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Beaufort Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 24 and 29 August 2017. We last inspected Beaufort Care Home on 10 July 2015. At the inspection in July 2015 we rated the home as 'Good' overall and for the domains of 'Effective', 'Caring', 'Responsive' and 'Well-led'. We rated the home as 'Requires Improvement' for the 'Safe' domain as we made a recommendation about staffing levels and how these potentially affected people's social needs.

Beaufort Care Home is on a main road position in Burscough. Accommodation is provided for 32 adults requiring personal or nursing care. At the time of our inspection there were 26 people living at the home. The majority of rooms are of single occupancy, with en-suite facilities. The environment is spacious, well maintained and tastefully decorated with good quality furnishings. All amenities are easily accessible within the nearby village of Burscough and public transport links are close by.

There was no registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager at the home who had been in post for approximately four months at the time of our inspection. The manager had begun the process of registering with the CQC at the time of our inspection.

People told us they felt safe living at the home and that staff were kind and compassionate to their needs. Appropriate safeguarding practices were in place and staff knew how to recognise and report potential safeguarding issues.

We looked at the way the service supported people with their medicines. During the inspection we observed people being sensitively and safely supported with their medicines. We found medicines were being stored safely and securely. Room and fridge temperatures were monitored in order to maintain the appropriate storage conditions. Processes were in place to manage the appropriate disposal of medicines, including returns to the pharmacists. Controlled drugs were administered and stored appropriately.

We found some examples of 'as needed' medicines protocols which included pre-printed 'generic' instructions, they were lacking in person centred detail to ensure the medicine was administered safely and effectively in response to the person's specific needs. We have made a recommendation about this.

During the course of our inspection we found there were sufficient numbers of staff to meet people's assessed needs. We asked people and relatives about staffing levels and we received mainly positive responses.

We found the home to be clean, free from clutter and devoid of any malodours. There was an efficient

cleaning and infection control regime within the home.

Staff received the appropriate training to undertake their specific role effectively. We reviewed the homes training matrix, discussed training with staff and spoke with the external training advisor for the home. People we spoke with had no concerns regarding the ability or competence of staff.

The home was working within the principles of the Mental Capacity Act and any conditions or authorisations to deprive a person of their liberty were being met.

The home supported people with their nutritional needs including catering for people with specific needs such as those needing a diabetic or soft diet. Feedback regarding the quality of food was positive and the dining experience was seen to be a positive one.

We spoke with staff about the needs of the people who lived at the home. It was evident that staff knew people well and were able to describe people's preferred routines, likes and dislikes. There was evidence within people's care plans to show that this was documented.

The service had policies and procedures for dealing with any complaints or concerns. People told us they felt comfortable raising issues and that they felt any concerns would be dealt with appropriately.

Care plans evidenced that people were able to make choices across a number of areas including; food, clothing, activities undertaken and if they preferred a male or female carer to assist them. People we spoke with expressed no concerns in being able to make their preferences known.

We spoke with people who lived at Beaufort Care Home about the management and culture within the home. The responses we received were positive.

The organisation had introduced a 'service hub' which assisted managers and regional managers to oversee the performance of each home within the group. The hub contained information from audits undertaken as well as staffing, resident, financial and estates information for each home.

A range of meetings took place within the home so people, relatives and staff could raise issues in a formal setting.

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.

People told us they felt safe living at the home and that staff were pleasant and kind.

Safeguarding processes were in place and staff were aware of how to recognise and raise safeguarding issues.

Medicines management for people requiring 'as needed' medication was not always person centred which meant that people may have been left without the correct level of pain relief.

The home was clean, tidy and free of any malodour.

Is the service effective?

Good

The service was Effective.

Staff were suitably trained and supported to carry out their roles effectively.

The service was working within the principles of the Mental Capacity Act.

People were supported to eat a health and balanced diet and any specific needs were catered for.

Is the service caring?

Good

The service was Caring.

People and their relatives told us that staff were caring, compassionate and knew the needs of the people they cared for well.

There were no issues raised or seen with regard to privacy, dignity or confidentiality.

People's wishes were discussed with regards to how they were

cared for at the end of their life.

Is the service responsive?

Good

The service was Responsive.

The service had appropriate procedures in place for dealing with complaints and people told us they felt comfortable raising issues..

Care plans were reflective of the needs of people, person centred and were reviewed regularly.

Appropriate activities took place both within and external to the home.

Is the service well-led?

Good

The service was Well-led.

People knew who the manager of the home was by sight and told us she was approachable.

A comprehensive suite of auditing and monitoring was in place via a newly developed 'hub' system.

Meetings took place with people, relatives and staff at all levels.

Beaufort Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 24 and 29 August 2017. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the Provider Information Return (PIR) which had been sent to the provider for completion. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was completed in detail and we asked for further updates on this information when we visited the service.

We spent time speaking with and observing people who lived in the home, as well as staff. We were able to see some people's bedrooms, bathrooms and the communal bathrooms. One member of the team also shared a meal with people who lived in the home. In total we spoke with four people who lived at the home, eight visiting relatives and nine members of staff including the manager, one of the registered owners, the cook, activities co-ordinator as well as care and domestic staff. We also spoke with the home's training advisor, quality assurance manager and regional manager.

We looked at care plans for six people living in the home, their medication records and care plans relating to the use of their medicines. We observed medicines being handled and discussed medicines handling with staff. We checked the medicines and records for people and spoke with members of nursing staff with responsibility for medicines.

We looked at records relating to the maintenance and management of the service and records of checks or audits being done to assess and monitor the quality of the service provision. We also looked at the staff rotas for the previous month and staff recruitment and training records.

Before our inspection we reviewed the information we held about the service. We spoke with commissioners of the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there.

Good

Is the service safe?

Our findings

We asked people who lived at the home whether they felt safe. People told us they felt safe living at the home. One person we spoke to told us, "Yes I feel safe, the environment is very good no one can just walk in." Another person said, "Yes, absolutely. I cannot speak highly enough of the staff they are very good. I visited six homes before I came here and I knew this was the right place for me, because they made me feel at home straight away. They are very good at giving me my medicine. They never forget and they make sure they watch me taking it." All visiting relatives we spoke with told us they felt their loved ones were safe residing at Beaufort.

Staff knew how to keep people safe and how to recognise safeguarding concerns. They had a clear understanding of the process or procedure to raise any safeguarding concerns for people. This meant people could be assured that staff would raise safeguarding concerns if they noticed someone being ill-treated. We found staff had received training in safeguarding adults from abuse. The home had a clear safeguarding policy in place that meant there was guidance for staff and people in residence at the home and their families.

We looked at the way the service supported people with their medicines. During the inspection we observed people being sensitively and safely supported with their medicines. The medicines administration records (MAR) included a photograph of the person to assist with identification. The printed details on MAR provided clear information on the name and strength of the medicines and dosage instructions. We noted the MAR were continuously checked and people were discreetly asked their names before being offered their medicines.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. The processes included staff having sight of repeat prescriptions for checking prior to them being sent to the pharmacist. This was to ensure all the required items were included on the prescriptions. There was a monitored dosage system (MDS) for medicines. This is a storage device provided and packed by the pharmacy, which places tablets in separate compartments according to the time of day. We found medicines were being stored safely and securely. Room and fridge temperatures were monitored in order to maintain the appropriate storage conditions. Processes were in place to manage the appropriated disposal of medicines, including returns to the pharmacists. Arrangements were in place for the safe management and storage of controlled drugs; these are medicines which may be at risk of misuse. We checked two people's controlled drugs and found they corresponded accurately with the register.

There was information in the care records we reviewed; of people's ability and preferences to manage or be involved with their medicines. The person's consent had been sought in agreement with the outcome. This meant there was some information to demonstrate how decisions around how people not self-administering their medicines had been made. There were 'medicine profiles' which listed the prescribed items, dosage instructions and any known allergies. The profiled provided scope for people's involvement and needs with their medicines to be noted.

We found there were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. The protocols are important to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered. We noted some examples of protocols which included pre-printed 'generic' instructions, they were lacking in person centred detail to ensure the medicine was administered safely and effectively in response to the person's specific needs. However we found evidence to demonstrate progress was on-going to rectify this matter and more appropriate protocols had been introduced.

Processes were in place for care staff to sign in confirmation of the application of people's external medicines, such as topical creams. There were recording charts with 'body map' diagrams for care staff to refer to and complete.

Staff had access to a range of medicines management policies, procedures and nationally recognised guidance which were available for reference. Information leaflets were available for each of the prescribed items. Records and discussion showed staff responsible for medicines management had received various levels of training. We looked at records which demonstrated staff had been appropriately competency assessed in undertaking this task. We noted one staff had not been competency assessed for over 12 months. However the manager had identified this shortfall and a competency assessment had been arranged, further medicines management training had also been scheduled. There were on-going daily and weekly checks of some medicine management practices.

We recommend that the provider consider current recognised guidance on person centred medicine management and take action to review and update their practice accordingly.

At our previous inspection we made a recommendation about staffing levels within the home as whilst people told us that their basic care needs were met we were told, and observed there to be a lack of activities and social interaction for people living at the home. We saw at this inspection that staffing levels were in place to support people's care and social needs. A full time activities coordinator was in place and had been employed at the home for approximately 18 months. We spoke with the activities coordinator at length and observed their interaction with people across the two days of our inspection. People, relatives and staff spoke highly of the activities coordinator and it was obvious from observing some of the activities that people enjoyed this interaction. It was evident from speaking with the activities coordinator that they knew people at the home well, what they enjoyed taking part in and when they did not enjoy activities.

We asked the activities coordinator what types of activities were undertaken at the home and they told us, "We tend to do exercises in the morning such as throwing soft balls and also try and get people singing. There is a sewing club that contributes to the craft fair we hold in October. Half the money goes to charity and half to the activities fund. We do story boards using whiteboards and get each person to say a sentence and we make up stories. We do play your cards right, bingo, hangman and memory and reminiscence sessions." The activities coordinator also told us that they spent 1-1 time with people who were unable to leave their bedroom or did not want to engage in group activities.

During the course of our inspection we found there were sufficient numbers of staff to meet people's assessed needs. We asked people and relatives about staffing levels and we received mainly positive responses. One relative we spoke with told us, "The staffing has changed with the new management. There are more staff now so I know my relative is safe and being looked after well." Another relative said, "There are enough staff but on rare occasions at weekends the staff seem a bit thin on the ground." Two relatives said that they felt there could at times be more staff in the lounge area to assist people but understood that staff were also required in other parts of the building and that the layout of the home meant that it was not

always obvious how many staff were working. It was evident from speaking to people, relatives and staff that there had been a high turnover of staff but that this had now settled as the new manager had established themselves in their role.

We reviewed staff rotas for the four week period prior to our inspection as well as the week of our inspection. It was evident that there was still some agency staff used but that this was reducing as recruitment progressed. Agency staff were being used for people who had 1-1 staff commissioned but the manager told us that they were looking to facilitate these hours via their own staff team going forward. There was one agency nurse on duty on the first day of our inspection.

We saw that accident and incidents were recorded via hard copy forms and then transferred onto a database that the organisation had in place. The database enabled managers to look at trends such time, location and type of accident as well as being able to isolate individual peoples, staff and visitors and if the accident resulted in a safeguarding referral. If any trends were apparent the system enabled the manager to produce an action plan for individuals. The system was also set up to monitor other areas such as infections, pressure sores and deprivation of liberty referrals to assist the management team to monitor a number of areas in the home. The system could also be accessed by area managers and the owners of the organisation so there was additional oversight and scrutiny.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of four staff members. We found that robust recruitment procedures had been followed including Disclosure and Barring Services (DBS) checks and seeking appropriate references from previous employers. We found evidence that people completed an application form and were interviewed as part of their recruitment. We did however see that interview notes were not always consistently scored. We discussed this with the manager who assured us that going forward this would be addressed. We did see evidence from one of the files we looked at that a negative comment received within a reference was followed up and investigated before making an offer of employment.

We saw evidence that disciplinary procedures were being followed. Within one of the staff files we reviewed a formal letter explaining the disciplinary issue had been sent to the member of staff in question and a meeting had been held to discuss the issues. The outcome of the disciplinary meeting was also on record. The process followed the homes staff disciplinary procedures and staff we spoke with were aware of these procedures.

We looked at how people were protected by the prevention and control of infections. Infection control policies were in place at the home. There had been no infection outbreaks at the home since our last inspection. During the course of our inspection we toured the premises, viewing a selected number of bedrooms and all communal parts of the home including bathrooms and toilets. The home was observed to be clean and pleasantly decorated throughout. We saw that there was personal protective equipment in place for staff, who also confirmed this when speaking with them, and cleaning schedules were in place. We spoke with the infection control lead who had worked at the home for a number of years and was the head housekeeper. They took us through the cleaning schedules within the home, the laundry system and clinical waste procedures. They told us that they had sufficient budgetary resources to attain the equipment and materials they needed to carry out their duties effectively. They also told us that they were well supported by the new manager.

Every person we spoke with said that the home was clean. People made similar comments such as, "Yes my

room is very clean. It is cleaned every day and the bathroom is cleaned too. The bedsheets are washed very regularly, I think it might be every day but I am not sure. My clothes are kept clean too". One visitor told us, "His room is kept very clean, the sheets are washed every day. The lounge is always clean. They keep his clothes clean."

We had no concerns regarding the safety of the environment or fire procedures. People had personal emergency evacuation plans (PEEPs) in place for staff to follow should there be an emergency. The home completed a number of risk assessments on the environment of the home and the activity undertaken within it. We did however find the sluice room on the first floor to be unlocked on two occasions on the first day of our inspection. We informed the manager about this and when we checked this room later on the first day and on the second day of our inspection the room was locked.

We saw that a dedicated fire file was in place. The fire file contained the policy and procedure for the home, an evacuation policy, PEEPs, the fire zones and plan of the building and an up to date fire risk assessment. We saw that recent fires drills had taken place and that the fire systems in place were maintained by an external contractor. There was also a fire 'grab bag' that contained the PEEPs, staff contact list, maintenance contacts and family sand friend contacts. There were also foil blankets, torches and wrist tags for people so they could easily be identified by emergency services.

Good

Is the service effective?

Our findings

We asked people who lived at the service and their relatives if they felt staff were competent and suitably trained to meet their needs. One person told us, "I have no problems with any of the staff, they all do their best and I know how busy they are." One relative we spoke with said, "Some staff are brilliant and there are a few that I feel need a bit of a shakeup. Generally, they all know what to do and some just can't do enough." Another relative said, "They all seem to be very knowledgeable about what they are doing'. I have not experienced meeting anyone who I felt is not adequately trained."

We looked for evidence to prove that staff received the appropriate training to undertake their caring role effectively. We were given a copy of the homes training matrix. The matrix showed that the majority of training given to staff was up to date and that training covered a wide range of areas. Staff we spoke with said that the training they were given was of a good quality and they could discuss or request additional training needs via formal supervision, or informally with the manager. One member of staff told us, "I've done lots of training. I recently attend an end of life and communication session at a local hospice with a few other staff members. I've also recently done training around dignity, DoLS (deprivation of liberty safeguards) and dementia." Other staff members we spoke with gave us good examples of training they had attended since they began their employment at the home.

We spoke with the home's training advisor who worked for an external training organisation. They told us that after an initial high turnover of staff at the home, following the previous registered manager leaving, that the home had settled down and they thought the current staff team were committed and competent. They told us, "There has been a big improvement across the group (of homes) over the last 12 months. A culture has been established to invest in staff and give them effective training and support. The manager here is excellent and very supportive to staff and has a real commitment to give staff quality training." The training advisor told us that the majority of training was face to face with some e-learning done as a back-up. Staff we spoke with confirmed this to be the case.

We saw evidence to show that new staff received an induction prior to working unaccompanied at the home. Staff we spoke with confirmed that they received an induction and that this consisted of being taken through the homes policies and procedures, having time to read people's care plans and being orientated with the building. Staff told us they were also introduced to people living at the home and worked at least two days supernumerary so they could shadow more experienced members of staff. All the staff we spoke with told us that they felt the induction they received was of a good quality and that they felt they could have asked for additional time shadowing other staff if they had felt this was necessary.

We saw evidence that staff had regular supervision meetings and were able to raise issues within this forum. Staff we spoke with talked positively about their work and told us that they felt they were part of a team and could approach their line manager or peers with issues both formally and informally.

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 the 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 or authorisations to deprive a person of their liberty were being met. People spoken with indicated they were involved in decisions about their care and support. During the inspection we observed staff regularly consulting with people on their individual needs and preferences. There were instances where staff involved people in routine decisions and sought their consent to provide care and support.

The provider had introduced a mental capacity assessment tool. This was to highlight people's capacity to make their own decisions, or if they lacked capacity to consent to care, the process to follow to ensure their care and support was provided in their best interests. We noted examples where mental capacity assessments had been appropriately completed and responded to. There was supporting information in people's care records to provide guidance for staff on least restrictive practice in order to protect people's rights and maintain their choices. We noted in care files, there were signed records of people consenting to their care and support. There were specific consent agreements relating to matters such as, photographs, sharing information and medicines. We found consent to care records had been signed by the person or their representative as appropriate in the majority of cases. But we did find some examples were consent forms had not been signed. There was information to demonstrate appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. Records had been kept to monitor and review the progress of pending applications.

Staff spoken with indicated an awareness of the MCA and DoLS, including their role to uphold people's rights and monitor their capacity to make their own decisions. The service had policies and procedures which aimed to underpin an appropriate response to the MCA 2005, DoLS and consent. Records and discussions showed that staff had received training on this topic.

We looked at how the service supported people with their nutritional needs. We spoke with the cook who explained the processes in place to offer people choices and respond to individual dietary needs. Most of the meals were prepared, cooked and frozen by an outside caterer. The four week rotating menus we looked at showed variety of meals were offered. People had been asked for their views meals and menus during a recent resident's meeting. Following this a 'taster menu' event had been arranged for people to try a selection of the meal time options.

There were various choices routinely offered at breakfast, including cereals and freshly cooked foods. The main meal was served at lunch time and included two choices. People were asked daily for their preferences of main meal, vegetables and dessert. A lighter meal was offered at teatime. Specific diets, for cultural, religious and health needs could be catered for. Soft diets were blended in separate portions to palatable and appealing. Information had been shared with kitchen staff on people's individual dietary needs, likes and dislikes. One relative we spoke with whose loved one was diabetic told us, "They know [Name] is diabetic and they are very good at giving her the foods she can eat."

The cook told us that people could have whatever they wanted and that every effort was made to provide for people's specific requests. We discussed with the cook and manager ways of involving people with menu planning and further promoting mealtime choices. One of the inspection team had lunch with people living at the home and found the experience to be a pleasant one and the food to be of a good quality.

We noted various cold drinks were accessible in lounges and hot and cold drinks were offered to people throughout the day. Care records we reviewed included information about people's individual dietary requirements and any risks associated with their nutritional needs. Records showed people's weight was checked at regular intervals. This helped staff to monitor risks of malnutrition and support people with their diet and food intake. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary.

We spoke with the organisation's catering manager who visited the home during our inspection. They had worked for the organisation for over four years and had previously been employed as a chef at one of the homes within the group. They told us they had no issues with the quality of people's dining experience at the home at the time of our inspection. The home used an external catering company which was contracted across 11 of the groups 18 homes. The catering manager told us that the four weekly menu was changed three times per year and that tasting sessions were held prior to menu changes within the home. Feedback forms were sent out and collated by the external company and shared with the home on an annual basis. The home had a food hygiene rating of five which was the highest score available. This had last been awarded in February 2017.

Good

Is the service caring?

Our findings

People who lived at the home and their relatives were very complimentary about the approach of the staff team and the care they received. One person told us, "The staff are really good. I can't speak highly enough about them. They are kind and very thoughtful. They watch us very closely and get to know us well." Another person said, "They will stop and chat with me when they have time." We observed people receiving good support throughout the day. We saw staff interacted well with people in a pleasant and kind manner and approached them with respect. For example when one person was being transferred via a hoist, staff prepared the person for what was going to happen and why, and talked to the person throughout with patience and encouragement.

People also told us that they felt respected by staff and that their confidentiality and dignity was respected at all times, including when receiving personal care. One person told us, "They ask for my permission before they help to wash me" and another person said, "They are good when they are washing me, I never feel embarrassed, they cover me up well." Personal records were retained in a confidential manner. Staff were seen to promote people's privacy and dignity by knocking on bedroom doors before they entered and asking people's permission to do so. The home had up to date and relevant confidentiality and dignity policies in place that staff were aware of and staff talked through how they would promote people's dignity when undertaking personal care.

We spoke with staff about the needs of the people who lived at the home. It was evident that staff knew people well and were able to describe people's preferred routines, likes and dislikes. There was evidence within people's care plans that people were asked their opinion and to state their preferences across a range of areas to help to maintain as much independence and control as each person wanted to over their care and daily life and people we spoke with confirmed this to be the case.

There was information in the reception area of the home with regards to palliative care and we saw evidence that there were good links in place with a local hospice. We saw some recent good practice at the home in how end of life care had been carried out via positive feedback from one family. There were plans in place to use the manager's office as a family room so people could have a private place to use if they wished to be with them at the home at the end stages of their life. There were also plans to formalise end of life training with care staff and we saw that some staff had already attended end of life training. One relative we spoke with told us how they had discussed planning for end of life with their loved one, they told us, "We were asked about our preferences regarding end of life and we discussed the issues that might arise when we first arrived."

We saw that information for people on local advocacy services was on display in the home. We were told discussions on advocacy were held with people and the local authority as necessary, if they had no family or friends to assist them. No one at the home was using a formal advocate at the time of our inspection.

Good

Is the service responsive?

Our findings

We looked at how the service managed complaints. The complaints procedure was on display in the service. The procedure provided directions on making a complaint and how the process would be managed, including timescales for responses. The contact details of the provider and other agencies that may provide support with raising concerns were included. We noted the procedure did not include the contact details for the health or social care ombudsman; however the quality manager agreed to amend this and did so prior to the end of our inspection.

We reviewed the records of the last formal complaint. The response to the complainant provided an indication that the matters raised had been taken seriously and responded to. Some of the complaints records, including the actions taken to investigate matters were not readily available for us to review. However the manager provided us with additional information during the inspection to demonstrate the action taken to investigate the issues raised. We discussed with the area manager the significance of ensuring appropriate complaints records were maintained, to show how concerns are objectively investigated managed and responded to.

We asked people if they felt comfortable raising complaints or issues and if they knew who to approach to do so. Everyone we spoke with told us they would know how to complain, most said they had never had a reason to complain. One relative told us, "My father had to complain some time ago, I can't remember when. It was regarding a hospital visit they knew about it. They had the date for a long time but they only informed us on the day about the visit which they wanted us to attend. It was difficult for one of us to be at the hospital with her at such short notice. An apology was made. Another relative said, "If I had to complain I would go to the manager. If it was something small I would speak to any of the staff. I haven't really had to complain, only just to raise a few minor issues. It was when the last manager went off and they were short staffed. But everything is much better now."

We examined the care files of six people who lived at the home. We found documentary evidence to show that people had their care needs assessed by the home and by external healthcare professionals prior to moving to the home. Assessments included areas such as moving and handling, falls, environmental and night care needs. We saw that all care plan documentation, including assessments of people's needs were reviewed monthly.

We found people's plans of care to be person centred, which outlined clear aims, objectives and actions to be taken. These provided staff with detailed guidance about people's assessed needs and how these needs were to be best met. Staff we spoke with were happy with how care plans were organised and the information within them. It was evident that a lot of hard work had been undertaken reviewing all people's care plans and this had resulted in clear, concise and easy to follow information being presented within them.

People who had capacity knew about their care plan as did all the relatives we spoke with. People and relatives had either been involved in their design or subsequent reviews, or knew that another relative had

been. One relative told us, "There are lots of regular meetings and they ask if there is anything I want changing or adding." Another relative said, "I was involved initially in the care plan. It was gone through in detail. Another relative told us, "Yes I have spoken to the manager and we went through [Name] care plan. It is reviewed quite frequently. [Name] has been here for (number) weeks and we have gone through it twice." Over the course of the inspection we observed the manager speaking to several relatives regarding people's needs.

Care plans evidence that people were able to make choices across a number of areas including; food, clothing, activities undertaken and if they preferred a male or female carer to assist them. People we spoke with expressed no concerns in being able to make their preferences known.

As referred to in the 'Safe' domain of this report we saw evidence of activities taking place both within and external to the home. We observed activities taking place within the communal lounge area throughout the days of the inspection and saw evidence that people who were unable to take part had one to one time with the activities coordinator. Within some files we saw some good information about people's past work and life histories which enable staff to relate to people within the home. This information was dependent on the ability of people or the willingness of families to participate.

It was evident from speaking with the activities coordinator that they knew people at the home well, what they enjoyed taking part in and when they did not enjoy activities. We asked the activities coordinator what types of activities were undertaken at the home and they told us, "We tend to do exercises in the morning such as throwing soft balls and also try and get people singing. There is a sewing club that contributes to the craft fair we hold in October. Half the money goes to charity and half to the activities fund. We do story boards using whiteboards and get each person to say a sentence and we make up stories. We do play your cards right, bingo, hangman and memory and reminiscence sessions." The activities coordinator also told us that they spent 1-1 time with people who were unable to leave their bedroom or did not want to engage in group activities.

Good

Is the service well-led?

Our findings

We spoke with people who lived at Beaufort Care Home about the management and culture within the home. The responses we received were positive. People who were able to converse with us told us they knew who the manager was by sight but no-one we spoke with could remember the manager's name. One person told us, "The manager is lovely, I know who she is by sight but I'm sorry I can't remember her name." However everyone told us they felt comfortable approaching her and all the staff at the home. No-one we spoke with raised any issues about the culture of the home or gave us any indication that they felt the home was not run efficiently or professionally.

Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We sat in on one such meeting between the night nurse and agency nurse who was coming onto the day shift and found the level of information passed on was of sufficient detail, as every person was discussed. We found the service had clear lines of responsibility and accountability. All of the staff members confirmed they were supported by their manager and their colleagues and that Beaufort was a good place to work. All the staff we spoke with told us that the culture in the home was positive and that the new manager had instilled a much more effective way of working and that staff now worked in a much more structured way.

We saw that a wide range of audits were carried out at the home that helped inform and improve service delivery. These included audits in the areas of; health and safety, Infection control, care plans, medicines management and the home's environment. We spoke at length with the homes regional manager who showed us the new 'Dovehaven Hub' which was a bespoke website across the group that centralised a number of quality auditing tools as well as staff information, including training, supervision and staff performance.

The hub had been online for approximately two months at the time of our inspection and was accessible to the owners, regional managers, registered or home managers and office staff. Different staff had different levels of access to the system dependent on their role and responsibility. For example a home manager could only access the information pertinent to their own home and regional managers only had access to the homes they had oversight of. The regional manager took us through some of the areas relevant to Beaufort Care Home. This included auditing information which was set up to meet the Care Quality Commission key lines of enquiry against each of the five domains of Safe, Effective, Caring, Responsive and Well-led. For each audit, e.g. medication management, an action plan was set up based on the findings of the last review and this then set timescales for the manager of the home. Only the regional manager was able to sign off the actions once they had been completed, to ensure that actions were completed to a consistent and appropriate standard. The system indicated when the last time any action plan was updated so any activity could be audited and monitored.

The home manager submitted weekly audits via the hub which included information about occupancy, admissions, agency use, training, annual leave, sickness, vacant staffing hours and a number of other areas. This in turn enabled the regional managers to focus on specific areas of needs such as recruitment, high use

of agency staff or financial issues. The hub was able to produce statistical data for issues such as staffing which then informed the staff dependency tool used by each manager. It was also able to plot trends for people living at the home and monitor people's needs, progress or deterioration. The system also analysed incidents within the home as detailed within the 'Safe' domain of this report, as well as estates management issues such as repairs and renovation activity.

Whilst the system was in its early stages it was evident that it was, and would, improve the auditing processes within Beaufort and the other homes in the group across a range of areas and meant that oversight could be managed externally to each home. We saw that the regional manager did visit the home regularly, as did the group's quality manager so there was a physical presence at the home. The manager told us that she felt very supported since commencing employment at the home and that they felt comfortable contacting any of the senior managers or owners with issues or requests.

The home was introducing a 'candour' board so people, visiting relatives and friends could have sight of some of the performance information the new hub was able to capture. For example information about the number of falls, pressure sores, staffing levels and use of agency staff. This information was to be high level only and would not contain any information that revealed people's identity. Prior to the board being introduced it was to be discussed at resident and relative meeting to ensure that people were comfortable with the information being presented.

We saw evidence of a number of meetings taking place at the home including resident and relative meetings, staff meetings and handovers and there was also a monthly regional managers meeting to discuss broader issues within the organisation.

The home was displaying the latest inspection rating both within the home and on the website so people who were looking to live there were aware of the last inspection rating and report. We received notifications in line with the homes regulatory requirements. Whilst there was no registered manager at the home the manager had submitted an application to become registered and this had been done within a reasonable timeframe from them beginning their employment.

A wide range of up to date policies and procedures were in place at the home, which provided the staff team with current legislation and good practice guidelines. These included areas, such as health and safety, equal opportunities, infection control, safeguarding adults, Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). We saw that policies and procedures were reviewed periodically within a timescale dependent on their purpose or if specific practice or legislation changed.

The home had an informative and up to date website which helped people and relatives gain an idea about the home prior to visiting and potentially choosing the home as a place to live. A range of information was also available within the reception area of the home including the homes statement of purpose.