur. Although the home manager had audited staff employment records they had not learned from the shortfalls identified and improvements had not been made to ensure the same concerns did not continue.

Cleanliness audits had been completed regularly however these were not sufficiently comprehensive to ensure all aspects of infection control for example; appropriate waste management, was not checked. Infection risks might therefore not be identified and addressed to protect people's health.

The analysis audit undertaken of people falling failed to identify that people's care plans had not always been reviewed following a fall to minimise the risks of reoccurrence of falls or injury at the home. The audit also failed to identify inconsistencies in accident and incident reporting and applying the home's post-falls protocol by staff. People's care plans had been re-written but staff had not identified where these were not sufficiently detailed. For example, where there were insufficient moving and handling information. These shortfalls had been identified by the specialist community nurse for care homes and the community occupational therapist. However action was still to be taken to implement their recommendations.

Monthly provider visits continued to take place to gain people and staff's feedback about the quality of food and the service in general but records showed these provider meetings were still not effective in identifying the regulatory failings within the service that had not been picked up by the home manager. This was a continuous breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Beacon House did not have a registered manager in place on the days of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The home manager's application to be registered was being considered at the time of the inspection.

The home manager was temporarily absent from the home and was not available at the time of our inspection. The assistant manager and head of care were responsible for the day to day running of the home during this time with support from the provider. The assistant manager and head of care had both worked in the home for a few months. They had a good understanding of people's needs but were not up to date with the service improvements that needed to be made or sustained.

Staff were complimentary of the leadership of the new assistant manager and the head of care. One staff member told us ''It is better with them here, they check that things are being done''. However staff told us they were not always clear which of the managers held responsibility for what and who they needed to report what to. Records showed when risks for example; in relation to staff practice had been reported to the assistant manager and head of care they had taken action to address any immediate risks to people and communicated their concerns to the home manager. However action had not always been taken by the home manager and the provider to address the underlying practice and staff performance concerns.

Staff told us they were at times frustrated with the lack of action and they did not feel confident that the home manager and provider would resolve concerns to ensure they did not reoccur. The provider told us

they had not been made aware by the home manager that practice concerns were still continuing. At our previous inspection we found communication within the home in relation to the reporting of risks to the home manager and provider were not effective. Systems were still not in place to ensure the provider could easily track, evaluate and retrieve information relating to the management of the home. At this inspection we found the provider and senior staff still did not have a shared understanding of safety and quality concerns in the home and therefore action had not always been taken to ensure people were safe and shortfalls were addressed.

Team meetings had not taken place regularly and records showed at the last meeting in November 2016 staff were told some shortfalls had been identified at our previous inspection in September 2016. However staff told us they were not clear what action was needed and what their role and responsibilities were in ensuring the service improved. One staff member told us ''Professionals are always coming in but I do not know why and I can't really say what changes have been made''. We found concerns and risks in the service were still not effectively communicated to staff and the provider had not fostered an open culture of improvement where staff understood and shared the responsibility for improving the service provided.

The provider was displaying their inspection rating in the home and on their website as required by law.