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Beechwood Nursing Home

Inspection report

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Date of inspection visit:
20 December 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
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 20 December 2016 and was unannounced. The home was last inspected on 2 February 2016. This was a comprehensive inspection and we identified a breach of regulation in respect of Regulation 17: Good Governance in respect of record keeping. At this inspection we identified a repeat breach of Regulation 17 in respect of record keeping. We are taking action to ensure the registered provider understands that improvements have to be made to record keeping at the home otherwise enforcement action will be taken by the Care Quality Commission.

The home is registered to provide accommodation and nursing care for up to 32 older people, including people who are living with dementia. On the day of the inspection there were 26 people already living at the home, and one person was due to be admitted. The home is situated in Scarborough, a seaside town in North Yorkshire. The home has three floors and a passenger lift operates between all levels.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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. The manager was registered with CQC on 28 October 2016 and prior to that had been the registered manager for two other services within the organisation.

Some records were not up to date, some information was missing from care plans and some care plans included contradictory information. In addition to this, food and fluid charts and positional change charts had not been consistently completed. This meant there was a risk that people's up to date care needs might not be met. This was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Although people had care plans in place, we saw that some information that should have been recorded in these plans was missing and some was contradictory. This could have led to people not receiving person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Discussion with staff showed they understood their responsibilities in respect of protecting people from the risk of harm or abuse.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and the registered manager had informed the Care Quality Commission when DoLS applications had been authorised.

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. Staff told us that they were well supported by the registered manager and they were happy with the training provided for them.

We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home and relatives told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff, and that staff had a good understanding of people's individual care and support needs.

People's family and friends were made welcome at the home. A variety of activities were provided and people were encouraged to take part, although we considered that more one to one time needed to be spent with people who remained in their own room. We have made a recommendation about this in the report.

People told us that they were happy with the food provided and we observed that there were choices available for them. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met. However, we found that some people required more assistance from staff to eat their meals to ensure they had enough to eat and drink. We have made a recommendation about this in the report.

People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements. There were systems in place to seek feedback from people who lived at the home, relatives and staff.

Quality audits were undertaken by the registered manager to ensure that systems at the home were protecting people's safety and well-being.

The home was clean and hygienic on the day of the inspection but we noted the laundry room required refurbishment as it was difficult to keep clean. Work had commenced to refurbish the laundry room and we asked the registered provider to let us know when this work is complete.

We found two breaches of regulation during this inspection. You can see the action we asked the registered provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures. There were sufficient numbers of staff employed to ensure people received safe and effective support.

The areas of the premises used by people who lived at the home were maintained in a clean and hygienic condition, although the laundry room required attention.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively. They felt they were well supported by the registered manager on a day to day basis and also via supervision meetings.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood by staff.

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual dietary requirements. Health care professionals were contacted when there were concerns about people's nutritional intake.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home, relatives and staff.

People were encouraged to be as independent as possible, with support from staff.

People's individual care and support needs were understood by staff and we saw that people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People's care plans recorded information about their support needs although we found some information was not consistently recorded and this could have led to people's needs not being met.

Activities were provided but some people did not receive one to one interaction to reduce social isolation. Visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. There were opportunities for people who lived at the home and relatives to express their views about the service they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found that records were easily accessible and stored securely. However, information in care plans was not always up to date and some information was contradictory. This could have led to people's current care needs not being met.

There was a registered manager in post, and people told us that they had confidence in the registered manager. The registered manager had submitted notifications to CQC as required by legislation.

Quality audits were being carried out to monitor the effectiveness of the service.

Beechwood Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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.

The inspection took place on 20 December 2016 and was unannounced. The inspection was carried out by two adult social care (ASC) 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.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection, as they had submitted one at the time of the inspection in February 2016. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with five people who lived at the home, three relatives, five members of staff, the registered manager and the general manager. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home and other records relating to the management of the home, such as quality assurance, staff recruitment, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe living at Beechwood Nursing Home. One person said, "There is a call button if I need help. [Staff] are very kind and pleasant" and another told us, "I feel safe. There are always people about to see if I am okay." This view was supported by relatives who we spoke with. One relative told us, "Yes, quite well staffed. I am confident in the way they are looked after" and another said, "They are well observed – my mum feels safe."

People who needed assistance to move around the premises or to be assisted with transfers by staff had been provided with suitable equipment to enable this to be carried out effectively. We observed staff transferring people using mobility equipment and noted that this task was carried out safely. Some people were at risk of developing pressure sores due to their poor mobility and we saw they had been provided with the appropriate equipment to minimise this risk. When people required assistance with positional changes, this was recorded by staff but not always consistently. We saw one positioning chart that recorded the person required four hourly positional changes. The records showed they had been moved at 3.05 am and not again until 10.35 am. Another chart recorded that the person was moved at 11.00 am and then not again until 6.35 pm. This was discussed with the registered manager who assured us that these people had been assisted by staff to have a positional change, but staff had neglected to record this information. They acknowledged that recording needed to improve, and we saw that this had been discussed with staff at a recent staff meeting. We have addressed this breach in the Well-led section of the report.

Staff told us that they completed training on safeguarding adults from abuse. They were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager and were confident they would be listened to and that appropriate action would be taken.

Prior to this inspection we had received information of concern in respect of safeguarding incidents from a local authority. We discussed some recent safeguarding incidents and associated investigations with the registered manager and general manager. Some of these incidents had been investigated by the local authority safeguarding adult's team and others were still under investigation. The managers were able to explain the circumstances of the incidents we discussed with them, and the action they had taken to make any improvements. For example, one safeguarding incident had involved the use of an Apomorphine pump and at the staff meeting in November 2016 a guest speaker had been invited to explain to staff the use of this equipment. Apomorphine is a drug used to treat Parkinson's symptoms. All nurses were given the opportunity to use the pump and said that they felt more confident following the demonstration. At another meeting nurses and care staff were reminded they were responsible for ensuring care records, including food and fluid charts, were completed consistently and were up to date. This was because another safeguarding incident had been in respect of the recording of fool and fluid intake. We noted there was evidence that the registered manager worked well with commissioners around responding to safeguarding alerts. Some paperwork had been changed to reflect more detail around clinical care needs, and accountability for care tasks.

We checked the recruitment records and these evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS) prior to the employee commencing their duties at the home The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained, and interview questions explored any gaps in the person's employment history. These checks meant that only people considered suitable to work with vulnerable adults were employed at the home. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

We saw that there was a dependency tool in people's care plans. However, this tool was not used to assist the service to determine staffing levels. The registered manager told us that the standard staffing levels on day shifts were five care staff and one nurse throughout the day, and two care staff and a nurse during the night. We checked the staff rotas and saw that staffing levels had been consistently maintained, and that most staff absences were covered by permanent staff working additional hours.

In addition to care staff, there was a cook and one or two domestic assistants on duty each day, and a laundry assistant on duty each day, Monday to Friday. The registered manager was on duty in addition to care staff. This meant that care staff were able to concentrate on supporting people who lived at the home.

People told us that the call bell was answered promptly so they did not have to wait for assistance. This was confirmed by a relative who we spoke with, who told us, "There are always staff around but staff are very busy" and "If people need assistance, it usually happens promptly."

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for falls, people who were unable to use the call bell, pressure area care, choking, nutrition, mental capacity and the use of bed rails and bumpers. The risk assessment for people who were unable to use the call bell recorded that regular checks were needed, and we saw that these had taken place.

We noted that the sluice room door was not locked and cleaning materials had been left unguarded by domestic staff on two landing areas. At the time, there was no-one on these floors who could mobilise independently so no-one had been placed at risk. The registered manager assured us that domestic staff were aware of the need to keep cleaning materials with them or locked up to protect people from the risk of harm. However, this could have resulted in people being harmed.

There was a crisis (contingency) plan in place that included advice for staff on how to deal with emergencies such as a lift breakdown, the loss of utilities, flood and fire. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

We observed that medication was appropriately managed and administered to people. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Medication was stored securely in a medication trolley, and the trolley was kept in a locked medication cupboard when not in use. We saw that controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication held in the cabinet balanced. The nurse on duty told us that night

staff audited CDs each week to ensure no errors had occurred.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the area where medication was stored were checked to ensure that medication was stored at the correct temperature. Medication that was no longer needed was destroyed on site. This was recorded in a 'returns' book so there was a record of all medication destroyed by the home.

When a GP left a prescription at the home, there was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. When the prescription was sent directly to the pharmacy, there was no audit trail. The registered manager told us they would raise this with the pharmacist used by the home.

We looked at medication administration records (MARs) and found that they were clear, complete and accurate. Handwritten entries were signed by two people; this reduced the risk of errors occurring when transcribing information from the label on the medication to the MARs. We saw that there were no gaps in recording and there were protocols in place for the administration of 'as and when required' (PRN) medication.

We checked the accident and incident records in place at the home. Accident forms were completed in respect of each incident. The registered manager completed a monthly audit that recorded the action taken following each fall or accident, and to identify if any trends or patterns were emerging. We noted that, when people had an accident or sore areas had been noted on their body, this was recorded on a body map. This information helped staff to monitor a person's progress.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, gas appliances, the electrical installation, portable electrical appliances, hoists and slings, and the passenger lift. Weekly in house checks were taking place on the fire alarm system and door closures, and monthly checks were carried out on emergency lighting. Various audits were carried out each month to check on the safety of equipment, such as window opening restrictors, the emergency call system and room temperatures.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Relatives and people who lived at the home told us the home was maintained in a clean and hygienic condition. One person told us, "The clean it [my room] every day." A relative told us, "They have fantastic cleaners." There were two domestic staff working on the day of the inspection and we observed that communal areas of the home, bedrooms, bathrooms, toilets and the sluice room were clean. However, we saw that the laundry room required attention. We found broken and missing tiles, and that the grouting was not clean. There was dirt behind the piping. This meant it was difficult for domestic staff to keep the laundry room clean. The registered manager told us that the laundry room was identified as needing attention in November 2016 but no action plan was documented. Some initial work had already taken place and there were plans in place to complete the refurbishment. We have asked the registered provider to inform us when this work has been completed.

Good

Is the service effective?

Our findings

People told us that they liked the meals at the home. One person told us, "Very good. I like the corned beef hash and I am having it today." We were aware that this had been made especially for them. Other comments included, "I have a softened diet so I can swallow easily – they blend it," "Food good, good choice" and "I am diabetic but I eat everything. I shouldn't eat the puddings as it shoots up my diabetes." We discussed this with the registered manager, who assured us that all puddings were made with reduced sugar so were suitable for people with diabetes to eat.

We spoke with the chef who showed us a list of people's special dietary requirements, such as pureed or softened diets. The chef said there was usually a choice of two main meals on offer and that they prepared different meals if people did not want either choice, or at the request of one of the nurses. The chef told us, "The kitchen is open 24 hours a day so staff can access food for people at any time."

We observed the lunchtime experience. Tables were set with tablecloths, tablemats, napkins, cutlery and glasses. There was a large menu on display in the dining room and people were served with a main meal and dessert they had chosen earlier in the day. A choice of water or orange juice was offered and people were asked if they would like a glass of sherry. One person was provided with a clothes protector. The registered manager told us that the home had plate guards, non-slip mats and 'feeder' cups to promote people's independence when eating, but we did not see any of these being used on the day of the inspection.

We noted that approximately half of the people who lived at the home chose to eat in their own room rather than the dining room. We saw that one person was sitting in the dining room for 30 minutes before their meal was served. One person fell asleep and another person struggled to eat with a fork. When staff passed by they assisted but they did not stay with these people to provide one to one support. We felt these people would have eaten more if a member of staff had stayed with them. A relative told us that they had lunch at the home and at the same time assisted their family member to eat their lunch. They felt that this arrangement worked well, as they had the time to spend with their family member to offer encouragement. One person said their meal was not hot. Staff took it back to the kitchen to re-heat it.

We recommend that the mealtime arrangements are reconsidered to ensure that people receive appropriate support to eat their meals.

We saw that referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutritional intake had been identified. Any advice given was recorded in the person's care plan. We saw the charts that were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored. Care plans recorded people's target fluid intake and fluid had been recorded in millilitres, although we saw it had not been totalled for the day. This made it difficult to see at a glance if the person had taken sufficient fluids. This was discussed with the registered manager who told us that more detailed fluid charts were used when people were considered to be at risk of dehydration. This was confirmed by staff who we spoke with.

Patient passports are documents that people can take to hospital appointments and admissions to inform health care staff about their specific care and support needs when they are not able to communicate this themselves. People had patient passports in place but some included very little information. This meant that health care staff might not have had sufficient information to support people in the way they required.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that some applications submitted to the local authority had been authorised and there was a record of when the applications needed to be resubmitted to renew the DoLS authorisation.

The staff who we spoke with understood the principles of the MCA and DoLS and could describe the main principles, such as assuming capacity and supporting people to make decisions that included unwise decisions. One member of staff said, "We would work from a person having capacity, and help them to make decisions by offering them choices, and giving them time to respond to us." We noted that care plans recorded a person's ability in respect of decision making. One care plan recorded, '[Name] can only understand simple things; they cannot understand elaborate talk.'

People told us that staff asked for consent and that they were consulted about their care. One person told us, "I feel I am [in control of my care]. There are lots of choices" and another said, "They know and I know what is happening." However, another person told us that they usually went to bed at 7.00 or 7.30 pm and if they 'missed' the day staff that might have to wait until 9.00 pm to go to bed, which was too late for them. We fed back this information to the registered manager following the inspection and they told us they would discuss this with staff to ensure the person's wishes were met.

People's care records included forms that recorded people's consent to their care plan, having their photograph taken, staff assisting them with medication and staff sharing information with health and social care professionals. These had been signed by the person concerned when they had the capacity to make this decision. One person's care plan recorded that they were not able to provide their consent and their consent forms had been signed by their spouse. There was no record of whether or not the spouse had power of attorney. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. A relative who we spoke with confirmed they had power of attorney (POA) for their family member and that they were consulted about decisions that needed to be made. We discussed with the registered manager that information about a person's POA needed to be clearly recorded in their care plan.

People told us that staff had the right skills to do their job. One person said, "They seem to be very efficient, very capable" and another told us, "Yes, new staff are taught (by experienced staff)." Records showed that staff followed an induction programme when they were new in post, and then completed training that was considered to be essential by the registered provider. This included training that was specific to people who lived at the home, such as dementia awareness and pressure area care.

The registered manager told us that six staff were due to commence the Care Certificate with an external training company; the Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. They added that this would include working towards the Qualifications and Credit Framework (QCF) award. QCF has replaced the National Vocational Qualification (NVQ) award and is the national occupational standard for people who work in adult social care.

The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. One member of staff said they would appreciate more training on how to deal with behaviours that challenged the service, as they sometimes found it difficult to know how to manage individual situations that might occur. The registered manager told us that all staff had attended a supervision meeting in November 2016 when they were asked if they required any further training. Some staff requested training on wound care, end of life care and dementia but none had requested additional training on behaviour that could challenge the service. All of these suggestions had been included in the home's training plan.

Staff told us they were well supported by the management structure in place. One member of staff said, "Supervision is good and the registered manager has an 'open door' policy for support at other times. Some staff have had an annual appraisal."

Charts were used by nurses to record wounds and to monitor their treatment. Care plans evidenced good liaison with other health care professionals such as GPs and the speech and language therapy team, and we saw that any contact with health care professionals was recorded. People told us that they could see their GP whenever they needed to. Communications from the NHS were also retained with people's care records so that they were available for staff.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff cared about them. Their comments included, "[Staff are] very touching – they are so nice with you" and "Seem to be [caring]. No problems. You can have a laugh." Comments from relatives included, "Mum tells me they are so nice" and "Staff genuinely care. Mum seems very fond of them. They have positive relationships. It's lovely to see." One relative added that they would have moved their family member out of the home if they had not been satisfied.

We saw positive interactions throughout the day between people who lived at the home and staff. We saw that people were comfortable in the presence of staff, and that staff were attentive, patient, kind and compassionate.

On the day of the inspection we saw that staff encouraged people to be as independent as possible. Relatives confirmed that staff encouraged people to be independent and only assisted them with the things they found difficult or could not achieve. One relative told us, "[My relative] has improved a lot. They encourage her to feed herself" and another said, "They try to get [my relative] to walk with two members of staff so they get some exercise."

Some people told us that staff shared information with them appropriately but other people were not sure about this. One person told us, "[Staff] share information every time they pop in to check all okay" and "Yes, when they come in to my room, but they haven't much time." Relatives told us that communication was good between them and staff. One relative told us, "Yes, they ring me up at home."

Care plans recorded people's preferred name. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. This was confirmed by relatives and people who lived at the home, who told us, "I'm comfy with the carers" and "Two girls came and gave me a shower yesterday." We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some ladies were wearing makeup and jewellery.

We saw information about advocacy services displayed within the home. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw that people had a care plan in place that recorded their religious and cultural needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered manager told us that their staff were working with staff from a local hospice who were

helping to train them in end of life care. Staff were working towards the Gold Standard Award; this is a system for ensuring people receive appropriate and compassionate care at the end of their lives. We saw that people had 'end of life' care plans in place when this was appropriate, and that any 'Do Not Attempt Cardio Pulmonary Resuscitation' forms in care plans had been completed appropriately.

Requires Improvement

Is the service responsive?

Our findings

The care records we reviewed included care needs assessments, risk assessments and care plans. We observed that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included personal care, mobility, continence, tissue viability, diet and nutrition, privacy and dignity, pain, social activities, medication and physical health. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

However, we observed that, on occasions the main care plan and the summary care plan contained conflicting information. There was also some contradictory information in care plans. For example, one person's care plan recorded that they needed to be encouraged to take part in activities in the lounge. However, we noted this person was nursed in bed. The care plan did not contain any information about how social stimulation should be provided in their room. This contradictory information could have led to people's current care needs not being met.

Daily notes we saw in care plans were very detailed although they focused on clinical interventions rather than information about how people had spent their day, activities taken part in or visitors seen. This was highlighted as a concern at the previous inspection in February 2016. Although some improvements had been made in respect of personalised information being included in care plans, we considered that further improvements needed to be made.

Care plans were reviewed each month and audits were carried out by the registered manager to check that care plans were up to date. We noted that some amendments to care plans had been dated and others had not. This meant it was not always clear when a person's care needs had changed.

Care plans included little evidence of people's input into their care plan. However, two relatives told us they had been involved in developing their family member's plan of care. One relative said they had checked it a few weeks after their family member had been admitted and noted that there were some inaccuracies. When these had been pointed out, they were corrected. Another relative told us, "I wrote the life history in the care plan. Mum has dementia so I completed this with everything I knew." One person had a form in their care plan entitled 'Historical facts about me'. This recorded information about their family, pets, hobbies and where they had previously lived. However, not everyone had this type of information within their care plan meaning that staff did not have access to these details for some people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how they got to know about people's individual needs and they told us that the clinical lead shared information with nurses and care staff, and that they read the care plan summaries in each person's

room. Staff were aware they could view the full care plan to gain more information. Staff added that nurses prepared written handover notes at the beginning of each shift, and this kept them up to date with people's changing needs.

Care plans were reviewed each month and audits were carried out by the registered manager to check that care plans were up to date. We noted that some amendments to care plans had been dated and others had not. This meant it was not always clear when a person's care needs had changed.

We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage these behaviours to diffuse such situations. The registered manager told us about one person who could become verbally or physically aggressive. We checked their care plan and noted it recorded how this person might behave, the triggers to this behaviour and how staff could reduce the risk of this occurring. This showed that staff had guidance about how to approach risky situations.

Relatives told us that they could visit the home at any time and were made to feel welcome. This was confirmed by the people who lived at the home who we spoke with. One person said, "My family are made welcome and staff ask them if they would like a drink."

There was an activities coordinator employed at the home. People told us they enjoyed the activities on offer. One person said, "Entertainers come in on a Wednesday afternoon. It is super. I would like it if they did a quiz." Some people told us they did not join in activities, but this was their choice. We did not see an activity plan on display or any activities taking part on the day of the inspection, but we were aware that the activities coordinator had taken someone out. There was a hairdresser at the home on the day of the inspection and we were told they visited the home each week. There was a poster that displayed details of the Christmas party planned for 21 December 2016 and the home was decorated for Christmas with decorations and a nativity scene.

The registered manager told us that the activities coordinator spent one to one time with people in their bedroom. However, some staff felt that more time needed to be spent with people who remained in their bedrooms to provide them with social interaction and to avoid social isolation. The registered manager told us that these activities were recorded in an activity folder but we noted that how people socialised was not included in their care plans.

We recommend that the activity programme is reconsidered to ensure that everyone who lives at the home has the opportunity to take part in their chosen activities.

There was evidence that people were supported to take part in the local community. We saw that one person went out for brunch with an off duty member of staff, another person went out in their motorised wheelchair 'for a breath of air' and another person regularly went out in the evening to follow their interest in Jazz

The complaints policy and procedure was displayed within the home. There was a form ready for people to complete should they wish to make a complaint. We saw some correspondence that had been sent to people in response to complaints made and that this was satisfactory. However, we noted that this information was not recorded in the home's complaints log. Complaints were audited by the registered manager, but the most recent audit we saw had been carried out in August 2015.

People who lived at the home told us that they felt able to express their concerns, and they told us who they would speak to. Comments included, "There is a notice that tells you [how to complain]. I would go to the

manager, although I have never had to", "I would tell any of the staff" and "I have never had to [complain] but I would speak to the lady in charge." Relatives told us they would speak to the manager and felt that the manager was approachable. One relative said, "I would speak to [Name of manager] or [Name of nurse] - they would listen and put things right if they could." Another relative told us, "I would see the manager or one of the nurses." They went on to tell us about complaints they had made and said that they were satisfied with the response from staff. They said all of the situations had improved following them making a complaint, which showed us that people's complaints were listened to and acted on.

Requires Improvement

Is the service well-led?

Our findings

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. We found that these were easily accessible and stored securely. The judgements from the most recent inspection report were on display in a prominent position within the home. However, some records in care plans were not up to date, some were not dated and some care plans included contradictory information. In addition to this, some complaint information had not been recorded in the home's complaints log, and some positional change charts had not been consistently completed.

This was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant that we were able to check that the correct action had been taken by the registered persons following any accidents or incidents.

We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that these interactions were positive and friendly. It was clear the registered manager knew the people who lived at the home well. We asked people if they knew who the registered manager was, and if they felt able to speak with them. One person said, "Not sure, I think it's [Name of manager]. She is lovely. Very kind and helpful" and another told us, "I know her by sight and I could talk to her." A relative told us they were happy to approach the registered manager. They said, "If I have niggles I tell them."

Staff told us they felt the home was being well managed. They said management were supportive and that the home was much more settled now the registered manager was back at work following sick leave.

The registered manager carried out various quality audits to monitor that the service was being operated safely and to meet people's assessed needs. These included audits of accidents, medication, pressure sores, the nurse call system, wound care, care plans, catering and infection control. Action plans were produced when concerns had been identified in audits. The catering audit had been analysed and changes had been made to the menu in line with people's suggestions, including individual preferences. The infection control audit recorded that the handyman would be asked to re-decorate one bedroom, and on the day of the inspection we saw that this work was being carried out. However, the audits carried out in April and November 2016 did not record the concerns we identified with the laundry room during this inspection, although the registered manager told us these had been identified in the November audit.

A relative described the culture of the home to us as, 'Friendly, caring, family orientated'. They said they were definitely satisfied with the service provided and that they would recommend the home to other people.

All of the people who we spoke with told us they were not aware of 'resident' meetings or satisfaction surveys. One of the relatives who we spoke said that they had received an annual survey that they had completed, but they had never seen any information about the outcome. They also said that they had attended meetings. They said, "We are asked for our opinions and we are listened to." A relative told us that the meeting scheduled for 23 November 2016 had been cancelled. We saw a notice displayed that gave details of three-monthly 'resident and relative' meetings. This confirmed that the meeting on 23 November 2016 had been cancelled, and that the next meeting was scheduled for March 2017.

Various staff meetings were held; we saw meetings for domestic, night staff and the full staff group. The minutes of the full staff meeting in August 2016 showed that the topics discussed were documentation, infection control / creams, night duties, mobile phones, the allocation sheet, wheelchair safety and the key worker role. There had been another full staff meeting in November 2016 when a recent safeguarding incident had been discussed. Staff were told that they had 'let themselves down' by the lack of documentation, and that they must record the actual position on turn charts. One member of staff said, "The manager listens to us and asks us what we think. She has clear ideas and is good at solving problems and explaining why we have to do certain things."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not always designed care or treatment with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to each service user and the decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)