Ideal Carehomes (Number One) Limited

Beaumont Hall

Inspection report

120 Beaumont Leys Lane
Leicester
Leicestershire
LE4 2BD

Tel: 01162323291
Website: www.idealcarehomes.co.uk

Date of inspection visit:
04 May 2016
05 May 2016

Date of publication:
15 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 May 2016 and was unannounced. We returned on the 5 May 2016 to complete the inspection.

Beaumont Hall is a care home that provides residential care for up to 60 people. The service specialises in caring for older people, those with physical disabilities and people living with dementia. The service is purpose built and provides accommodation over three floors. All the bedrooms have an en-suite facility. At the time of our inspection there were 57 people in residence.

At the last inspection on 17 and 18 August 2015, we asked the provider to take action to make improvements to the staffing levels, ensuring people's privacy and dignity was maintained and the quality assurance system was used effectively. We found that service had made some improvements, however further improvements were required.

At the time of our inspection a registered manager was not in post. The service has been without a registered manager since January 2016. However, the provider had appointed a manager in March 2016 who facilitated this inspection.

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

We found that people did not always receive their prescribed medicines at the right time. Systems to ensure adequate stocks were kept were ineffective. Although checks were carried out on the medicines administered and the records, errors were not identified therefore people's health was put at risk.

Staff training and support provided was not always kept up to date. The planning and monitoring of staff's skills needed to improve to ensure staff were able to meet people's needs safely.

The provider's quality governance and assurance systems were still not used fully or monitored to ensure people's health, safety and wellbeing was maintained. People's confidential information was not always maintained. There was limited opportunity for people to share their views about the service to influence changes to the care being provided.

People's care needs were assessed including risks to their health and safety. Care plans were written to reflect people's needs, which included the measures to help promote their safety and independence. These were regularly monitored and reviewed.

People told us they felt safe at the service and with the staff that looked after them. Staff were recruited in

accordance with the provider's recruitment procedures, which helped to ensure suitable staff, were employed to look at Beaumont Hall.

People lived in an environment that was kept clean. All the bedrooms had an ensuite facility and were personalised.

We found the requirements to protect people under the Mental Capacity Act and Deprivation of Liberty Safeguards had been followed. People's mental capacity to make decisions about their care had been assessed and their wishes were known and kept under review. The service acted in accordance with their legal responsibility to ensure that any best interest decisions made involved the relevant people and health care professionals where the person lacks capacity to make decisions or are unable to do so.

People's views about the quality of food had been listened to and action had been taken to change the menu choices. However, the dining experiences for people varied, which meant meal times were not always pleasurable.

People told us that they were treated with care and that staff were helpful. We observed staff respected people's dignity when they needed assistance. People's health needs were met by health care professionals and were supported to attend routine health checks. Records showed staff sought appropriate medical advice and support when people's health was of concern.

Although the service had a programme of activities these were not of interest to everyone. People were not always supported or encouraged to pursue their hobbies or interests.

People who used the service and relatives felt confident to raise concerns with the manager. Complaints were investigated in line the provider's policy.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing had been assessed. However, people's health was put at risk because prescribed medicines were not always available nor given correctly.

Safe staff recruitment procedures were followed and sufficient staff were available to support people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training and support was not up to date to ensure care and support provided met people's needs.

People's consent to care and treatment was sought and their care plans showed the principles of the Mental Capacity Act were used. People were encouraged and supported to make decisions which affected their day to day lives.

People's nutritional needs were met which took account of their preferences.

People were supported by staff to maintain good health and to access and liaise with health care professionals as required.

Is the service caring?

Good

The service was caring.

People were treated with kindness, their privacy and dignity was respected.

People were involved in making decisions about their daily care needs and staff respected their choices and lifestyle.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and care plans detailed the support people needed. However, staff were not always aware of how their own behaviours and the environment that could affect the quality of care people experience.

People were encouraged to maintain contact with family and friends. Activities and social events were not always available or of interest to everyone.

People felt confident to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in post.

The provider had assurance and governance systems in place but these were not used consistently to assess, review and monitor the quality and safety of care provided. Staff were not routinely supported nor their training monitored. People had little opportunity to share their views about the service. As a result improvements were not sustained.

Beaumont Hall

Detailed findings

Background to this inspection

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

This inspection took place on 4 May 2016 and was unannounced. We returned on the 5 May 2016 to complete the inspection.

The inspection was carried by three inspectors and an expert-by-experience on 4 May 2016. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned on 5 May 2016 to complete the inspection.

Before the inspection we looked at the action plan sent to us by the provider which detailed the improvements they planned to make from our last inspection in August 2015. We reviewed the provider's statement of purpose, information received about the service and the notifications we had been sent. A statement of purpose is a document which includes a set of information about the service and the support people can expect to receive. Notifications are changes, events of incidents that affect the health and safety of people who used the service that provider's must tell us about and included changes to the management of the service.

We also looked at other information sent to us from people who used the service, relatives of people who used the service and health and social care professionals. We contacted commissioners for health and social care, responsible for funding people that use the service and the dispensing pharmacy and asked them for their views about the service.

We spoke with 18 people who used the service and seven visiting relatives. We used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service. We used SOFI to observe people in the lounge during the morning and at the lunch time meal service.

We spoke with the manager, deputy manager, two senior carers and seven care staff. We also spoke with the front of house staff, chef, maintenance staff and the domestic staff. We spoke with the regional manager and the registered provider who visited the service.

We looked at the care records of nine people, which included their care plans, risk assessments, medicine records and records relating to their daily wellbeing and health. We also looked at the recruitment files of four members of staff, maintenance records for equipment and the building, quality assurance audits and the minutes of meetings.

We asked the manager to send us information in relation to the staff training, policies and procedures and the service improvement plan. This information was received in a timely manner. The provider also sent us the manager's induction programme.

Requires Improvement

Is the service safe?

Our findings

We found that the management and administration of medicines was not safe. People did not always receive their medicines at the right time and may not receive their medicines at all. One person said, -"I had no medication for 3 days and had to ask my son to go and find out what was going on. It could have been dangerous couldn't it?" Another person told us that their evening medicines were given late and said "Sometimes I am asleep already when they come round with my tablets. I expect it's because they are so busy. I do sometimes have trouble going back to sleep for a bit then though." This meant the gaps between each administration may not always be sufficient, which put people's health at risk.

We saw the morning medicine round started at 10am and staff were still administering medicines towards lunchtime. Staff told us this was not uncommon, which meant people were regularly receiving their prescribed medicines later than required, which placed their health at risk.

We checked the medicine administration records. We found these were not always completed accurately when people had refused to take their prescribed medicines and what if any action was taken by staff to help maintain the person's health. Records showed two people had not received their prescribed medicines. One person had not had their medicine to help them breathe easier and three other medicines for two days which they needed four times a day. Staff had recorded on the medicine records that 'ran out' and 'out of stock'. Another had not received their prescribed medicine for their heart condition for three days. That meant people's health was placed at risk because their prescribed medicines were not available.

We found there was a lack of effective communication amongst the staff responsible for medicines management and the system to ensure repeat prescriptions were ordered in time and sufficient stocks remained. A relative told us they had obtained a prescription for their family member's medicines because they had not been re-ordered.

We found staff did not always record the current balance of some medications so it was difficult to reconcile them accurately to check that all medicines had been given. Records showed one person had not had their medicines for two days following the changeover of the medicines system. Another person was not given their prescribed medicine to prevent their blood clotting without consulting a health care professional. This raised concerns about staff's competency and effectiveness of the training completed. The manager told us they took action immediately as this was against company policy, which we confirmed with the medicines policy and procedure.

One's person was prescribed topical creams to because they were at risk of skin damage and developing pressure sores. Their care records had no information available to staff as to where topical creams should be applied to prevent further risks to the person's health. This was raised with the deputy who quickly produced the information and placed on the person's file and in their bedroom. Although the staff knew where to apply the creams; this was the potential the risk that the topical cream may not be applied to the correct area.

The weekly audits showed issues that continued to be identified. Actions taken were ineffective because these had not been identified through the provider's audit checks carried out each month. This was further supported by the issues we found that meant people's health continued to be placed at risk.

This was a breach of Regulation 12 (2) (g) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our previous inspection of 17 and 18 August 2015 we found there were not sufficient numbers of staff available to ensure people's safety and care needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make improvements. They told us they would be monitoring the staffing levels to ensure people's safety and their care needs were met. We found the provider had made the required improvements.

People told us staff were available and supported them when they needed help. One person said, "I ring my bell if I need help, and most of the time I don't wait long, but sometimes if the carers are all busy helping, then it can be a bit of a wait." A relative said, "I come at different times of the day, but there are never staff standing around. They are always busy. If Mum needs anything though, I only have to ask. They [staff] do their best." Throughout our inspection visit we saw staff responded to the emergency call bell in a timely manner to assist people in their rooms.

Staff told us that staffing levels had improved and when required staff from the other two floors would help. Staff told us there were enough staff on duty to meet people's needs. However, if staff called in sick at short notice, bank staff were used or staff worked past the end of their shift to ensure people's needs were met.

The manager told us that they had assessed people's needs since they were appointed and considered the skills mix of staff needed to meet people's needs. The staff rota was consistent with the staff on duty. The previous months' worked rota showed the shifts were covered with the required staff. Staff recruitment was ongoing and the newly recruited staff were completing their induction training. This meant people could be assured their needs would be met.

The local authority commissioners responsible for funding some people's care had investigated a number of concerns. Some were substantiated and others were not. The concerns related to unwitnessed falls and incidents where people required medical treatment.

People told us they felt safe. One person said, "I know that I have to tell someone if a carer is horrible to me or they are rough. My family always question if I get a bruise." Another said, "I have to have that hoist thing, which I hate, but the staff are always really kind to me and that helps my nerves. They never shout." A relative said, "The staff are very nice to mum on the whole. Some of them are better than others, but they always look after her well even if they don't have time to sit and chat – which I know she would love" and another "I know she's safe here otherwise she would have told me to take her home."

Staff spoken with had received training in how to protect people from harm and abuse and could refer to the provider's safeguarding (protecting people from abuse) policy which had guidance as to the actions staff should take. One staff member said, "I have never dealt with a safeguarding incident myself but I would know what to do through the training I have undertaken". Staff could describe how they would refer an incident or concerns about people's safety to the manager and the external agencies if they felt the manager did not take action. This showed staff understood the process to protect people.

People looked after their own finances or were supported by the service to do so. Financial transactions received were maintained and audited regularly which helped to ensure people were protected from financial abuse.

People's safety was protected by the provider's recruitment practices. We looked at recruitment records for staff and found that the relevant checks had been completed before staff commenced work at Beaumont Hall.

People's care records included assessments where potential risks associated to individual needs had been identified in relation to their nutrition, mobility, moving and handling, falls and risk of developing pressure sores. These were used to develop plans to promote people's safety. Care plans provided staff with clear information as to the support people required; managing risks safely and where appropriate using the correct equipment. For one person who requires the use of hoist for all transfers; their risk assessment detailed hoist and sling that should be used. Care records showed that health care professionals such as the dietician and specialist nurse were involved when people weight or health needs were of concern. This meant that risks to people's health, safety and wellbeing were managed effectively.

We saw people moved around safely on their own or with support from staff. The wide corridors and the good level of lighting promoted people's independence. We saw staff assisted one person to transfer from their armchair to their wheelchair using a standing hoist, which was done safely. A relative said, "Security here is one thing I don't have to worry about. The front doors were open when I came in today, but there is always someone in the reception area."

Records showed systems were in place for the maintenance of the building including the servicing of equipment such as hoists, slings and electrics, which were up to date. Staff knew how to report faults if they had any concerns and repairs carried promptly.

The manager reviewed all incidents and accidents to ensure the action taken by staff were appropriate. Records we viewed showed that incidents affecting a person's safety were reported to the relevant authorities, which included details of the action taken by staff such as requested an ambulance or the person was observed for up to 72 hours following a fall or any other incident where their health was of concern. The manager told us that they reviewed the person's care plans and risk assessments to ensure those remained appropriate.

Requires Improvement

Is the service effective?

Our findings

The management knew that staff needed training and support but this was not kept up to date or covered the area expected by the provider to meet people's needs, such as safeguarding and manual handling. The staff training matrix showed that some staff had received training on a range of topics in relation to health and safety, first aid, moving and handling, safeguarding. However, there were gaps in training and some staff's training had lapsed. That meant shortfalls in training may affect people's care.

Staff told us that they had received induction and training, which they felt had enabled them to be effective in their role to support people safely. One staff member found the induction training was informative. The induction consisted of practical training in how to use equipment safely when supporting people, reading through policies, procedures and they also worked alongside experience staff. This helped staff to get to know people and their individual needs.

People told us that staff knew how to care for them. A relative told us that they found staff to be trained and commented that staff wore gloves and aprons when they helped their family member with their personal care needs. During our visit we observed staff supported people safely and used equipment such as the hoist correctly. We saw a staff member was careful and offered assurance as they supported a person to sit in the wheelchair.

The manager told us that the staff training programme would be developed from the information gathered through staff supervisions. They had planned to enable staff to access the 'Care Certificate' training. This is a set standard for care staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

Health care professionals we contacted prior to our inspection told us that they had provided training in pressure care management to staff. This helped to raise their awareness and support people at risk of developing pressure sores.

Some staff had had a supervision meeting with the manager. They found the process was open and transparent as they received a copy of the supervision notes for reference. The newest staff member had had a supervision meeting with the manager during their induction training and found the meeting was useful as the manager had helped them to identify how they could improve and develop their working practices.

The manager had held staff meetings with all the staff since they were appointed. The meeting minutes showed topics discussed included concerns about people's health, issues relating to health and safely, improvements to practice such as accurate recording keeping, communication and timely checks on people who could be at risk of falling. Meeting minutes were available to all staff including those who were unable to attend. The meeting minutes did not refer to the actions required or review of issues from the previous meetings. Dates for future meetings were yet to be confirmed. Although the manager was starting to support staff, the support was not fully in place.

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

The manager and staff had an understanding of the MCA and how this applied to people who they supported. One member of staff said, "I always seek consent before I support people with their personal care. Most people can tell you if there are happy for you to support them. Other people use non-verbal communication so I watch their facial expressions and body language to make sure they are happy with what I am doing." Another staff member gave examples of how they supported people living with dementia and described how important it was for one person to be in a quieter environment when making decisions and avoiding loud noises which could unsettle them. Staff told us some people needed assurance and extra time to process information before they were supported with their personal hygiene needs.

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 found conditions on the authorisation to deprive a person of their liberty were being met.

People's care records showed that people's mental capacity to consent to their care had been assessed and where appropriate their representatives such as a relative and health care professional had made best interest decisions on their behalf. These included health specific capacity assessment, where a person had their medicines disguised in food and drink. Records showed appropriate authorisation had been sought from the GP and pharmacist. This showed that the principles of the MCA were being followed.

We observed the lunchtime experience across all three floors. Most people chose where they sat for their meals, whilst others remained seated in the lounge or chose to have their meal in their room. Although there was a menu board with the menu choices for the day the meals served were no the same. This could result in people not receiving their choice of meal. The manager assured us they would discuss the menu options with people at the next resident meeting.

We saw the meals were served individually and looked balanced. People were offered a choice of drinks. People were provided with adapted cutlery, so they could to eat independently. We saw staff supported one person to eat by cutting up the food into small bite size pieces. Another member of staff knelt down next to someone and spoke in a calming manner, encouraging them to eat. They did this successfully as the person ate more of their meal. Some people were offered an alternate meal because they did not like the menu choices, which the chef prepared.

We observed a number of instances where people were not supported to eat their meals. One person struggled to eat because their dentures were loose, which hindered their eating and another was unable to eat independently due to their physical health. Staff did not offer assistance until we brought it to their attention. Their care plans stated how staff were to support them and ensure they were comfortable and the meals provided were suitable but clearly that had not happened. Several people left over half of their meal but staff did not ask whether they had finished the meal and served the next course. This meant people's health could be placed at risk because they were not always supported appropriately. When we shared this with the manager they took action to alleviate the issues. On the second day of our visit we saw people were eating their meals comfortably.

People told us the quality of meals was variable and there comments showed that meal times were not always a pleasurable experience. One person said, "It's very nice; there's always something on the menu that I like." Another said, "I have my own stash that my family bring in, so I never get hungry. They know what I like." A third person said, "I prefer to eat here [in their room] because it's really noisy down there in the dining room. The food is a bit lukewarm when it comes though, but I guess that's the price you pay. I know I get served last."

We shared our observations with the manager. They assured us they would speak with the chef and ensure people health needs and risks were managed to enable them to eat their meals.

Records showed that an assessment of people's dietary needs had been undertaken. People's weights were measured and where concerns about people's food or fluid intake had been identified, they were referred to their GP, speech and language therapist (SALT) and the dietician. Staff did monitor how much a person with a poor appetite ate and drank. However, it was difficult for staff to know whether the person had had enough because their care records had no guidance as to what the recommended intake should be or what staff should do. When we raised this with the manager they assured us action would be taken to confirm the recommended daily intake for those people and care plans would be updated.

People told us they were able to see their GP as and when required. One person told us that the GP came to the home to see people every week. People's care records showed that they had access to a range of health care support to meet their health needs. A relative said, "I take mum to all her appointments." This meant people's health and wellbeing was maintained.

We contacted health care professionals prior to our visit and also spoke with a visiting health care nurse. They told us that staff were knowledgeable about the care needs of the people they supported. They felt staff were better at seeking advice when they had any concerns about people's health and followed the guidance provided to meet people's needs.

Good

Is the service caring?

Our findings

At our previous inspection of 17 and 18 August 2015 we found people were not always treated with respect and their dignity was not always maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements through providing more support and training to staff, improved staffing levels and observations and gathering people's views about the support provided. We found the provider had made the required improvements.

During our inspection visit we saw people looked clean and dressed in clothing of their choosing. We saw staff always asked people if they wanted to be helped and supported them accordingly. One person said, "They [staff] always ask nicely and when you do ask for something, it's never a problem." A few ladies showed us their nails which had been painted to match their outfits. One person said, "I've always had painted nails but couldn't do it anymore because my hands were not steady. It's nice that staff do it for me." We saw staff acted quickly when someone's dignity had been compromised and encouraged them to return to their bedroom for assistance to help maintain their personal hygiene.

People's bedrooms were respected as their own space and we saw that staff always knocked and did not enter until asked to do so. All the bedrooms had an ensuite shower and toilet facility which prompted people's privacy. The bedrooms we saw looked comfortable and were personalised to reflect individual taste and interests.

Staff described ways in which they preserved people's privacy and dignity which supported our observations and comments received from people using the service. Staff had read people's care records to find out what was important to the person and their life history, which enabled them to prompt conversation on topics that were of interest to people.

People told us that staff were kind and caring. One person told us that the staff knew how they wished to be supported and enjoyed being out in the fresh air. Another person said, "The staff are lovely, well most of them anyway. They always remember my family's names and tell them to just help themselves to a drink from the kitchen if they would like one. They are always made to feel welcome." A third person said, "I told them I don't like to go to bed early, so they just check in on me to make sure I don't need anything late at night."

We observed people being supported by staff in a caring manner. People were heard laughing and chatting with staff over lunch and as they were being supported. Staff communicated with people effectively and used different ways to offer support. For instance, when a member of staff asked a person sat in the chair, if they could put their slipper back on; they were grateful and responded positively to the staff member's conversation. We saw staff were at the same eye level with people who were seated; spoke clearly and discreetly when people needed assistance to maintain their dignity.

We found staff approach to people was caring and provide an environment that was pleasant. Most people had their meals at the dining tables which were laid out with condiments, cutlery and matching tablecloths and napkins. We some people difficult to see the napkins to wipe their face with. When we shared our observations with the manager who they would purchase different coloured napkins. We saw staff supporting people to return to sit in a 'comfy' seat after they had finished lunch.

People told us they knew about their care and support arrangements. One person told us that they spoke with staff about the support provided to make sure it was right for them and had signed to the care plan to confirm the agreed support. Another person told us that their relative supported them to make decisions about their care.

A relative told us that they were involved in the care planning process for their family member who was living with dementia. This helped staff to ensure they had information about the person's likes and dislikes and what was important to them. Another relative said, "My sister deals with all that for dad. I know they do talk about what is happening, especially changes in medication, but I don't know more than that."

Requires Improvement

Is the service responsive?

Our findings

We asked people if the care and support they received was tailored to their needs. One person said, "I know used to I have a shower in my room, but I don't like showers at all. They now give me a bath once a week because they know I won't change my mind." Another person who was not keen on moving to a care home and said, "Staff have made it comfortable for me" and "I think the staff are lovely here. Sometimes they do get busy but they always find time talk to me."

A relative said, "There is no consistency of staff. They seem to be moved from floor to floor, so the residents aren't able to get used to them." They added, "The senior on the first floor is good." When we raised this with the manager they told us that although the senior staff were assigned a dedicated floor they were looking to improve the staffing arrangement to provide continuity of care.

Staff told us they read people's care plans to find out what support the person required and were able to describe in detail people's needs and how they wished to be cared for. One staff member said, "I encourage people to be independent every time I support them. For example, someone might need help getting on and off the toilet but they may be able to clean themselves and adjust their own clothing so I would let them do this for themselves."

People's care plans set out the support people needed along with information about their life history, interests and ability to make decisions about their life. For example, one person preferred to have the bedroom door left open. Even though this may present a security risk and details of where the emergency call bell should be place to enable the person to call for assistance as and when they needed, was recorded. We saw this was in place and checked with the person each time their care plan was reviewed. Records showed people were involved in the review of their care and any decisions made were also recorded. This helped to ensure people received support to suit their choice of lifestyle.

The daily records completed by staff included information about the care and support provided to the person. Staff had recorded how the person had spent their day and activities they took part in such as the choir singing, spending time with their visitors and also some information about their general health and appetite. Record showed people's health was monitored and if required, the GP was contacted. That showed staff were responsive and ensure information was shared with staff to ensure people's wellbeing was maintained.

We found the service was responsive to people's health needs and advice was sought from health care professionals. Short term care plans were put in place to manage health conditions such as water infection or support to prevent the person developing a pressure sore. These plans provided staff with the guidance including any recommendations made by health care professionals such as the dietician or the specialist nurses. Care plans were updated as people's health and care needs changed to ensure staff had the correct information to support the person appropriately.

We saw posters of the activities planned for the month of May, which also included external entertainers and

a trip local concert hall. However, the information on the electronic screen in reception area differed to that on the poster. A member of staff told us that activities took place that were of interest to some people but not all. A number of people told us that they were 'bored'. However, when prompted by staff people recalled some of the activities they had taken part in this included the gardening club, knitting and armchair exercise.

On the second day of our visit a number of people were sat in the garden in the morning, whilst others were having their hair done at the in-house salon. Before lunch a number of people with some staff and the manager all joined the choir singing. This had been organised by a person using the service who also played the organ. People looked to be enjoying the singing and laughter and conversation.

We saw a staff member supporting a person who uses non-verbal communication. They placed three jugs of juice in front of them and asked which colour they liked best. The person nodded to indicate the drink they wanted with their lunch time meal. We saw staff did not always recognise how the environment could affect people. For instance, because the dining tables were close together, some people found it difficult to sit with their friends and enjoy conversations over lunch. Whilst some people were reminiscing amongst themselves, staff did not encourage conversations with others who sat quietly. This was further hindered by staff loading the dishwasher whilst people were still eating and talking with others. That meant staff were not always proactive and aware of how their behaviours, which sometimes was focussed on tasks, affected people.

People were encouraged to express their views about the service individually. Several people commented on the 'new manager' as they had introduced themselves to each person individually and their relatives. The manager told us that a 'residents' meeting was planned for 6 June 2016.

The provider's complaint procedure set out how complaints would be managed and what people can do if they remain unhappy with the response. The contact details for the local authority, CQC and the local advocacy service should people require support to make a complaint. The complaint procedure displayed was not easily accessible as the print was too small. This was addressed when we raised it with the manager.

People told us that if they had any concerns they would speak with the staff member in the first instance. A relative said, "I have made a number of complaints but 'top management' don't listen." They went onto explain they meant the senior management that were not based at the home. Another said, "I would have no trouble speaking up for mum but in fact she is only too happy to do that for herself and does attend the residents meetings. It does seem to revolve mainly around the food so far though."

The service had received 14 complaints, which four were upheld. The remaining complaints were yet to be concluded and included the concerns that CQC had referred to the provider to investigate. Investigation records and correspondence were kept including any actions taken where the complaint was concluded. That showed complaints were investigated and managed to ensure people's needs continue to be met.

Requires Improvement

Is the service well-led?

Our findings

We the Care Quality Commission (CQC) had received a number of concerns about the service which we referred to the local authority where concerns related to safeguarding matters and also to the provider to investigate using their complaints procedure. Some of the concerns related to poor practice, unsafe support and staffing levels. All the concerns we received were taken into account as part of this inspection.

At our previous inspection of 17 and 18 August 2015 we found the provider's quality assurance system was in place but not used consistently in determining the quality of care provision. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining their plans to implement the quality assurance system. They assured us that the registered manager at that time would be supported to ensure audits were carried out and people's views were sought about the quality of care provided. At this inspection we saw the provider had not made all of the required improvements

Following our last inspection the provider wrote to us and told us that the registered manager had resigned. The provider appointed a new manager in March 2016. They were supported by the regional manager through the manager's induction programme.

We spoke with the provider who was visiting the service on the first day of our inspection visit. They told us that the improvements planned were not sufficiently sustained and management of the service needed to improve.

We found people's views about Beaumont Hall had not been sought in line with provider's policy. Meetings for people who used the service had not taken place although one was planned for June 2016. The manager told us that satisfaction surveys would be sent later in the year as they were addressing issues and complaints received from people using the service and relatives.

The complaints about the service were still being investigated by the manager, of which some related to historical issues that had not been resolved. This showed the provider had not assured themselves that people's concerns were managed promptly at Beaumont Hall.

We found the service lacked effective leadership with regards to the supporting and training of staff. Staff told us that they were not supported prior to the manager being appointed and there was little evidence to show the action taken by the provider to ensure people were not at risk of receiving unsafe care. The staff skill mix could not be ascertained because training was not provided and training records were not kept up to date. Although the provider had appointed an interim manager to manage the service, we found gaps in staff's training and the lack of formal support had not been addressed by the provider.

We looked at the provider's quality assurance system to find whether these were used effectively. The provider monthly programme of audits was comprehensive and covered all aspects of the service. However,

these were not being completed in full in accordance with the provider's expectations. For instance the audits for January and February 2016 completed by the interim manager were incomplete, no evidence of what if any action was taken and furthermore no evidence that the provider had taken action.

The manager had started to complete the quality audits for March 2016 onwards. However, those were still not completed in full and no evidence of what was found, and the actions being taken or were planned to bring about the improvement. Furthermore, we found the manager was not fully supported by the provider to ensure the completion of the quality assurance was done correctly and took account of other checks being carried out. For instance, the medicines audit completed by the manager did not take account of the issues identified in the weekly audits completed by the senior staff. The weekly audits identified a number repeated issues concerns the lack of adequate supply of prescribed medicines, recording issues on the medication administration records and ordering systems not being effective. That meant improvements were not actively monitored to maintain people's health.

Following our inspection visit we received a copy of the medicine management audit completed by the dispensing pharmacist. The issues found demonstrated management needed to improve the monitoring in place to ensure people's health and wellbeing was maintained.

We looked at a sample audit of people's care records that had been checked by the manager. Although issues had been identified, staff had not acted promptly to make the improvements. For example, there was no evidence to demonstrate that the named people's care plans and risk assessments had been updated promptly. Gaps in recording of people's weight and the amount of food and drink consumed meant people's health was not managed or monitored effectively. That could place people's health at risk.

We found people's confidentiality was not maintained or protected. We saw there was an accepted culture to discuss people's health condition on the telephone in the presence of other people using the service and visitors. This is because no other staff challenged their colleagues when they discussed people's health publically. We found people's care records were not stored securely and left on the filing cabinet or dining table when staff were called to support someone.

The provider assured us that the manager was being supported and being given the resources to make improvements to the service. This included development of social activities for people using the service, ongoing staff recruitment, training programme for all staff and gathering people's views about the service through surveys.

This was a continued breach Regulation 17(2) (a) (b) (e) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Following our inspection the manager sent us the evaluation of the quality assurance audit completed for April 2016, which included an action plan to address the shortfalls identified.

Records showed the manager had also analysed the accidents and incident reports to see whether any trends or patterns evident that would indicate wider issues. For example, records showed the manager had reviewed a person's care needs due to the number of falls occurred in a short space and referred them to the falls clinic for advice and another person was referred to the dietician because of their weight. The manager showed that they had learnt lessons from incidents. For example one improvement has been made to the admission process; whereby with the person's consent a floor sensor would be placed in their room to help assess whether the person would be at risk of falls. They monitored the person and used the information to put plans in place to manage the risk.

We asked people who used the service and visiting relatives for their view about the quality of care and the management of the service. One person said, "There seems to have been a lot more smiley staff since the new manager arrived." A relative spoke positively about the manager and changes being made to improvement people's quality of life and the care provided. Another relative told us the manager "seems approachable and seems keen to get things into shape which is comforting. The staff at least seem a bit happier now and things seem more open." This showed the service also received compliments for the care provided to their family members.

Staff spoke positively about the manager and changes that were being introduced. Comments received included, "Things are much better now since the new manager and deputy started. She [manager] is very supportive. I can go to her at any time with concerns and she will sort it out there and then," "There is a good, open culture here. There is a mix of skills amongst the staff team and you find you do have to run around after some staff. I just accept that now" and "There is a very different atmosphere here now. Before the new manager started, I wouldn't see a manager whilst I was on shift. Care staff were all doing their own thing and not working as a team. Now we are all working together. We know where we need to improve and we are doing it slowly. I have seen family members and people who live here much happier now."

The manager showed us the examples of the new care planning documentation being introduced, which looked at the person's holistic needs not just their care needs. This showed the provider was taking steps to develop better systems to promote accurate recording that reflects people's needs and monitor their health.

The local authority responsible for the funding the care of people who used the service had identified areas for improvement which they planned to follow-up at the next monitoring visit.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed and administered correctly to make sure people received their prescribed medicines safely.

The enforcement action we took:

Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance system was not used fully to assess, monitor and make improvements to the quality of care provided. Gaps in monitoring and managing risks and which meant improvements were not sustained. People's information was not kept secure or up to date. Staff support and training was not managed. Limited opportunity to gather people's views about the service. The registered person had not provided the Commission with the requested information to improving the services provided.

The enforcement action we took:

Warning notice issued.