Wilton Rest Homes Limited

Beacon House

Inspection report

Victoria Hill Road
Fleet
Hampshire
GU51 4LG

Tel: 01252615035
Website: www.beaconhousecarehome.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Beacon House on 7, 9 and 15 September 2016. This was an unannounced inspection. We brought this inspection forward following concerns received about the safety and welfare of people.

Beacon House provides care for up to 23 people living with differing stages of dementia. There were 18 people living at the service on the days of our inspection. Accommodation was provided over three floors of a converted residential dwelling, with a passenger lift that provided access to the second floor and a stair lift to the top floor.

Beacon House did not have a registered manager in place on the day of the inspection for both their registered activities. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had started their application to be registered with the Care Quality Commission to ensure the provider would meet their registration requirement to have a registered manager in place.

The manager had been absent from the service for two months and returned to work on 12 September 2016. During their absence the deputy manager, senior care workers and the provider were responsible for the day to day running of the service. We found at the time of our inspection a comprehensive and effective governance system to monitor the quality of the service and identify the risks to the health and safety of people was not in place. A regular programme of audits had not been completed in relation to the management of people's medicines, infection control practices, and quality of care records and the manager, deputy manager and provider had not identified all the areas of concern we had found. As a result limited action had been taken to improve the quality of care and ensure the safety of people. The manager, deputy manager and provider were unclear about their overall responsibility to meet and sustain all the legal requirements of a registered person to ensure the safety and welfare of people.

We found people's safety was being compromised in a number of areas. People had not received the support they needed in accordance with national best practice guidelines to mitigate their risk of choking. People were at risk of injury when receiving moving and handling support and when people had developed pressure ulcers they had not always received the support and treatment they needed to prevent their health from deteriorating.

People's care records did not include all the information staff would need to know about how to provide people's care and when people received care this was not always recorded. Staff and the managers could therefore not judge from people's records whether people had received their care as planned and their medicines as prescribed. The managers' and provider's knowledge of the service was not up to date and communication in the service was not sufficient to ensure people would receive the care they required when their needs changed.

The provider's philosophy at Beacon House was that each resident should live as full and independent a life as possible. However, people living with dementia did not always receive the support they needed to remain independent, express their wishes and make sense of their environment. We made a recommendation to support the provider to improve the communication between staff and people living with dementia.

People's privacy and dignity were not always respected. From observing staff interactions with people it was clear the values of the service were not yet fully embedded into practice as care was at times task based rather than person centred, for example when moving and handling tasks were undertaken. We saw poor practices which were undertaken by some staff but not challenged by other staff.

Decisions about people's care had been guided by the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity. However, were it was deemed to be in people's best interest to restrict their freedom to keep them safe their rights had not been protected. The provider had not requested appropriate authorisation when placing restrictions on people and had not met the requirements of the Deprivation of Liberty (DoLS) safeguards.

Recruitment arrangements were not safe. All the information required to inform safe recruitment decisions was not available at the time the provider had determined applicants were suitable for their role.

Some improvement was needed to ensure the arrangements in place for people and relatives to provide feedback about the service would be taken into consideration when making improvements to the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

We found six of 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?

Inadequate

The service was not always safe.

People were not protected from risks to their health and safety. Staff did not always follow best practice when supporting people which put them at risk of harm.

People were deprived of their liberty to keep them safe without the appropriate legal authorisation to ensure their rights under the MCA were protected.

People's care plans did not always include all the information staff would need to be able to support people safely if they were to rely solely on the care records when delivering care. People's medicine administration records did not support staff to know whether people had received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received regular supervision or appraisal to enable them to discuss their performance and identify areas where their practice needed to improve.

Improvement was needed to ensure best interest decisions made on the behalf of people who lacked the mental capacity to make their own decisions, were always recorded in accordance with the MCA.

People were supported to access the GP and supported to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always treated in a way that respected their dignity and supported them to feel valued.

People living with dementia were not always communicated to in way that would support their understanding and enhance their daily decision making and participation in the service.

People were supported to follow their faith and attend religious services.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

People living with dementia did not always receive the support they required to retain their skills, remain involved in their care and live a stimulating life.

Improvements were needed to ensure the provider's feedback arrangements were implemented effectively so that people would be assured that their views would be taken into account when improvements were made to the service.

Is the service well-led?

Inadequate

The service was not well led.

Management awareness of risks in the service was limited and action had not always been taken to address safety and quality concerns. Governance systems were not in place to effectively monitor the quality of service people received and this had placed people at risk of not receiving safe and effective care.

Communication with staff was not always sufficient to support them to understand their roles and responsibilities in providing quality care.

The service had a values statement, however staff were not clear on the service's vision and it was not yet fully embedded into practice as care was at times task based rather than person centred.

Beacon House

Detailed findings

Background to this inspection

This inspection took place on 7, 9 and 15 September 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They returned a PIR and we took this into account when we made the judgements in this report.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. During our inspection we spoke with six people using the service and four relatives. We also spoke with the provider, the deputy manager, the maintenance person, a kitchen assistant, a laundry assistant, the cook and six care staff.

We spoke to the commissioners and specialist community nurse for care homes prior and after our visit. We spoke with a community psychiatric nurse who visited the service during our inspection. We reviewed records relating to six people's care and support such as their care plans and risk assessments and the medicines administration records for 17 people. We also reviewed training records for all staff and personnel files for five staff, and other records relevant to the management of the service.

We previously inspected the service on 29 September 2014 and found no concerns.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Beacon House. One person said, "I know I'm safe, I get everything I need." However, relatives gave us mixed views about people's safety. One relative told us ''I was not sure my mother got enough support to make sure she took her tablets and was supported to safely move up and down the stairs'', whilst other relatives told us they were confident their relatives were safe. Staff told us they did not have any concerns about people's safety in general but were concerned that one person's pressure ulcer had not been managed appropriately. We found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Some risks to people's safety had been identified. These included risks when people were supported by staff to move or transfer, risk to people of falls, weight loss, choking and pressure damage to their skin. People's risk management plans were not always up to date or sufficiently comprehensive for staff to know from people's records how to keep people safe or whether action had been taken to keep people safe.

Mobility plans were in place for people at risk of falls and we observed staff supporting people who were walking to remain safe. They reminded people to walk slowly, highlighted trip hazards and reassured people if they became unsteady on their feet. However, we found people did not always receive all the support they required to ensure the risks to their health and safety were mitigated following a fall. The service's post falls guidance instructed staff to continue to observe people regularly for at least 12 hours following a fall to ensure any injuries were identified. Records showed that these observations had not always been completed for the required length of time or at all. The manager and staff told us they did not think all staff had completed these checks. This meant staff might not always have identified any falls related injuries that might require prompt treatment from healthcare professionals. People's falls care plans had not been reviewed following a fall. This would be good practice to determine whether the risk management plans in place were still sufficient and whether additional safeguards or checks for people at high risk of falling were required. Staff might therefore not have all the information they needed to support people experiencing recurrent falls to mobilise safely.

People were not protected from avoidable harm due to inappropriate moving and handling techniques. One person required the support of two staff to safely transfer from a sitting position with the use of a standing hoist and sling. We asked the care worker who had supported this person with their morning care routine, which other care worker had supported them with the transfer. The care worker told us they had completed this transfer alone. This was not in accordance with this person's risk management plan and had put the person at risk of falling. Throughout our inspection we observed staff at times supporting people inappropriately by grabbing onto people when they were unsteady to put their hands onto the standing hoist and removing people's wheelchair footplates without supporting their feet or informing them that they will be removing the footplate. We saw staff pushing wheelchairs without first putting a person's feet onto the footplates or telling them that they will be pushed. We saw one person's foot had got caught on the carpet and they called out in pain when staff pushed their wheelchair without warning them or supporting them to put their feet on the footplates when pushing their wheelchair to the dining room. People were not appropriately assisted when using their wheelchairs thereby placing them at risk of bruising, skin tears or

soft tissue injuries.

People were not supported to eat safely which put them at an increased risk of choking. One person had been assessed by a Speech and Language Therapist (SALT) following a choking incident that required hospitalisation. They had been assessed as at high risk of choking and SALT guidelines were in place to inform staff how to support them to eat safely. On the first day of our inspection we observed staff were not supporting this person to eat in accordance with their SALT guidelines. Staff used a dessert spoon instead of a tea spoon and left the person to eat by themselves unattended. Records showed not all staff providing meal time support had completed dysphasia (swallowing difficulty) training and staff we spoke with could not correctly describe the person's SALT guidance in place. Another person had no eating guidelines in place and we saw staff supporting them at a fast pace, without checking if they had finished the previous mouthful before offering them more to eat. They did not slow their pace when the person still had their mouth full and pulled their head away from the spoon being offered. When they started coughing staff did not return to the table to check if they required any assistance. This person had not been assessed as being at risk of choking however, the way staff were supporting them to eat could place them at risk of choking. Although there had not been any further choking incidents people were not appropriately assisted when eating thereby placing them at an increased risk of choking and aspiration pneumonia. Aspiration pneumonia can develop when people accidently inhale food and liquid into their lungs.

We found two people had developed pressure ulcers in the home. The management of these pressure ulcers were poorly documented in these people's care records. Staff had completed daily notes that made some reference to 'dressings coming of' and 'dressing' one person's pressure ulcer but these records were not sufficient to track the management of this ulcer. The provider's protocol for wound management had not been followed. There were no wound care plans, description or photographs of this person's wounds for staff to monitor improvement or deterioration. The deputy manager and staff could not tell us if the person's pressure ulcers had regularly been reviewed or if they had contacted the district nurses or tissue viability nurse for guidance when the pressure ulcers deteriorated. They could not explain why the pressure ulcer had not been discussed at the monthly meeting with the community specialist nurse for care homes in accordance with their protocol and how treatment decisions had been made. The GP had identified these pressure ulcers following a visit to the service on 26 August 2016. Although a written wound management protocol was not available to staff, all staff we spoke with were aware of the provider's wound reporting and management arrangements but could not explain why this had not been followed in this instance. People were placed at risk of ill health when their skin deteriorated as pressure ulcers had not always been managed in accordance with good wound management practice. At the time of our inspection the local safeguarding team was investigating the concerns raised about people's pressure ulcers not being managed sufficiently to prevent their health from deteriorating.

Following interventions from the district nurse team the other person's pressure sore had been documented appropriately, treated and reviewed with support from the district nurse team. However, we could not be assured that all future skin concerns would be identified and managed appropriately by staff at the service.

People were assessed by staff monthly for the risk of them developing pressure ulcers. Care plans showed where people had been identified as at risk, arrangements had been made to prevent their skin from deteriorating. People were prescribed topical creams to hydrate and protect their skin in order to minimise their risk of developing pressure ulcers. Daily care records did not always confirm that staff had applied people's topical creams when providing their personal care. Staff were also not always clear where they needed to record people's topical cream applications. One person who could not change their position independently to relieve the pressure on their skin was supported to reposition regularly to protect their skin from pressure damage. However, their daily notes did not always demonstrate that staff had changed the

person's position at regular intervals throughout the day in accordance with good practice. Accurate repositioning and topical cream charts were required to be maintained for people to evidence they had not remained in the same position for too long and received support to keep their skin hydrated. This would ensure that the manager had all the information they needed, to evaluate whether the preventative action they had instructed care staff to take to protect people's skin, had been implemented appropriately.

The provider had arrangements in place for the safe management of people's medicines. However, we found records in relation to the management of medicines were not always kept in accordance with good practice to support the safe management of medicines. For example, temperature records were not always completed for medicines stored in the medicine trolley to ensure they were kept at the required temperature to remain effective; and people's medicine administration records (MAR) were not locked up securely and could be accessed by visitors or staff not authorised to view people's confidential information. We found a number of staff signature omissions (identified as gaps) in people's MAR which had not been identified by the staff administering medicine on the next shift. These recording gaps had not been followed up to determine whether it was a missed signature or a missed dose. There was no explanation recorded on the MAR as to why the medicines had not been administered. We checked some of these and found people had received their medicines as prescribed but it had not been recorded as taken. Records relating to one person's glucose monitoring and insulin administration was recorded in two places and were not always signed to ensure the record would always be accurate. Inaccurate record keeping placed people at risk of not receiving their medicines as prescribed as care workers would not know from the MAR whether people had received their medicines.

All of the above information demonstrated that care and treatment was not provided to people in a safe way. The provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and had applied for the necessary authorisation when depriving a person of their liberty.

People's rights and liberty had not always been protected when care and treatment arrangements were made to keep them safe. Assessments, planning and delivery of care had not been carried out in accordance with the Mental Capacity Act 2005 (MCA). For example, the manager had completed mental capacity assessments for some people living with dementia who would not be safe to leave the service unsupervised and would require constant support to keep them safe. Following their assessment the manager told us they had made the decision that it would be in these people's best interest to live at the service with these restrictions in place and that a DoLS application needed to be made. However, no DoLS applications had been made to ensure the lawful authorisation of these restrictions. One person in the home had a DoLS granted and this needed to be renewed annually if it was still deemed to be required. The manager told us a DoLS was still required and had lapsed a year ago but they had not made an application to the authorising authority to have the person's DoLS renewed. People who could not consent to restrictions being placed on them to keep them safe were being deprived of their liberty without appropriate safeguards being in place.

People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from the employment of unsuitable staff. The provider's recruitment policy did not detail all the recruitment information that was required prior to making a recruitment decision to support the manager to make safe recruitment decisions. Some recruitment checks, such as proof of applicants' identity, investigation of any criminal record, and declaration of fitness to work, had been satisfactorily investigated and documented. However, one of the five recruitment files we reviewed showed no evidence of employment history. There were gaps in employment history for another two applicants which meant periods of possible employment may be unaccounted for. An applicant's employment history could provide information that might make them unsuitable to work with people who use care and support services. The provider had not always gathered this information to support them to make safe recruitment decisions. The provider had also not recorded the reasons why they considered an applicant to be suitable when information obtained through recruitment checks indicated possible risks to people. This would ensure a record would be available to evidence how the provider had considered and mitigated any potential recruitment risks.

We found that the provider had not protected people by ensuring that the pre-employment information required in relation to each person employed was available. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were in place and staff could describe the action they needed to take if they identified people were at risks of abuse or had been abused. However when we asked staff if they had referred the concerns they shared with us in respect of one person's pressure ulcers to the local safeguarding team, they told us they hadn't because they had not identified it as abuse. So whilst staff had received training in safeguarding adults at risk, further embedding of the learning from the training is needed. This was an area that required improvement.

From our observations there seemed to have been sufficient staff numbers; for example, we did not notice any people being left waiting to be attended to, and on the occasions when we heard the call alarms being sounded these appeared to be responded to quickly. The people we spoke with said that staff would always respond to any requests for attention but that some took longer than others. The manager told us the provider was purchasing a new call bell system as the current systems did not always work and staff might not be alerted when people requested assistance. The manager told us they adjusted staffing when people needed more support and was working with the provider to keep staffing levels flexible. For example when people required staff support to attend appointments or returned from hospital. They explained how the activities co-ordinator worked additional hours the day before to support a person to attend a hospital appointment. The manager told us ''we sometimes are stretched if the appointments are not taken into account''. They acknowledged some improvement was needed to ensure that in their absence people's appointments would always be taken into account when staffing numbers were calculated.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the service. Comments included, "Staff are good here'' and ''They contacted the GP to get me some tablets for my chest''. However, we found staff and management at Beacon House did not consistently provide care that effectively met people's needs.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. Some staff told us they were behind in some training such as supporting people to eat safely and fire training and this was already known to the manager. Whilst training was available it was not effective in all cases. We found poor practice in moving people safely from a commode to their wheelchair, assisting people with their food and wound care. There was also a lack of understanding shown by some staff in supporting people who lived with dementia. This was observed by the lack of interaction with people and not effectively supporting them during meal times to make their meal choices.

We looked at staff training records. The manager had identified that training needed to be improved when they completed the PIR during the first week in August 2016. It was difficult to track training as the training matrix was not up to date. It did not reflect training offered by the specialist nurse for residential homes in for example, skin health and had not been updated to reflect the moving and handling training staff had completed in June 2016. Following our inspection the manager provided us with a copy of staff's up to date training. Training records indicated that provider's mandatory training for all staff was mostly up to date, for example; moving and handling and infection control. Additional training specific to the needs of people living in the service, such as, wound care, dysphasia and nutrition had not been undertaken or updated to ensure best practice was followed by all staff. There was a risk that staff might not have the skills to support the needs of people in the service effectively. The manager assured us they would be taking immediate action to arrange for staff to complete the required training. The local authority representative told us they would also be offering support to the service to ensure staff could put their training into practice.

One to one staff supervision was not routinely provided to staff. Supervision helps staff identify gaps in their knowledge, which could be supported if necessary by additional training and provides an opportunity to provide feedback about any concerns staff might have. Staff said, "I cannot remember when last I had supervision'' and ''We discuss things with the manager as we go along we do not have formal sit down meetings with them on our own''.

Staff records of supervision were not available and the manager confirmed that staff supervision had fallen behind for all staff and had not been undertaken. Records showed some staff had started completing their appraisal self-assessments as staff appraisals had been planned to determine staff's ongoing development needs. However, the deputy manager could not tell us when these would be completed. The deputy manager told us medicine competency assessments were completed for staff every six months to ensure they maintained their skills to administer people's medicines safely, however; records showed these assessments had not been completed for all staff administering medicines.

Competency assessments were not routinely completed to ensure staff could safely perform practical care

tasks like moving and handling, mealtime support and wound care in line with good practice guidelines. Staff had therefore not been provided with an opportunity to review their leaning and development needs and for their manager to appraise their performance. Any additional skills and knowledge that may be required from staff as people's needs had become increasing complex had not been identified so that action could be taken to ensure appropriate training was provided. There was a risk that staff might not be able to fulfil the requirements of their role if people's needs changed or people with more complex needs were admitted to the service.

Staff told us they had felt unsupported due to the lack of leadership. This was reflected in the unsafe practices we observed. The induction programme in place for new staff was not sufficient to prepare staff for their role. The manager told us staff received the provider's mandatory training and shadowed experienced staff. It was not a structured programme that showed how new staff would be supervised until they could demonstrate the required levels of competence to carry out their role unsupervised. The manager told us they were aware of the Care Certificate standards but had not yet introduced them to ensure new staff were supported, skilled and assessed as competent to carry out their roles. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. If the provider was to employ new staff there was a risk they would not receive sufficient support to adequately prepare them for their role in accordance with national good practice guidance.

Staff had not all received the supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living with dementia did not have the mental capacity to independently make decisions about their care arrangements. 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.

Staff understood the importance of gaining people's consent before undertaking care tasks. They were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example, when asking a person if they wanted their medicines or if they wanted to see a doctor. Some staff still needed to complete training to develop their understanding of the principles of the MCA. Staff could describe how they would identify when people's mental capacity might be fluctuating and therefore knew when people would be most likely to be able to contribute meaningfully to decisions about their care and treatment.

We saw the manager had needed to make a recent decision on a person's behalf in relation to their need to have regular bed rest. Records showed that they had completed the mental capacity assessment and best interest recording paperwork to ensure the recording of best interest decisions, made on people's behalf, met the requirements of the MCA. When decisions were made about people living in the home, records did not always show what less restrictive options had been considered. Time was needed for staff to embed learning into practice to ensure mental capacity assessments and associated best interest decisions would always be completed in accordance with current best practice guidance.

Staff understood the importance of supporting people to drink enough to prevent dehydration and associated complications. People told us drinks were placed within their reach and we saw people were encouraged to drink throughout the day. People at risk of losing weight were supported to make sure they

ate and drank enough. The GP and Specialist Nurse for Care Homes had been involved to provide nutrition guidance when required.

The cook was kept informed of people's dietary needs and they were able to describe how they provided meals that met the needs of people with swallowing difficulties and allergies. We saw soft or pureed foods were prepared for people when they experienced difficulty chewing or swallowing and the information available to the kitchen staff about people's needs and preferences was up to date.

People received a varied diet and this included a different main meal option throughout the week. People told us they liked the food and we saw during meal times people ate most of their food.

People were supported to access health practitioners when needed. Records showed people were routinely able to see a number of health care professionals including, a chiropodist, physiotherapist, district nurses and community psychiatric nurses (CPN) as required. The CPN visiting the service told us they had worked with the service before and were always satisfied that staff followed their guidelines. A local GP visited the service when needed and records showed staff were in regular contact with the GP practice to discuss people's health concerns.

Requires Improvement

Is the service caring?

Our findings

Staff, people and two relatives told us staff had developed caring relationships with people. One person told us ''Staff will have a joke with me and they always make me feel better''. However, we did not always observe caring interactions between staff and people during our visits.

We saw some examples of staff protecting people's privacy by ensuring doors were closed whilst people completed their personal care. However, staff did not always understand the importance of promoting people's dignity and showing them respect. For example, in planning the personal care for one person staff had not taken their dignity into account. We saw them taking a standing hoist into a person's bedroom. They had to open the door wide to get the equipment in resulting in the person being visible from the corridor sitting on their commode. Whilst staff hoisted another person in the communal area their clothes rode up exposing their stomach area, staff did not stop to readjust the person's clothes to protect their dignity.

During the lunch time staff were seen speaking to each other about the staffing arrangements for the weekend while supporting people to eat, they did not include people in their conversation or changed the topic to ensure this would be of interest to people. When people are excluded from conversations they might not always feel they are valued and respected. We observed staff were at times very familiar with people calling them ''love and darling'', kissing and touching them. Staff intended this to be affectionate but we saw one person living with dementia turning their face away on two occasions when being kissed. It was not noted in their care plan that they preferred such expressions of affection and we could not be sure that the person had experienced this as a positive respectful interaction with staff.

People were not always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living with dementia did not always receive the support they required to make sense of their world. For example, we saw people sitting at the dining room table for a long time waiting for their lunch time meal, some people had fallen asleep and others were getting confused and frustrated. Staff were not always present in the dining room while people waited, reassuring and explaining to them what the delay was and distracting them with conversation to prevent them from getting anxious and agitated.

People living with dementia were not always communicated to in way that would support their understanding and enhance their daily decision making and participation in the service. We saw people living with dementia struggling to make their meal choices and staff repeatedly asking them what they would like and as they could not decide staff made the decision for them. The inspector asked one member of staff whether they ever showed people the two meal options available to support their decision making. The staff member said this was not something they did but brought two plates from the kitchen and showed the person the two choices. They instantly pointed to the plate they wanted, which was different to the choice the staff member had made for them. People might not always have their preferences met because they had not been supported to make their wishes known. At times staff did not take the time to explain care

tasks clearly to people, for example when undertaking moving and handling tasks. People were not always given time to respond or fully partake in these tasks. This gave the impression that staff were focused on getting tasks done which could make people feel rushed and not understood.

We recommend the provider seeks training and guidance in relation to current best practice on the different methods of communication that can be used to support people living with dementia to express their views.

People were encouraged to personalise their environment to make them feel at home and comfortable. We saw people were able to bring in personal items from their homes and we could see that a number of people had brought in their own bedding and picture of their families and friends.

People were supported to follow their faith and attend religious services. Staff explained that religious beliefs were recognised and that leaders from people's own faith could visit the service as people wished. We saw two religious services were undertaken within the service every month.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed prior to being offered a place at Beacon House to ensure the service could meet people's needs. Initial assessments had been used to plan people's care following their move to the service. People's care plans provided information for example, about people's needs in relation to their personal care, mobility, skin, eating and health needs. The information in people's care plans had information about people's preferences and their likes and dislikes to support staff to know how to provide care that met people's needs.

Records showed people's care plans had generally been reviewed monthly, however we found these reviews had not always been meaningful and did not indicate how people and their relatives had been involved in reviewing people's care. In most instances staff had just signed to show they had reviewed people's care plans but had not always noted when people's needs had changed and what additional support they required to meet their changing needs. Some people living with dementia had found it increasingly difficult to plan and execute tasks for example, when eating and drinking. Care plans did not show how these people were to be guided and assisted to enhance their independence and maintain their skills. For example by breaking down the task or providing hand over hand support when the support provided was not deemed to be effective. We saw staff fully assisted one person to eat during mealtimes however; this was not reflected in their care plan and it was not recorded how this decision was made. This person had also been assessed as needing four staff to support them in the morning and medicine to manage their behaviour. Staff told us this was not needed anymore. Their care plan did not reflect what the new support arrangements were and how the decision was made that additional staff and medicines would no longer be required . Staff did not have all the information they needed to know how to support people if they had to solely rely on their care plans and people might therefore not always receive the support they needed.

Some people required support to complete their personal hygiene tasks to the level they wanted. A hairdresser regularly visited the service to support people to maintain their appearance. People's daily personal care charts did not always show whether all the planned hygiene tasks had been completed for each person. Staff could not be assured from people's records that people had received a regular bath, mouth and nail care and that their personal hygiene needs had been met. Records completed by staff each day did not always demonstrate that care had been given as set out in the care plans.

The provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a planned programme of leisure and social based activity provision at the service. Activities were provided in the home by an activity coordinator that visited the service in the afternoons for about three hours and provided gentle exercise, games, and arts and crafts for people to remain occupied. One person told us ''I enjoy the bingo, I won a prize''. Trips were arranged monthly and people told us they enjoyed these social opportunities. One relative told us ''Relatives are always welcome and they made an effort to ensure my father is included''. People were not always supported on an individual basis when their

behaviours indicated the need for engagement in meaningful activity. For example, one person was observed at times to be restless and seeking staff support. On the morning of our inspection, this person was not supported to engage during breakfast or provided with company and they became more agitated and distressed and continued to express a desire to leave the service. This meant their individual needs for company and reassurance were not always met.

We found during the hours when the activities coordinator was not at the service people were left for long periods of time watching television in the Oak lounge or sitting alone in the dining room waiting for meal times. We did not see staff seeking people out to provide them with company or meaningful activity and we were concerned that people's social needs might not always be met. This meant people might get lonely and isolated if they did not receive regular visits from their families. The environment did not support people living with dementia to find their way around the service and did not create opportunities for stimulating occupation. For example, bedroom and bathroom doors were white and people with dementia could have difficulty differentiating rooms and to find their bedroom and a bathroom independently. We had to support two people to find their way to the lounge when they became confused. We saw one person had a doll that seemed to provide them with comfort but not all people living with dementia had memory boxes or objects scattered throughout the service to support them to remain occupied if they became restless or bored.

People we spoke with did not always know or understand how to raise their concerns or provide feedback about their experience of the care they received. The provider had arrangements in place to gather information from people living with dementia. We saw the provider visited the service every month to speak with staff and gain feedback from people and their relatives. Records showed improvements had been made about the quality of food following people's dissatisfaction. The manager had produced a satisfaction questionnaire with pictures to support people living with dementia to provide feedback. However only two questionnaires had been returned despite the manager's request to staff at the team meeting on 20 May 2016 to ensure people and their relatives were supported to complete the questionnaires.

The provider had received one complaint from a relative in the past year. Records showed the manager had investigated the complaint and written to the relative with the outcome of their investigation. The relative told us they would have appreciated the opportunity to be part of the investigation to support the manager to better understand their concerns and what they had hoped to achieve through the complaint. They told us they were not clear on the improvements the manager was going to make following their complaint and how they were going to monitor that improvements were sustained.

Improvements were needed to ensure the provider's feedback arrangements would be implemented effectively so that people would be assured that their views would be taken into account when improvements were made to the service.

Inadequate

Is the service well-led?

Our findings

We received mixed responses from staff and relatives when we asked about leadership at the service. Staff comments included ''the managers work very hard and we can always go to them for advice'', 'the manager is harsh and critical of staff'' and ''we tell the manager when we are concerned about people but it does not always get followed up''. Relatives told us ''the manager always take quick action when I raise any concerns'' and 'there is never a manager to discuss concerns with and when I do I am not sure they will make any changes''. At the start of our inspection the manager was not available as they had been absent from the service since 5 July 2016 and returned on 12 September 2016. The deputy manager and senior care worker had been responsible for the day to day running of the service during this time. The deputy manager could not explain the action they had taken when risks relating to people's health and welfare had been raised in the manager's absence to ensure people remained safe and healthy. We found the leadership, management arrangements and monitoring systems were not effective in ensuring shortfalls in the service were identified. Action had not been taken to prevent the quality of the service from falling below an acceptable standard and people had been placed at risk of receiving unsafe care.

The manager and deputy manager told us that they checked the quality of the service regularly as they were in day to day control of the service. The managers told us they did these checks but did not document anything to show what had been looked at. They had made some improvements to the service when they had identified for example, that people were not happy with the food and had recently changed their community pharmacy service when they found concerns with delivery and disposal of medicines. However, robust systems were not in place or effectively operated to support the managers and staff to continuously evaluate and improve the quality and risks in the service. They had not identified the concerns we found and the risks these could pose to people's health and safety prior to our visit, therefore action had not been taken to ensure these were addressed. There were no recorded audits completed for instance in areas such as care plans, medicines, wound and falls management, staff recruitment, staff training and staff supervision. These were some of the areas where we had identified concerns with during this inspection. Records showed the manager had discussed with staff the need to complete a full employment history and use yellow waste disposal bags at the team meeting in May 2016, however this meeting had not been effective in bringing about the required improvements. Monthly provider visits took place to gain people and staff's feedback about the quality of food and the service in general but records showed these provider meetings were not effective in identifying the regulatory failings within the service that had not been picked up by the managers.

The manager, provider and deputy manager were unclear about their overall responsibility to meet and sustain all the legal requirements of a registered person to ensure the safety and welfare of people. They could not always provide us with the documents and information required relating to the management of the service to evidence how the service met the regulatory requirements. For example; staff interview records were not on file to show how the manager and provider had determined applicants were suitable for the role and checked all the required recruitment information was available. A written contingency plan was not in place for staff reference to ensure people would continue to receive a service if an emergency was to occur, for example if the service was to become flooded. Records of all the Specialist Community Nurse

for Care Home's meetings with the manager and deputy manager were not available. The deputy manager was not aware the service had dropped from a five star to a four star rating following the Environmental Health service's inspection in August 2016. They could not explain what concerns had been found during the Environmental Health inspection and the action that was being taken to rectify this. They could not provide us with up to date information about training completed by staff. The provider and managers told us they had not been aware of concerns relating to wound care or moving and handling support provided to people. This meant information provided to us by staff could not be corroborated and we found it made tracking, evaluation and retrieval of information relating to the management of the service very difficult or not possible for the provider. The lack of effective governance systems had resulted in the provider and managers not having a comprehensive awareness of risks in the service and therefore action had not been taken to ensure people were safe.

At the end of our first and second day of inspection on 7 and 9 September 2016 we provided feedback to the deputy manager about our findings. The deputy manager told us they would immediately address issues such as the concerns we raised relating to gaps in the MAR, MAR's left unsecured and care workers being interrupted when administering medicines. However, when we returned to the service on 15 September 2016 six days later, these issues had still not been rectified. The deputy manager was not present on the third day of the inspection and the manager told us they had not received a detailed handover on their return and had not been made aware of these concerns. They could not tell us why immediate action had not been taken to address these risks. We were concerned when managers had been alerted to risks in the service they had not taken prompt action to ensure people would be safe.

Systems were not always in place to identify risks posed to people by their environment. We saw some people's toothbrushes were at times left lying on their basin which could increase the risk of them getting dirty and we saw used continents pads lying in a bag in a bathroom which could increase the risk of infection. We asked the deputy manager if they had identified these issues when completing their audits and they told us they did a walk around the service but structured checks did not take place to ensure health and safety requirements had been met in relation to infection control. Infection control audits had not been undertaken to assess whether house cleaning, clinical waste management, hand hygiene and infection prevention practices were adequate. People could therefore be at risk of infection without the managers being aware so that action could be taken to keep people safe. Regular fire alarm checks and fire evacuation practices had been completed but the environment and fire risk procedures had not been assessed by an appropriately skilled person to ensure they were sufficient to keep people safe. Following our inspection the provider informed us that they had instructed an external consultancy to complete a fire risk assessment of the service.

Recording systems had not been operated effectively to support quality and risk monitoring, for example; care plans did not always support the managers to evaluate the effectiveness of care planned and delivered for people as they did not contain all the information staff needed and had not always been completed when people received their care. Although the managers told us care workers reviewed people's care plans and checked the quality of care plans monthly their checks had not been effective in identifying the omissions we found in for example, people's medicines, wound and personal care tasks records.

Communication systems were not operated effectively to ensure staff would always have up to date information about people's needs and be clear about their roles and responsibilities on each shift. We asked the deputy manager how staff would know how to support people's changing needs. They told us this would be discussed at the daily shift handover meeting or staff would share it with each other during a shift. We observed a handover session between staff at the end of their shift and staff who had just arrived for the start of their shift on 9 September 2016. The handover was not detailed and did not provided an update on

each person's health, emotional and personal care needs that day. No written record was provided to staff about changes in people's needs such as one person's chest infection or information about any accidents or incidents that might have taken place on the previous shift so that staff who might not have worked a few shifts, to refer to. We found staff could not always explain how people's needs had changed and we saw they did not always support people in accordance with best practice. Staff could therefore not always be relied on to provide new staff or agency staff with up to date information about the support people required and there was a risk that people might not receive care that did not meet their needs and preferences.

Staff were aware of their role in reporting and recording accidents and incidents to support the manager to monitor risks in the service. This included for example, the reporting of people's falls and behaviour incidents. However, we found the safety incident reporting system was not sufficiently comprehensive to ensure the managers would be informed of all safety concerns that could indicate people's health and safety were at risk. For example; the manager told us staff would tell them if they identified any concerns with people's skin, however there was no reporting system for staff to record these concerns to ensure the manager had a written record to refer to. The managers did not have a system in place to routinely check whether staff had completed wound plans appropriately and had not routinely reviewed the management of people's wounds. They had not ensured appropriate notifications were made to the local authority and the CQC promptly so that they could review the provider's response to incidents and take swift action to ensure people were safe if any concerns were identified regarding the provider's management of people's risks.

A system was not in place to check whether post falls observations had been completed after each fall. The managers told us they did not think staff always completed these checks but could not tell us what action they had taken to ensure staff would always follow the provider's guidelines to keep people safe following a fall. Each month the manager reviewed people's safety concerns and reported on these to the Specialist Community Nurse for Care Homes to ensure action was taken in line with national best practice guidance. However, they might not always have had all of the information they needed to have a good overview of all people's risks as the safety concerns had not always been recorded and monitored. Staff 's management of safety concerns and associated risks had therefore not always been reviewed with the Specialist Community Nurse for Care Homes and swift action had not been taken to keep people safe, for example; the provider had not identified that staff had not followed best practice when managing one person's pressure ulcers and action had not been taken to prevent their health from deteriorating.

An effective system was not in place to ensure staff training, observation of their practice and supervision would be completed routinely to ensure staff were supporting people in line with their care plans and national best practice guidelines. The manager and deputy manager told us although one to one meetings did not routinely take place they worked with care staff and used this as an opportunity to identify any concerns in practice. However, we found this system was not effective. During both our meal observations the deputy manager was present and they did not identify or address the poor practice we saw in respect of staff supporting people to eat too quickly and not in accordance with their SALT guidance. When we asked what action they would be taking with staff to address our concerns they told us ''I will be having a serious chat with them'', they had not previously used the service's disciplinary process and did not feel this would be appropriate. A system was not in place to ensure when poor practice was identified action would be taken to address and monitor staff's performance to ensure they would provide safe care for people.

This inspection highlighted shortfalls in the service that had not been identified by the provider's monitoring systems. There was a lack of appropriate checks and audits in place to assess, monitor and improve the quality and safety of the service provided. There was a lack of systems and processes in place to assess, monitor and mitigate the risks associated with service user's health and welfare. This was a breach of

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's philosophy noted on their website stated that Beacon House aimed to ensure that each resident should live as full and independent a life as possible. They also noted that people's privacy and dignity would always be respected and that all aspects of safety and security were taken care of for people. Not all staff had an understanding of the values of the service. From observing staff interactions with people it was clear the vision of the home was not yet fully embedded into practice as care was at times task based rather than person centred and caring.

Beacon House did not have a registered manager in place on the day of the inspection for both their registered activities. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had started their application to be registered with the Care Quality Commission to ensure the provider would meet their registration requirement to have a registered manager in place.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care they carry on at Beacon House. They are required to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They must send a monthly report to CQC detailing the audit dates, the outcomes of these and any actions taken or to be taken as a result.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively to ensure the service; assessed monitored and improved the quality and safety of the service provided and assessed, monitored and mitigated risks relating to the health, safety and welfare of people who used the service and others. The provider did not maintain securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided.

The enforcement action we took:

We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care they carry on at Beacon House. They are required to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They must send a monthly report to CQC detailing the audit dates, the outcomes of these and any actions taken or to be taken as a result.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had not protected people by ensuring that the information required in relation to each person employed was available.

The enforcement action we took:

We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care they carry on at Beacon House. They are required to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They must send a monthly report to CQC detailing the audit dates, the outcomes of these and any actions taken or to be taken as a result.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff received appropriate training, professional development and supervision.

The enforcement action we took:

We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care they carry on at Beacon House. They are required to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They must send a monthly report to CQC detailing the audit dates, the outcomes of these and any actions taken or to be taken as a result.