Care UK Community Partnerships Ltd

Beech Hurst

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Beech Hurst on 20 March 2018. Beech Hurst is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beech Hurst is registered to accommodate up to 60 people, some of whom were living with dementia, mental health issues and other chronic conditions. Beech Hurst is comprised over two floors, with several lounge and dining areas. There were 56 people living at the service during our inspection. We previously inspected Beech Hurst on 23 January 2017 and found areas of practice that needed improvement. Some improvements had been made, however, we found further areas of practice that needed improvement.

A registered manager was in post. 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 and associated Regulations about how the service is run.

Emergency procedures were in place in the event of fire and people knew what to do, as did the staff. However, risks associated with the environment and equipment had been identified, but not routinely managed.

People's independence was not routinely promoted and their dignity was not always respected. Procedures in relation to infection control were not robust.

There were some arrangements in place to meet people's social and recreational needs. However, activities were not routinely organised in line with people's personal preferences.

People's medicines were stored safely and in line with legal regulations and people received their medication on time. However, safe procedures for the administration of the medication were not routinely being followed, which placed people at potential risk of receiving their medicines incorrectly.

We saw that information had not always been updated in people's care plans to guide staff on how to deliver care.

There was a range of quality assurance systems to help ensure a good level of quality of care was maintained. However, these systems had not fully ensured that people received a consistent and good quality service that met their individual needs.

We have made a recommendation about systems being implemented to comply with the Accessible Information Standard (AIS).

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and

people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. People's end of life care was discussed and planned and their wishes had been respected.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people at the end of their life. Staff had received both supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

People were encouraged to express their views. They also said they felt listened to and any concerns or issues they raised were addressed. People were also encouraged to stay in touch with their families and receive visitors. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

We found three 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Potential risks were not identified, appropriately assessed and planned for. Medicines were not always managed and administered safely. Infection control protocols were not routinely followed.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not routinely offered choices in relation to their care and treatment. Their dignity and independence was not always respected or promoted.

People were supported by kind and caring staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The service had some arrangements in place to meet people's social and recreational needs. However, activities were not routinely organised in line with people's personal preferences.

Care plans were in place, however, they were not always up to date or personalised to reflect people's needs and wishes.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

There were not effective systems in place to assure quality and identify any potential improvements to the service being provided.

People and staff spoke highly of the registered manager. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

Forums were in place to gain feedback from staff and people. Staff had a good understanding of equality, diversity and human rights.

Beech Hurst

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 20 March 2018 and was unannounced. The inspection team consisted of four 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. The expert-by-experience for this inspection was an expert in care for older people.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounges and dining areas of the service. Some people could not fully communicate with us due to their conditions, however, we spoke with seven people, eight relatives, six care staff, a registered nurse, the chef, the deputy manager, three ancillary staff and the registered manager. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including eight people's care records, six staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "I feel safe, this is my home". Another person said, "I've only been here short while, but the staff seem nice and very helpful". A relative added, "The staff are friendly and smiley and the nurses are willing to listen, so I think [my relative] is probably safe". However, despite the positive feedback, we saw areas of practice that need improvement.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP). However, records showed that an external contractor had conducted a fire risk assessment and management report on 12 October 2017, which recorded several areas which needed immediate attention. For example, 95% of fire doors were found at fault and not likely to cover 30 minutes of fire. The risks regarding fire doors had not been addressed and there were several other areas of concern which had not been rectified by the provider to date. Staff told us the provider was aware of the issues, but had not yet planned the remedial work. This placed people at risk and has been identified as an area of practice that needs improvement.

We looked at the management of medicines. Registered nurses and care staff were trained in the administration of medicines. We observed the medicine round on all units of the service. Staff administered medicines sensitively and in a discreet and respectful way. Staff were also aware of people's preferences in regard to how they wished to take their medicines. For example, one person had their medication dissolved in water and wanted to take their time when taking it. A member of staff demonstrated patience and understanding whilst giving this person their medication and told us, "I just take my time". Medicines were stored appropriately and securely and in line with legal requirements and medicines which were out of date, or no longer needed were disposed of safely. We also saw that auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. However, we were given examples whereby not all the medicines were delivered to the service in a timely fashion, due to communication issues with the pharmacy. Furthermore, some information in relation to people's medicines was not documented, for example, start dates of courses of medication and details of specific procedures to follow when administering certain drugs. The registered manager was aware of these issues and had made arrangements to change the pharmacy supplier. However, we have identified this as an area of practice that needs improvement.

People were on the whole cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the service had an infection control policy and other related policies in place. Staff told us that Protective Personal Equipment (PPE) such as

aprons and gloves was readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The registered manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly. However, in certain areas of the service that were not accessible to people living there, we saw potential risks to effective infection prevention and control. For example, the clinical room floors were dirty and needed cleaning and staff were unable to tell us if the room was scheduled to be cleaned at any particular time. We observed several commodes had rusted frames, which means these particular commodes cannot be effectively cleaned. In one communal toilet, there was no soap in a dispenser or bin for disposal of hand towels, which meant hand hygiene could not be practised in this room. Furthermore, we saw a soiled continence pad being stored alongside clean pads, which placed people at risk of infection. Procedures in relation to infection control were not robust and this has been identified as an area of practice that needs improvement.

Nobody we spoke with expressed any concerns around their safety. However, the above issues placed people at risk and are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The registered manager told us that existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. A relative person told us, "Mostly there seem to be enough staff, but sometimes they're agency, I think". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the Nursing and Midwifery Council (NMC).

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns. There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Good

Is the service effective?

Our findings

At the last inspection on 23 January 2017, we identified an area of practice that required improvement. This was because we found issues in relation to the mealtime experience for people in some parts of the service. At this inspection we saw that improvements had been made. People told us they received effective care and their individual needs were met. One person told us, "They help me with things like washing and dressing they are good at that". A relative added, "We've never had cause to complain, I think they look after [our relative] well."

The registered manager told us how they had made changes to the dining experience, and had staggered eating times to ensure that people got the assistance they needed. We saw this was the case and we observed lunch in all units of the service. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and staff were checking that people liked their food and offered alternatives if they wished. People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. People were complimentary about the meals served. One person told us, "I've enjoyed every meal I've had here. It's very good, food chosen well, very attractive on the plate, very pleasant, very tasty". Another person said, "The pudding was delicious, extra good". A relative added, "The food here has got better since there has been a new chef. Our relative is a big veggie eater and likes salads and other options, but the food is not too varied". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Specialist diets were catered for, such as pureed. However, staff stated that any specific diet would be accommodated, should it be required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who

were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured when people were referred for treatment they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Staff had a good understanding of equality and diversity and this was reinforced through training. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

Staff had received training in looking after people, including safeguarding, food hygiene, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people at the end of their life. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. One member of staff told us, "The usual cycle is two supervisions and two appraisals each year, as a minimum. It is useful to find out what I am doing well and what areas to improve on. It is an opportunity for dedicated time to learn and reflect".

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service and there were slopes for wheelchairs. Other parts of the service were accessible via a lift and there were adapted bathrooms, showers and toilets.

Requires Improvement

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity. One person told us, "Very pleasant staff". A relative added, "All the staff are friendly and caring". However, despite the positive feedback, people told us they had concerns in relation to their independence being promoted. One relative told us, "The staff are the best thing about the home, they are kind, but they need to improve on encouraging people to do more". We found areas of practice that needed improvement.

Staff told us they supported people and encouraged them, where they were able, to be as independent as possible. One member of staff told us, "I like people to be independent and I encourage people to be independent by using different ways that work for them". Another member of staff said, "We are not here to disable, we are here to enable. I don't discourage people and I have not seen that happen here." However, feedback received from people and our own observation did not support this. One person told us, "I do not like to stay in bed, it's not my idea to stay in bed." A relative said, "If I have criticism, it is that they don't encourage enough. It's too easy to say 'we asked and she said no'. It's not good for my [relative] to lie in bed all day, and with the right approach she could and would get up, but they don't try. They take the first answer." Another relative told us, "[My relative's] life is very small now, he barely gets out of bed. They are supposed to help him mobilise with his frame, but it's just not happening." A further relative added, "I have noticed a deterioration in [my relative] within the last few weeks. She needs encouragement to leave her room, without that she will stay here and go into rapid decline. She is very undemanding, so the staff will love her. They can just leave her here and there is no real work involved in looking after her." Other comments included, "I know there's a big thing now about not forcing people to do things and giving them choice, but it's also important to keep people stimulated and there is no stimulation lying in bed all day. The staff are kind to [my relative] when they're helping, but I'd like to see her being got up more though" and "[My relative has] only been here for a few weeks, but I am already noticing a deterioration in her. She sits in her room with only the TV for company all day. She's not encouraged to mobilise, and not encouraged to drink. If things don't improve I will have to move her." Our own observation supported this and we saw that throughout the day people sat in their bedrooms alone and in the lounges with little stimulation or encouragement.

Furthermore, we saw that staff did not spend a great deal of time in communal areas with people, or having many personal interactions. For example, in Ashdown unit we observed six people sitting in the lounge from 11:45am to 12:17pm with no staff present. During this time several people became distressed and were arguing as they were upsetting each other. At 11:55am people were seen to be getting further agitated. A care worker entered the lounge at 12:17pm and said, "Behave yourself" and left the room. Subsequently two people continued to be agitated with each other and one became upset. A care worker returned at 12:31pm, but was unaware why the person was upset. The person reacted positively to the interaction with the care worker and asked to be taken out of the room at 12:40pm. Similarly, at 1:05pm in the lounge on Hickstead unit, there were four residents in the lounge with no members of staff and nothing to do. Two members of staff walked into the lounge to look at seating arrangements, but neither staff member spoke with anybody.

In Seaford unit we saw two people in the lounge with no member of staff and just the television for company for a significant period of time. Apart from when the drinks round was taking place, staff were not visible in the lounge engaging with the people or checking on them. This placed people at risk and did not encourage their wellbeing or involvement in their care. We raised these concerns with the registered manager as part of our feedback.

A fundamental part of providing people with dignity in care is ensuring that as far as possible, is that independence is encouraged and people are given the opportunity maintain a better quality of life which promotes physical, mental, social and emotional wellbeing. When a person enters a residential care setting, this service effectively becomes their 'home'. Unless a risk was too great, people within their own home should have their independence promoted and regular engagement with others.

The above evidence demonstrated that people's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

Despite the issues identified above, staff demonstrated a commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had an understanding of how best to support them. We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for and most staff also knew about people's families and some of their interests. When staff did interact with people, we observed them being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff enjoyed delivering care to people. One member of staff told us, "I love working here, it gives me a warm feeling inside. I go home happy everyday". This was echoed by people and relatives. One person told us, "I like it very much here, I have no complaints". A relative added, "The staff are really on point, they are really caring. We are happy for [our relative] to be here".

People, on the whole looked, comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. We observed staff speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. Staff encouraged people to maintain relationships with their friends and families. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. A relative told us, "The staff are always friendly when I come in and offered me tea when they do the tea round". People's equality and diversity was respected. Staff adapted their approach to meet people's individualised needs and preferences. Staff told us how they adapted their approach to sharing information with some people with communication difficulties. Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 23 January 2017, we identified an area of practice that required improvement. This was because we found issues in relation to the provision of meaningful activities for people. We also recommended the provider should take into account Common Core Principles to support good mental health and wellbeing in adult social care by Skills for Care. However, the required improvement had not been made, and we saw no evidence that our recommendation had been followed.

At the last inspection, we found the provision of meaningful activities for people were not consistently based on their assessed need and personalised to them. On the day of this inspection, there were not appropriate arrangements in place to meet people's social and recreational needs.

Staff were in the process of developing an activity programme. There were areas in the service dedicated to different themes, for example a fashion room, where people could be pampered and a garden room, for people to pot plants before planting them out in the garden. There was a list of activities displayed and staff mentioned some recent events including animals visiting, bingo, cooking and arts and crafts. The registered manager told us that on the day of our inspection the activity co-ordinator was not working and they were in the process of recruiting another member of staff to assist with activities. We were given examples of people judging baking competitions and dog shows, as well as being involved in biscuit decoration. The registered manager had also introduced 'Chat-Tea' where all staff stop what they are doing at 3:00pm and have a cup of tea and a chat with someone in the service. However, we saw limited activities taking place for people. People spent significant periods of time sat in lounges or their rooms with little or no interaction from staff, other than the delivery of care. One person told us, "There is a lack of variety and sometimes it can be boring". A member of staff told us, "When there are activities going on you can see people sparkle". Another member of staff said, "There are enough staff for safety, but not enough for wellbeing, to find the time to stop and talk, it can be task focussed". A further member of staff added, "Sometimes I just want to sit down and talk [to people]". The registered manager told us they were in the process of developing a person centred activity programme and we could see some progress had been made with this. However, it is important that people in care homes have the opportunity to take part in activities, including activities of daily living, which helps to maintain or improve their health and mental wellbeing. They should be encouraged to take an active role in choosing and defining activities that are meaningful to them. Furthermore, having companionship and someone to talk to is an integral part of providing person centred care.

In light of the continued improvement required around the provision of meaningful activities, the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that requires improvement.

Staff undertook an assessment of people's care and support needs before they began using the service. The pre-assessments were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people or their relatives were involved

where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews. A relative told us, "Yes we were involved in the setting up all the care plan when [our relative] came in". The care plans were detailed and gave descriptions of people's needs and the support staff should give to meet these. Each section of the care plan was relevant to the person and their needs. However, in three care plans that we looked at, we saw that information had not been updated to guide staff on how to deliver care. For example, two care plans had no details recorded in the person's care summary and we could not see evidence that these care plans had been reviewed. The registered manager told us they were in the process of reviewing everybody's care plans and we saw examples of care plans that were up to date, relevant and person centred. However, not all care plans contained person centred, up to date information, and we have identified this as an area of practice that needs improvement.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Nobody at the service who received funding had specific communication needs. However, staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. However, staff were not aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

We saw some good examples of person centred care and staff responding to people's needs, requests and preferences. For example, staff recognised that one person predominantly lay on their side and was invariably facing the wall. Therefore, staff rearranged their room, so that they were now facing the window and moved pictures of their loved ones, so that they could see them. Another person had been supported by staff to attend a wedding. Their relative told us, "A member of staff supported [my relative] to attend my wedding on her day off which was lovely and meant they could be a part of the day. [My relative] has a good rapport with the member of staff."

People's end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the registered manager and felt the service was well-led. Staff commented they felt supported and could approach managers with any concerns or questions. One person told us, "We moved [our relative] out of here due to their condition being less advanced than others, but we were happy to come back here". A relative said, "I've noticed a positive change with the new manager starting, it feels more driven and more energised". A member of staff added, "I think the registered manager is going the right way, she is exactly what this home needed". However, despite the positive feedback, we identified areas of practice that require improvement.

Quality assurance systems were in place to monitor the running and overall quality of the service and to identify any shortfalls and improvements necessary. Staff had conducted audits of areas including medication, accidents and incidents and people's weights. However, the systems of quality assurance had not fully ensured that people received a consistent and good quality service that met individual needs. For example, people were placed at risk as the provider could not demonstrate that planned essential maintenance had gone ahead and effective medication and infection control procedures had been followed. Furthermore, at the last inspection on 27 January 2017, we saw that the provision of meaningful activities required improvement and at this inspection the same issue had been identified. Additionally, people did not always have their dignity and independence promoted. The registered manage was aware of many of the issues that we raised and was in the process trying to drive change and improvement. However, the above has been identified as an area of practice that needs improvement.

People were placed at risk, as the provider did not have adequate systems and processes to enable them to fully assess and identify where quality and/or safety are being compromised and to respond appropriately and without delay. We have identified this as a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the culture and ethos of the service with people, the registered manager and staff. One person told us, "It's nice surroundings and the staff at pleasant that's the best thing". A relative added, "I would recommend the home to others". The registered manager said, "We provide a good service. We are compassionate with our care and we have genuine interest to be here, it's not just a job. We make the residents happy". A member of staff added, "We always helps and we are always patient". We saw a detailed philosophy of care displayed for people and staff to read.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager took an active approach. One member of staff told us, "I am exceedingly thankful that the registered manager is here, they are the most approachable person I have met. She is here for the residents; she is not afraid to have fun and has made it feel like our home". Another member of staff said, "The registered manager is making good changes, they have made a difference, and they are more supportive and gives guidance". The service had a strong emphasis on team

work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff said, "The registered manager is trying to improve things and bring up the standard. She tells you straight and is very approachable. The changes are positive". Another member of staff added, "I feel supported by my colleagues and management". The registered manager added, "As soon as I walk in, my door is always open, I'm here to listen".

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. There was information displayed around the service to encourage people to feedback their opinions of the care they received, and meetings and satisfaction surveys were carried out, providing the acting manager with a mechanism for monitoring satisfaction with the service provided.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice.

Up to date sector specific information was made available for staff, including guidance around the Mental Capacity Act 2005 and responsibilities in relation to recognising and acting on abuse. We saw that the service also liaised regularly with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that the care and treatment of service users was appropriate, met their needs and reflected their preferences. 9(1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that service users were treated with dignity and respect at all time. 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured they had done all that was reasonably practicable to mitigate risk, manage medicines safely and ensure robust infection control procedures were followed. 12(1)(2)(b)(g)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured they operated effective systems and processes to make sure they assess and monitor the quality of the service, drive improvement. 17(1)(2).