Barchester Healthcare Homes Limited

Beaufort Grange

Inspection report

Hatton Road
Cheswick Village
Bristol
Avon
BS16 1AH

Tel: 01173210430
Website: www.barchester.com

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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?	Requires Improvement

Summary of findings

Overall summary

We carried out a comprehensive inspection of Beaufort Grange in November 2016. At this inspection, we found breaches in the legal requirements relating to quality assurance and record keeping. We undertook a focused inspection in July 2017 in response to concerns raised by relatives, staff and health professionals regarding the staffing and management of the home. We found a further breach of the regulation relating to staffing. Following both inspections, the provider wrote to us and told us the actions they were taking to meet the legal requirements of the Health and Social Care Act 2008.

We carried out a comprehensive inspection on 15 November 2017 and reviewed the improvements that had been made since our last inspections.

Beaufort Grange is a 74 bedded home that provides accommodation for persons who require nursing and personal care. At the time of our inspection there were 38 people living in the care home.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

Overall, we found there had been significant improvements and the legal requirements had been met. Further work was needed to ensure that improvements were consistent, embedded and sustained.

Sufficient numbers of staff were deployed at the time of our visit when the home was only 51% occupied. Staff performance was effectively monitored. Staff had received supervision and training to ensure they could meet people's needs.

People's medicines were managed safely and audits and checks were completed. Actions were taken when errors were identified.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. We found people were being treated with dignity and respect and we found people's privacy was maintained.

Systems were in place for monitoring quality and safety and actions were taken where areas for improvement and shortfalls had been identified. Further improvements were needed to make sure shortfalls were promptly recognised and acted upon.

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 and relatives recognised the improvements in staffing levels.

Risk assessments were completed and risk management plans were in place to reduce and minimise the identified risks.

People's medicines were stored, administered, recorded and disposed of safely.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to carry out their roles and staff performance was sufficiently monitored.

People's rights were protected in accordance with the requirements of the Mental Capacity Act (2005). Further work was needed to make sure the supporting records were fully completed. Where people had been deprived of their liberty, this was in accordance with legal requirements.

People were supported to make choices with their food and drink, and spoke positively about the choices available to them.

People had access to healthcare professionals and staff responded when peoples' conditions changed.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by all staff.

Staff understood peoples' needs and supported people to express their wishes.

Staff provided compassionate kind and thoughtful care.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and reflected people' current preferences and needs.

A range of activities were provided to people in communal areas and in their rooms.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a new registered manager. Improvements had been made since they had been in post. These were still to be fully and consistently embedded in the home.

Systems were in place for monitoring quality and safety and actions were taken when areas for improvements had been identified.

Staff were supported and given opportunities to express their views and concerns.

The registered manager understood their responsibilities with regard to notifications required by the Commission.

Beaufort Grange

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.

We undertook a comprehensive inspection of Beaufort Grange on 15 November 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two 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. An inspection manager supported the inspection for part of the day and a recently appointed member of staff from the Care Quality Commission joined the inspection team as an observer.

Before carrying out the inspection we reviewed the information we held about the care home. This included the action plan we received from the provider which set out the actions they were taking to demonstrate they were meeting the legal requirements. We looked at information and reports received from Bristol City Council's quality assurance and safeguarding teams.

We looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 16 people who lived at the home and seven visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the regional director, the registered manager and 13 staff that included registered nurses, care staff, maintenance, housekeeping, activity and catering staff. We observed medicines being given to people and how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at eight people's care records. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the care home. We received feedback from two external health professionals involved with the home.

Good

Is the service safe?

Our findings

When we last visited the home, in June 2017, we found a breach in the regulation relating to staffing. At this visit, we found sufficient actions had been taken to meet the requirements of the regulation. There had been many changes of staff, including management changes. We found people, relatives and staff still expressed some reservations about staffing, and needed to be assured and have confidence that the changes made would be sustained. We also noted, at the time of our visit, the home was just 51% occupied. To make sure they continue to comply with the legal staffing requirements, the provider must ensure they are sufficiently resourced when their occupancy levels increase.

People and relatives told us they felt safe with a relative commenting, "I feel my wife is safe here." Whilst no one told us they felt unsafe, we received comments from relatives and staff who continued to feel that staff were not always sufficiently deployed. For example, comments from relatives included, "There is sufficient staffing during the week. At weekends they often rely on agency staff who do not always understand how to look after my [name of person using the service]" and, "Some of the staff are working across all areas, so do not know my husband so well." We spoke with staff who commented they were regularly moved around to work in different areas of the home. Staff told us they found this, "not a good idea" because it affected continuity and consistency of care. However, staff also recognised that staffing had improved with new staff recently employed.

We checked the staffing rotas and saw that staffing had improved, new staff had been employed and the use of agency staff had reduced significantly since our last visit, including at weekends. On the day of our visit, we noticed call bells were promptly responded to, and staff did not appear rushed during any part of the day. Staff gave us mixed feedback about their view of the sufficiency of staffing, with comments including, "Staffing is so much better now. I think there are enough of us" and, "I think we could do with more staff." However, staff also told us they felt confident that, on most occasions, they were able to meet people's needs in a timely manner.

The regional director showed us the dependency tool and the system they used to monitor staffing levels. They also told us they 'block booked' agency staff in advance to make sure they secured continuity, and staff who had become familiar with the home were provided by the agency. They showed us the information displayed in the reception area that confirmed who the person in charge was and the name of the available management cover and support. They had introduced this to assure people, staff and relatives that management cover was available, and often present, in the home at weekends. In addition the registered manager told us, "If there's a problem I just come in."

We found medicines were safely managed. One person told us, "They bring me my pills when I need them." There were photographs at the front of medicine administration records (MARs) which meant that new or agency staff could easily identify people. People's preferences in relation to how they took their medicines were recorded. For example, 'likes her medicines on time' and, 'tends to chew tablets'. MAR sheets were checked several times a day by staff to ensure medicines had been signed for. We saw no gaps in the charts we looked at which indicated that people received their medicines as prescribed.

Some people had medicines prescribed as required (PRN). PRN protocols were in place and these were detailed, person centred and included information for staff such as how people might appear when in pain and where they might experience pain. PRN protocols for the use of anti-anxiety medicines detailed the signs of agitation people might display and the steps staff should take to relieve anxiety before resorting to the use of medicines. All of the protocols we looked at had been regularly reviewed and updated. A relative told us, "[Name of person] has been seen by the doctor recently and the medication has changed."

We looked at the records for one person who was having some of their medicines covertly. This is when medicines are 'disguised' in food or drink. The principles of the Mental Capacity Act had been followed and there were records in place to show that although the person lacked capacity to consent to this, a best interest decision had been reached with input from external health professionals and the person's relatives.

Medicines were stored safely. Staff monitored the temperature of medicine fridges and of clinical rooms. Medicines that required additional security were safely stored. Regular stock checks had been carried out. Medicine audits had been completed. When shortfalls were identified, action plans had been completed. For example, one of the audits had noted that PRN protocols were not all completed. Actions were taken and, as stated above, protocols were now in place. This meant people could be confident staff understood their specific needs for PRN prescribed medicines.

During our visit a medicine administration recording error was identified by a member of staff. We saw that this was reported using the provider's incident reporting process and that staff had completed an investigation to ensure the person had received their medicines. The staff member said "I noticed the mistake. I've done a stock check with another nurse so I know the person had their medicines; it's just been signed for in the wrong place. I've reported it to the manager."

Risks to people's personal safety had been assessed and plans were in place to minimise the risks. All of the care plans we looked at contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. All of these had been reviewed monthly. When risks had been identified, the plans contained clear guidance for staff on how to reduce the risks of harm to people. The guidance was personalised and where relevant, referred to people's medical condition. For example, we looked at the plan for one person who had Parkinsons and had fallen previously. The care plan made reference to the person's fear of falling and how their condition increased the risk of falls as well as detailing the steps staff should take to support the person when moving around the home.

Some people had been assessed as having a high risk of developing pressure sores. The care plans contained details of preventative measures in place, such as pressure relieving equipment and the required frequency of position changes. Position charts we looked at had been completed in full and showed that people had their positions changed regularly and in line with care plan guidance. Air mattresses that we looked at had all been set correctly to make sure people were provided with the level of pressure relieving support they needed.

Most accident and incident reports were completed and reviewed to identify trends or patterns with regard to people's falls. We found one accident had not been fully recorded and have reported on this further in the well-led section of this report. People were referred to the GP for consultation or further investigations and referrals to other health professionals if needed.

We found people were protected from harm and abuse. Staff had a good understanding of their responsibilities with regard to safeguarding people from avoidable harm and abuse. They had received training. They were able to describe how they would recognise abuse, and how they would act on any

concerns. Staff told us they were confident that concerns raised would be acted upon by the registered manager and the deputy manager. They told us they also had access to the local authority safeguarding team contact details. Staff were also aware of what was meant by 'whistleblowing,' the reporting of poor practices, and helpline details were available and displayed in the home. One member of staff told us they would not hesitate to report concerns and said, "I won't accept anything less than good care."

The provider followed safe recruitment practices. Staff files included application forms and records of interviews and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control measures, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire risk assessments had been completed in June 2017. No remedial actions were required. Routine fire safety checks and staff training had been completed and was up to date. Personal emergency evacuation plans for each person were in place. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

The environment was clean throughout. We spoke with a senior member of the housekeeping team who described their role and responsibilities. They told us about the cleaning routines and how the housekeeping team were allocated to different areas within the home. They told us how they had worked to control the spread of infection when there was recent viral illness outbreak in the home. They had up to date protocols and guidance in place, staff had received training and the senior housekeeping staff monitored to make sure appropriate and best practice cleaning methods were used. The provider had noted, in one of their internal quality reviews, completed in October 2017, that an infection control 'champion' was to be nominated, regular infection control meetings were to be scheduled and an annual infection and mattress audit was due to be completed.

Good

Is the service effective?

Our findings

Feedback from people and relatives was generally positive and included, "The care here is very good, not excellent, but very good" and, "The staff look after me and spoil me." People's needs were assessed, initially before they moved into the home. Care plans provided detail about how people's healthcare needs should be met. The records we looked at showed that people and their relatives where appropriate, had been involved in planning and reviews of care. We spoke with a relative who confirmed they had been involved in "Care planning activities."

People had access to different services. Records showed that people had been seen by their GP, the physiotherapist, the care home liaison team and the speech and language therapist. A relative commented, "The staff have kept me informed of the changes and I am going to discuss with the doctor." We read the care plan for a person with complex neurological needs. The plan contained guidance from specialists. We spoke with staff who were familiar with, and followed, the guidance and recommendations that had been made.

We read the care plan for a person with diabetes. The plan contained clear information for staff on how they could support the person to manage this effectively. This included how to recognise and monitor for signs and symptoms of a low blood sugar level and the actions needed if this should happen. We spoke with staff who were aware of the person's needs and were able to tell us what actions they needed to take if the person was unwell.

When staff started in post, they completed induction training that incorporated the Care Certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support. Staff completed initial training and were allocated a mentor to support them though their induction.

Staff spoke positively about the support, supervision and training they received. A registered nurse told us, "I've completed lots of training specific to my role here. I've done syringe driver training, catheterisation training and medication training." Another member of staff commented, "Supervisions are good now." Staff had received training in a range of mandatory topics. These included moving and handling, fire safety, infection control, Mental Capacity Act 2005, safeguarding and first aid.

We spoke with a relative who told us that training had been provided for them, to help them better understand the needs of people living with dementia. They told us this was to help relatives understand why people may behave in certain ways, and how the illness may affect people. The relative told us the training was, "very well received".

The people and relatives we spoke with were positive about the food and feedback included, "The food is beautiful here," "The food is very good" and, "My wife is well fed here." People were supported to have enough to eat and drink. Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought in a timely manner. We looked at

the records for a person who had lost weight previously. This had been referred to the GP. They had been prescribed supplements and had subsequently gained weight. A member of staff also told us about the 'fruit smoothies' they offered to people during the afternoon. Care plans detailed people's preferred choice of food and drinks and any specific guidance for staff. For example, in one person's plan it had been recorded that staff needed to support the person's beaker when assisting them to drink. In another person's plan it was recorded they became easily distracted during mealtimes and needed encouragement.

Some people were having their food and fluid intake monitored. Monitoring charts had clear target daily intakes written on them and the reasons why people needed to have their intake monitored. When staff had offered drinks or food, the total amounts people had taken was recorded. When people had been offered and had declined, this too was recorded.

We observed meal service to people in their rooms and in the dining rooms. Two people were joined for lunch by their relatives. The atmosphere in the dining rooms was relaxed. People were supported at their own pace, and no one was rushed. It was clear that relatives had got to know each other. The discussions were friendly and light banter occurred. After they had finished eating people were served hot drinks.

Staff spoke with people while food was being served. People received the support they needed. For example, one member of staff spent considerable time with a person whose needs were high and who ate lunch in her room. The chef visited one of the dining rooms to obtain feedback from people using the service and from staff, about the meals they had eaten.

We spoke with catering staff and it was clear they knew the likes, dislikes, choices preferences and needs of each person. Changes were communicated at daily meetings. We attended this meeting on the day of our visit. The registered manager checked the catering team had met a person who had just moved into the home, which they had. They confirmed their awareness of the person's needs, preferences, likes and dislikes.

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.

Consent to care and treatment was generally sought in line with legislation and guidance. People had been assessed for their capacity to consent to specific aspects of their care. When people lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's.

Some people had sensor mats in use to alert staff when they moved around their bedrooms. We checked the records for two people with sensor mats in place. One person had been assessed for their capacity to consent to its use. For the other person, there was no documentation in place to show whether staff had undertaken a capacity assessment or how a best interest decision had been reached. Another person had a door sensor in place in their bedroom. This was to alert staff if other people walked into the person's bedroom. There were no records to confirm the person had provided consent for this or if a best decision had been made. We brought these recording shortfalls to the attention of the registered manager. They told us they would take action to address the records that had not been completed. We also received confirmation, following our visit, that staff had received further training to enhance their understanding of the MCA.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We read the records for a person with a DoLS authorisation in place and they had conditions stated within the authorisation. The records showed the actions that were needed and were being taken with regard to their social activity, to make sure the conditions were being met.

Good

Is the service caring?

Our findings

During our visit we received positive comments and feedback from people using the service and from relatives and visitors. People told us, "It's good here," "They are good to me," "The staff are wonderful. They spoil me" and, "Nothing is too much trouble." A relative commented, "I come every day and I feel part of the furniture. I feel at home here."

We observed interactions between people using the service and saw that people were treated with kindness and compassion. People appeared relaxed with staff, and there was smiling and laughter during the day. We also saw staff sat quietly with people, in the different areas of the home, providing comfort and reassurance where needed. The records for one person noted they sometimes 'walked around the corridors upset and crying' and they usually responded positively to 'sitting down and having a chat.'

We saw a member of staff walk into one of the lounges and they approached people sitting there and said "Hello there lovely ladies. Who wants a nice cup of tea?" They asked people if they wanted to listen to music or look at pictures with them. On another occasion we saw a member of staff go up to one person and hug them. The person said "I haven't seen you for a while" and the staff member said "How have you been? I've been off for a few days. It's lovely to see you again."

One person who had recently moved into the home was supported by a member of staff into the dining room and introduced by name to the other people sitting around the dining table. This was a kind gesture, and helped the person to feel settled. A member of care staff sat beside the person during the meal, offering both verbal and physical reassurance and held the person's hand.

People's privacy, dignity and independence was promoted. Care plans were detailed and people's preferences, for example, with regard to male or female staff had been recorded. A summary of people's care needs was available for staff to read and this included people's preferences. Staff were able to tell us how they made sure they protected and maintained people's privacy and dignity. Staff gave examples that included making sure they knocked on doors before entering, making sure people were fully covered when being supported with personal hygiene and making sure others didn't enter rooms when they were providing people with personal care.

The reception area was welcoming and we saw people enjoying spending time in this area with visitors during the day of our visit. There were fresh flowers on display, and newspapers and crossword puzzles were available. There were items of interest and information from the provider, such as their vision and values and, newsletters and events that had taken place. Hot and cold drinks and a selection of snacks were provided. We saw relatives and staff sitting in this area discussing plans to celebrate a person's birthday.

The staff we spoke with told us how they showed respect for people and treated people with kindness and compassion. A member of staff we had also spoken with when we last visited told us, "It's massively better now. I think morale has gone up and so staff think more about how they're caring for people. I'm not care staff, but I see the improvements and that staff are really kind to residents."

Staff knew how to communicate with people who were not able to communicate verbally. The staff we spoke with described how people expressed their views. For example, one person sometimes used a communication board. They also had a hearing aid, but, we were told by staff they, 'didn't like wearing it' much of the time and preferred to use the board instead.

We read recent compliment cards and letters received in the home. They included the following, 'Your care, patience and kindness were much appreciated' and, 'There will always be a special place in our hearts for you all.'

Good

Is the service responsive?

Our findings

At our last visit, we found improvements were needed to ensure that people received care that was personalised and responsive to their needs. At this visit, we found improvements had been made, with people and their relatives saying they felt, "more involved in decisions relating to care provided."

The provider also recognised, in their internal quality monitoring programmes, this was an area they needed to focus and build on. They had recognised that to make sure care was consistently personalised and not task orientated, they needed to continue to strengthen the leadership in each area of the home. Their review programme also noted, 'This is improving due to the support the nurses are receiving from the new management team.'

At the time of our visit, we found people were receiving personalised care that was responsive to their needs. Care plans showed that people and their relatives or advocates were involved in the care planning review process. The provider had stated on their website, the improvements they were making in response to our previous inspections. They stated, 'At a relatives meeting we agreed that six monthly reviews would be carried out, to include a review of every element of the care plan with the resident and relative, ensuring clear lines of communication and reflecting residents needs consistently.'

All of the care plans we looked at fully reflected people's physical, mental, emotional and social needs and people's personal life histories had been recorded. For example, one person's sleep plan provided detail of their preferred time to go to bed, what they liked to wear in bed, whether they wanted their door open or closed and how often they wanted staff to check on them. One member of staff told us, "We've worked really hard to improve documentation and care plans. It's been a huge pressure on staff, but has resulted in a massive improvement."

Care plans relating to people's mental health needs were detailed and personalised. We looked at the plan for one person who experienced episodes of anxiety and distress. The signs the person displayed were recorded and there was clear guidance for staff on how to reduce the person's distress. For example, the person responded well to therapeutic touch and liked staff to, 'smooth her head, touch her hand and, rub her back'. Staff had also noted the person tended to become more distressed during personal care. Staff were asked to try playing music. They also changed the time of when personal care was provided, from earlier in the day to the early evening period. This change, made in response to this person's individual and changing needs, was shown to reduce the person's distress.

The care records included communication plans that were personalised. Where people had communication difficulties the reasons for this were recorded. Guidance for staff included how staff should communicate with them. Examples included using short sentences or visual prompts for people. One person had hearing difficulties and the plan guided staff how best to meet this person's needs. The plan stated, 'Lip reads so it's important to face [person's name]. Ensure she can see your face and lips, speak normally' and 'has a wipe board to aid communication'. Details of how the person communicated with their family on a day to day basis were also recorded. The person had a mobile phone they used to send text messages to their family.

Staff were reminded to make sure it was always charged and ready to use.

One person's relatives had provided them with a diary so that they and staff could record particular activities or provide reminders of television programmes that might be of interest to them. We saw this was in use and the person confirmed that staff filled it in for them.

Summaries of people's needs and choices were available to care staff which meant they had easy access to relevant information about the people they were caring for. Staff told us the summaries were useful and provided a quick and easy guide they could refer to.

During our visit we saw activities were provided. During the week of our visit, the programme included music sessions, memory games, an art class and a wine and cheese evening. On the morning of our visit, we observed a game of bingo taking place. One person who used the service took responsibility for ensuring that everyone had bingo cards and counters. Some people showed a preference for playing the game in pairs, and this choice was respected. People were referred to by name throughout the game and there was a lot of good humoured banter and laughter. One person with a hearing impairment was sensitively supported so they could actively participate. When one person shouted out, "Oh, we've got one!" they were congratulated by others in the room. Everyone continued to join in and agreed to play a second game and the enthusiastic engagement in this activity continued until lunch time.

People were sensitively supported to communicate in ways that were meaningful to them. For example, one person with hearing difficulties was supported by a member of staff to participate in an activity. The member of staff clearly understood how to communicate effectively with the person who was supported to participate fully in the group activity. Another person used head and thumb gestures to communicate. Staff knew how to ask the person questions that could be easily answered with a thumbs up or down, or a shake or nod of the head.

We noted that books were available on a trolley in one of the lounges, with a reminder note to make the books available for people who may not be able to access the lounge. Puzzles and games were distributed to people in their rooms, who chose not to, or were unable to leave their rooms. We spoke with staff who told us they wanted to enhance the activity and engagement opportunities for people who stayed in their rooms. They recognised this as an area for further development and improvement.

Links had been developed within the local community. The activity staff told us about a recent event held to build mutually beneficial community links with other organisations and local people. The home had hosted a dementia awareness training session. Links had also been developed with the local primary school. On the day of our visit, the school had invited people from Beaufort Grange to attend their 'Christmas shopping event'.

The registered manager received an appreciative email a couple of days before we visited. A relative commented positively about the communion, songs of praise and the chat the person who used the service had with the vicar. They were pleased the person had joined in with the singing and that, 'Hopefully he will go again next time.'

People were supported to provide feedback and make suggestions about the provision of activities. For example, at a recent meeting, a local choir were recommended. They had been booked and a date confirmed, for them to perform at Beaufort Grange.

A complaints procedure was in place that was readily available to people and their relatives. We looked at

the complaints file and saw that complaints were now managed in accordance with the provider's policy. We had been made aware of complaints raised in 2016 that had not been managed in accordance with the provider's policy. This was during the time there was no registered manager in post. The registered manager now in post clearly understood their responsibilities and had shown how they investigated and responded to complaints received.

Requires Improvement

Is the service well-led?

Our findings

When we visited Beaufort Grange in June 2017, this was a focused inspection, and we did not fully inspect the quality assurance systems in place. When we undertook our last comprehensive inspection, in October 2016, we identified a breach of the regulation relating to quality assurance. The provider had not effectively assessed, monitored or mitigated the risks to the health, safety and welfare of people living in the home, and people's records were not always accurate.

The provider had completed and sent us an action plan that confirmed the actions they were taking to meet the requirements of the regulation. The provider also produced a summary of the action plan which they published on their website.

At this visit, we found significant improvements had been made, and sufficient actions had been taken to meet the requirements of the regulation. We found systems were in place that identified shortfalls, a range of audits and monitoring checks were completed and we saw evidence of actions taken in response. We found further improvements were needed to make sure the changes were embedded consistently. For example, the quality assurance system had not identified the couple of areas where recording was incomplete.

There was a shortfall in the recording of consent and best interest decision making for the use of sensor equipment for two people, as noted in the effective section of the report.

Most accidents and incidents were reported, recorded and analysed. We did find that one person who had fallen had records completed a photograph taken within their care records. Appropriate actions had been taken to make sure the person was safe. However, the provider's protocols had not been followed in that an accident form had not completed. After our visit, we received confirmation, from the provider's divisional director, of the actions taken. This included undertaking an investigation with the member of staff who did not complete the form. A 'lessons learned' exercise was to be completed and the shortfall was reported to the local authority safeguarding team. This showed the provider took opportunities to learn from such issues and take actions to make improvements in the future.

We also acknowledge in this report that the home was just 51% occupied at the time of our visit. The provider must ensure when they increase the numbers of people living in the home, they are sufficiently resourced to manage the changes and sustain the improvements they have made.

People and relatives spoke positively about the management arrangements. Everyone we spoke with was aware of the new management team and their views included, "I know who the manager is" and, "You see them (the management team) around the place all of the time." Two relatives also told us they had recently completed a survey and commented, "I told them they are excellent" and "I rated the home as very good." At the time of our visit, the survey for people using the survey had been completed. The results had not yet been received. The survey for relatives was 'still open' with the completion deadline not yet reached.

The registered manager told us they encouraged and obtained feedback from people and relatives at other times too, and used feedback as opportunities to make improvements. For example, they had received feedback following the replacement of the coffee machine in the reception area with a percolator. The percolator was not well received. The registered manager took action and purchased another coffee machine.

We attended the daily 'stand up' meeting held with the registered manager and heads of department from each team in the home. Each department representative provided an update about what was happening with their team on the day. The 'Resident of the Day' was discussed. When a person was the nominated resident of the day, a member of staff from each department visited the person to find out if they were satisfied with the service provided or if they wanted changes or improvements to be made. For example, the catering team checked and obtained feedback about the food provision and the maintenance team checked to see if there were any jobs that needed doing in the person's room. Following this meeting a brief clinical meeting was held with the registered nurses. The registered manager checked who was unwell, if any accidents or incidents had occurred, anyone with weight loss and actions being taken and other clinical or care issues.

Staff had the opportunity to express their views at staff meetings. We read the minutes from meetings held with different teams in the home. We saw that staff were provided with reminders about areas for improvement. For example, in one meeting that took place the week before our visit, care staff were reminded about the importance of making sure food and fluid charts were fully completed. There was also a part of each meeting allocated for staff to ask questions or provide feedback. An employee survey was being undertaken and the deadline for staff to participate was the 16 November 2017.

The regional director told us the provider's values and mission statement had recently changed. Staff workshops had been held and the new statement had very recently been launched. The staff we spoke with were not all aware of the provider's values. We provided this feedback to the management team during our visit. Following our visit, the divisional director confirmed that all staff had received individualised cards, with the values stated, in addition to the posters we saw on display in the home. They told us this would be, 'followed up regularly in staff meetings as an agenda item emphasising how we reach our goals and aspirations as a team.'

Staff spoke positively about the new registered manager and the deputy manager. Comments included "I haven't been here long, but I've seen improvements in a short time," "We've got more leadership now, more stability. We never had anyone to ask before, but now we've got real direction (from the registered manager)" "The new manager and deputy are both nurses so we have lots of clinical support now" and, "Massively better now we've got leadership. The [name of registered manager] gives us deadlines. The whole team feels better and morale has improved and the care is really good now." Another member of staff told us, "Before, we felt we were left to sink or swim. The manager is direct, but really good and supportive, much better."

The registered manager was able to tell us how they kept up to date with current practice. They also told us they were provided with information and guidance from the provider.

The manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.