Healthcare Homes Group Limited

Beaumont Park Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection of Beaumont Park Nursing Home on 29 and 30 August 2018. During our last comprehensive inspection in August 2017 we rated the service as 'Good'. During this inspection the rating changed to 'Requires Improvement'. This is because we identified that some improvements were required to ensure the service provided a good quality service to people who lived there. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 in relation to the deployment of staff and the management oversight of the service. You can see what action we told the provider to take at the back of the full version of the report.

Beaumont Park is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Beaumont Park accommodates up to 46 people in one purpose built building across two floors. The ground floor predominantly accommodates people who have residential care needs and the first floor, people with nursing needs. Some people living on both floors were living with dementia. At the time of the inspection there were 30 people living at the home.

The registered manager left the service in March 2018 and an interim manager who was also an operations manager for the provider, was in post. A new manager had been appointed but had not taken up post yet or registered with the Care Quality Commission. 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.

People were not supported in a timely manner and staff were not always visible in the home. The provider had not taken sufficient steps to analyse and address the reasons for this. The provider had robust recruitment processes in place.

Staff had good understanding of their responsibilities in relation to safeguarding people from potential harm. However, there had been an increased number of safeguarding concerns at the service in the last six months. This indicated that staff may have not always acted to ensure people's needs were met safely to the degree where neglect by acts of omission had occurred. The interim manager was taking action to improve staff practice and reduce the risk of people receiving poor or unsafe care.

Staff spoke kindly and were respectful to people but were very busy and did not have very much time to chat with them.

Risk assessments were in place that gave guidance to staff on how risks to people could be minimised without compromising people's independence. Medicines were administered safely and people were

supported to access health and social care services when required.

Staff understanding of their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was sufficient and we saw that they gained people's consent before they provided any care or support to them as far as possible.

Staff supervision had not been provided regularly over the past two years, although the interim manager had recently taken steps to address this. Training to enable staff to support people well had not been kept up to date over the last year. Again, steps had been taken to make improvements to this and staff had attended more training in recent months.

People were supported to pursue their interests through a wide programme of activities and one to one sessions for people who were at risk of social isolation.

Care plans took account of people's individual needs, preferences, and choices. However, some areas of need had not been fully considered and lacked detailed information to support staff to understand and meet people`s needs well.

The provider had a formal process for handling complaints and concerns and this was done in line with the provider's policy. People were aware of how to make complaints and were supported to do so, if assistance was required.

The provider and management team were committed to promoting a person- centred culture within the service and were supporting staff to understand what this meant and how to improve their practice to achieve this. Staff were positive about the changes that were being introduced and showed good understanding of the provider's values that these improvements were based on.

The provider had quality monitoring processes in place to ensure they were meeting the required standards of care. Some of the issues identified at this inspection had been identified by the provider and the interim manager, and action towards achieving the necessary improvements was ongoing. However, the work required was not yet complete and the improvements needed time in order to be embedded within the service. Some issues identified at the inspection, such as staff deployment and the impact this had on the quality of care, and content missing from care plans had not been picked up and addressed sufficiently.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not effectively deployed to support people to stay safe and to meet their needs in a timely way.

There were an increased number of safeguarding concerns relating to poor care and acts of omission at the service over the last six months. There were systems and processes in place to safeguard people from harm and the interim manager was working with staff to improve practice and ensure people received good quality, safe care.

Risks to people were assessed and their safety monitored and managed so they could be supported to stay safe and maintain their independence.

There were systems in place to support learning from when things went wrong.

The provider had policies and systems in place to protect people from the risk of infection.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was not up to date for all staff.

People's needs were not always met by the adaptation, design and decoration of the premises.

Staff had a good understanding of the principles of the Mental Capacity act, and consent was sought before providing care.

People were supported to eat and drink a nutritionally balanced diet.

People had access to healthcare services and on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and treated people with respect and compassion.

Staff were too busy to spend time talking with people and sometimes people's care was not dignified because staff were rushed.

People's privacy was respected.

People were supported to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always receive personalised care that was responsive to their needs.

A wide range of activities were provided which had been developed in response to people's interests.

People's concerns and complaints were responded to appropriately.

People's wishes for the end of their life were documented within their care plans.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was not a registered manager in post.

The provider had not identified and analysed the reasons for why care was not provided to people in a timely manner and they had not taken sufficient action to address this.

Systems to monitor the quality of the service were used to identify shortfalls and make continuous improvements to the service. However, some issues at this inspection had not been identified through these systems. Work was required to ensure improvements made were sustained.

The provider promoted a person - centred culture and staff understood and shared their values.

The people who used the service, their relatives public and staff were engaged and involved in the service. The service worked in partnership with other agencies to improve the care provided to people.	

Beaumont Park Nursing and Residential Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 29 and 30 August 2018 and was unannounced. The inspection team was made up of two inspectors, a specialist advisor and an expert by experience in caring for older persons living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This inspection was prompted by an increase in concerning information about the service being shared with us by a number of sources, including the local authority, the clinical commissioning group and members of the public. These concerns included allegations of neglect and omission, poor quality care, shortage of and insufficiently trained staff and poor record keeping. We considered these issues during the inspection.

Before the inspection we looked at all the information we held about the service and used this information as part of our inspection planning. The information also included the previous inspection report and notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about.

During the inspection, we spoke with 11 people who used the service, three relatives and friends, and one visiting professional. We also spoke with the interim manager who was also the provider's Operations Manager, the group lead for safeguarding, the regional clinical support , the regional director, the clinical lead, five care staff and an activities coordinator.

We looked at the care records for eight people who used the service, the recruitment records for four staff

and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they managed, assessed and monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that their needs were not always met in a timely way and we observed that in communal areas staff were not always visible on the day of the inspection. One person said, "I always feel hurried when they wash me, I suppose they have that many to do." People we spoke with told us they felt there were not enough staff available to provide support when they needed it. They told us that staff sometimes took a long time to answer when they used their call bells, leaving them waiting for care, which sometimes left them uncomfortable or distressed. One person told us, "I get washed in bed; it is quite late in the day sometimes, and once I'm dressed I'm not allowed to go back on my bed. I would like to get washed earlier, have my lunch in my room or downstairs. I like to play bingo or watch the other activities, but sometimes I would like to go back to my room and lay down for an hour, then maybe come down for tea later to break my day up; my bottom hurts if I am sat too long."

Most of the staff we spoke with also felt that there were insufficient staff available at busy times of day to provide essential care for people. One member of staff gave us an example of how this had a negative impact on people. They explained that on one occasion the previous week, they had gone home at 2pm at the end of their shift and not all people had been helped to get up for the day. Another member of staff told us there were times where lunch for all was delayed because staff had not yet managed to get everyone (who wanted to and were able) up and dressed. Other care staff told us they felt night staff did not help people who wanted to be up early to do so and this had a knock-on effect on what day staff were able to do.

Staff told us agency staff were used regularly. One member of staff said, "Some agency staff are good but some let the side down." Another member of staff told us they felt permanent staff knew people who used the service well but this wasn't always the case with agency staff. The interim manager acknowledged that the service did rely on agency staff to cover shifts but told us that, where possible, the same agency staff were booked to ensure some consistency was possible.

We observed that staff were very busy and were not always visible within the service. A visiting professional also told us that it was sometimes hard to find a member of staff when they visited. We noted on both days of the inspection that some people were not supported to get up and dressed until almost lunchtime. Although some people did not get up out of choice, or because they were nursed in bed for clinical reasons, others did not get up because staff had not had time to support them. On the second day of inspection the interim manager told us that, although a number of people had not received support to get dressed by midday, they had all been provided with personal care. Although this ensured people were clean and dry, this was not an acceptable level of care for people, who would have had a wash and then gone back to bed to wait again for support to get dressed. This increased the risks associated with long periods spent in bed, such as the development of pressure ulcers and skin integrity issues, as well as social isolation.

We discussed our findings with the management team. The management team told us that the needs of people living at the service were complex and that 26 out of the 30 people living at the service required support from staff with personal care. They confirmed, and we saw from records, that the provider used a dependency tool to identify the number of support hours each person required in a day. However, this tool

was not always being used effectively at pre- admission assessment to ensure the service had the capacity to meet the needs of new admissions as well as the needs of people already living in the service. It was acknowledged by members of the management team that the needs of people who had lived for many years at the service were changing, and this also had an impact on the service capacity to support new people with complex needs. The management team had not used information from the dependency tool and people's care plans effectively to identify the busy times of the day when more staff may be required. They also had not looked at how staff were organised at these times of day to best meet people's needs in a timely way.

We noted that the service only had one permanent nurse employed at the time of the inspection. The interim manager confirmed this and explained that recruitment was underway to appoint more nurses, but that progress was slow due to a lack of qualified nurses applying for jobs within the care sector. She acknowledged that the current situation placed all the nursing leadership responsibilities on one member of staff, which effectively took them off the floor in terms of providing care. Staff told us that the senior staff on the residential unit were also engaged in duties that took them away from
the direct care provided to people. This had an impact on the number of staff providing care to people at times throughout the day. This was significant when taking into consideration the complex and high support needs of the people living at the service.

The high number of people with complex support needs living at the service had a significant impact on the numbers of staff required to meet people's needs. We concluded that number of staff on each shift, and how they were currently deployed, was not sufficient to meet people's needs in a safe and timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the six months leading up to this inspection there were an increased number of concerns raised with the Local Authority Safeguarding Team and with us at the Care Quality Commission about the care provided to people at Beaumont Park. Some of these concerns met the local authority`s threshold for a safeguarding enquiry under section 42 of the Care Act 2014 and went on to be partially or fully substantiated. Others were either found to be unsubstantiated or were passed back to the service to investigate and make improvements as found necessary.

Staff we spoke with had an understanding about their role and responsibilities regarding safeguarding people from potential harm or abuse and were clear about what signs might indicate a person was at risk of, or had experienced harm. However, the increase in safeguarding concerns indicated that staff had not always recognised when people's needs were not met safely, and where acts of omission may constitute neglect. We discussed this at length with the management team over the two days of the inspection. The management team recognised that issues relating to staff practice and effective recording of the care provided had impacted negatively on people's experience of care. To address this, they were working with staff to improve their record keeping skills, and their understanding of their responsibility to ensure people received appropriate care in line with their care plans. Staff were receiving further training on safeguarding people from harm to refresh their knowledge, and we saw that staff meetings and group supervisions were used to underline the importance of providing safe, good quality care.

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have had about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed.

Following a recent review of care documentation by the management team, personalised risk assessments for each person had been reviewed and updated to give stronger guidance to staff on any specific areas where people were more at risk such as falls, nutrition, pressure areas, and mobility including those for people supported to move by staff.
Records were available that confirmed gas and electrical equipment had been regularly checked to ensure they were safe for use. Equipment including moving and handling equipment were also checked to ensure they were safe for use. Regular fire safety checks were carried out, including fire drills, and each person had a personal evacuation plan to ensure they could be evacuated safely from the building in the event of an emergency.

We saw that the provider had systems in place to support learning from when things went wrong. A log was kept of all incidents, accidents and near misses and these were analysed to identify any patterns or themes. The interim manager told us that they used incidents, accidents or errors as a learning opportunity. For example, recent incidents where poor record keeping had been identified led to further staff supervision and guidance about the importance of record keeping and as a result, more accurate records were being kept. We noted through our review of records that this was the case, although there was still room for some improvement to ensure all care provided was documented accurately.

We checked a sample of staff recruitment records and found that all the necessary pre-employment checks to ensure only suitable staff were employed had been completed. These included recent photographic identification, two references, with one from the most recent employer, a full employment history and a disclosure and baring check(DBS).

People and their relatives told us they felt safe at Beaumont Park. People said, "I do feel safe. It's 24-hour care here, that makes me feel safe. If I go in the garden or lounge I have a buzzer round my neck." and, "I have never seen anything to make me feel unsafe in the three years I have been here." A relative told us, "I come here three times a day and I have never seen or heard any unkindness."

People's medicines were managed safely because there were systems in place for ordering, recording, storing, auditing, and returning unrequired medicines to the pharmacy. Medicines were administered by nurses or senior care staff who had been trained to do so. We reviewed a sample of medicine administration records and saw that these were completed correctly. There was guidance on how staff should manage 'as and when required' (PRN) medicines to ensure people only received these as intended by the prescribing physician.

We noted that some bathrooms had been used to store equipment such as wheelchairs, hoists and a plastic mattress. It was not clear whether or not these bathrooms were in use, but this could have created a trip hazard for people attempting to use the toilet unaided. The service was clean and well maintained. Housekeeping staff had a robust system in place to ensure that the premises remained clean and that people were protected from the risk of infection. Staff had sufficient understanding of good practice in relation to infection control, and were seen to follow current guidance during the course of our inspection. We saw they used personal protective equipment (PPE), such as gloves and aprons when assisting people with personal care, and disposed of these appropriately once the task was completed. Waste and laundry were managed appropriately in relation to infection prevention and control, and staff were seen to wash their hands before and after providing support to people.

Requires Improvement

Is the service effective?

Our findings

Before this inspection we received concerning information in relation to skills and experience of key members of staff employed at the service. We discussed these issues with the interim manager and the Regional Clinical Support Manager who acknowledged they had been made aware of this. They were able to demonstrate that a programme of support and development had been put in place to assist the staff concerned to develop their skills. The programme included robust competency assessments to ensure that they had a good understanding of their learning.

Most staff told us that they received sufficient training to enable them to meet people's needs effectively. Members of staff made comments such as, "Training here is pretty good." and, "They're really hot on training here." Some staff felt that there was too much emphasis on online training and that more face-to-face training would have been more beneficial to them in gaining knowledge at greater depth. However, another member of staff told us that the provider was positive about requests for training and made efforts to identify ways in which staff could take up opportunities to develop their skills.

The interim manager told us that, when they had first started working at the service, they had found training had not been kept up to date for many staff. They had addressed this as a priority and now felt the completion of relevant training was moving in a positive direction. We looked at the training record for all care staff working at the service and found that approximately 80 percent of staff were up to date with training the provider considered mandatory, such as moving and handling, fire safety, safeguarding adults and health and safety. This was an improvement on the percentage noted by the interim manager several months ago.

The provision of training relevant to the needs of people living at the service, such as dementia awareness, the management of challenging behaviour and training in relation to specific chronic medical conditions people in the service lived with had not been completed by all staff. A member of staff told us that they would have been more confident to meet people's needs if they had received training about how their conditions affected them, and how their illness might progress. We discussed this with the regional manager, who was open to looking at further training for staff in relation to the specific needs of people living at the service.

We saw that managers had produced a document that identified when staff`s supervision and appraisals were due. This showed that, until recently, some care staff had not received formal supervision or appraisal in the last two years. We saw evidence that the interim manager ensured that supervisions and appraisals were now starting to take place regularly and staff confirmed this. Staff who had recently had supervision told us they found it useful and that it covered issues such as training needs, professional development, concerns, paperwork and confidence in caring for people.

The provider had an induction process for newly appointed staff and staff we spoke with confirmed this had been useful in supporting them to familiarise themselves with their role and the needs of the people using the service. On the day of the inspection a member of staff was shadowing a more experienced staff on shift

as part of their induction. They confirmed that, as well as this, they were having training and spending a week at another of the provider's services to get to know how the provider operated their services.

Before this inspection we received concerning information about a lack of support offered to people in relation to hydration. There was concern that people may not have had access to adequate fluids and this was sometimes because water jugs made available in people's rooms were left out of reach. There was also concern raised that fluid intake charts were not being recorded accurately. We looked at these issues during the inspection.

We checked whether people had a drink within reach in their rooms and found that all the people able to support themselves to drink had a full jug and a glass within reach. Some people who required support to drink did not always had a glass within reach, but we saw that records showed that most people had received regular support from staff to have enough to drink. During the course of the inspection we did note that one person, who required thickened drinks due to swallowing difficulties, had not been supported to have their drink. It had been left on the table beside them and because of leaving it for too long, it was too thick to swallow. This was brought to the attention of staff who replaced the drink with a fresh one. We did find that some fluid records had unexplained gaps, which may have indicated that the person had not had a drink. We saw, however, that the interim manager had recently introduced hydration calendars and that, where people's fluid was monitored, action was taken if the total amount of fluid taken was below the recommended intake. We saw that cold drinks were available at all times in the communal areas of the home, and tea and coffee were offered to people regularly throughout the day. Over the recent hot summer months, the interim manager confirmed there had been no hospital admissions from the home due to dehydration. We were therefore satisfied that adequate processes were in place to ensure people had enough to drink.

Before the inspection, we received concerning information about the quality of the food provided by the home. At the inspection, the interim manager told us that the service had been without a permanent chef for a period of time and this had resulted in an increase in dissatisfaction about the quality of the meals. A permanent cook was now employed and had been working with people to understand what they wanted to eat. However, the feedback about the food still varied. One person told us, "The food is not that nice; the choices are not very good. I ask for omelettes If I don't like what's on the menu. I haven't eaten my breakfast this morning; the porridge tasted burnt, and my cup of tea was cold." This contrasted with what another person said, "The food is lovely I eat like a horse!"

We looked at the menus for September 2018 and found that the menu was varied and offered alternative choices, including a vegetarian option for each day. We observed that the chef participated in a 'Resident's Focus Group' to discuss people's views about the food to support them to incorporate their suggestions into future menus. A choice of appetising snacks, such as home-made scones and muffins were offered to people regularly throughout the day to ensure that people were not hungry. We observed that there was a choice of hot meal provided at lunchtime. Food was served warm, appeared to be of a sufficient quality and quantity, and most people seemed to enjoy their meal. The menu was on display to help remind people what meal options were available and we saw that people could request an alternative if they did not like anything on the menu.

At lunchtime we noted that additional non- care staff, such as housekeeping staff, supported people at mealtimes to ensure they received assistance in a more timely way. Although we noted that some people waited a long time for their meals, when it arrived support was offered quickly to those people who needed it to ensure their food was still warm. We noted that staff supported people appropriately, going at the person's pace and engaging well with them. The atmosphere in the dining room was calm and staff and

people chatted together creating a comfortable and social environment. Some people were eating their meals in their rooms and we noted that, where it was needed, staff supported them appropriately.

Information had been sought from people during their initial assessment regarding their food preferences and dislikes, as well as any allergies, specific dietary requirement related to health conditions, cultural or ethical beliefs and whether assistance was needed with eating. Care plans were developed which took account of this information and kitchen staff also kept a record of this information to enable them to meet people's dietary needs.

People's needs had been assessed prior to admission in line with legislation and up to date guidance. The assessments identified people's needs in relation to issues such as eating and drinking, mobility, skincare, emotional wellbeing and mental health, personal care, specific health conditions and communication. This information had been used to develop a care plan to support staff to understand how to meet people's needs. There was evidence that the support of specialist professionals had been sought in relation to people's needs, such as Physiotherapists and Speech and Language Therapists, and that their advice was reflected in people's care plans. Care plans were in the process of being rewritten across the whole service. Those we reviewed clearly showed that people or others who knew them well, had been consulted in the development of these documents.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where it was assessed as appropriate, DoLS applications had been made to the supervisory body in line with legislative requirements. We saw from records that, where a person was believed to lack capacity to make a specific decision, capacity assessments were completed and best interest decisions were made by the relevant professionals and family members. Staff we spoke with had an understanding of the MCA and DoLS, and were able to tell us how this legislation impacted their work. We saw that staff asked people for their consent before providing care, and took time to support people to understand what they were saying. Where people lacked capacity, we saw staff talking through and showing them what they were doing before they did it.

Beaumont Park is a period property adapted across two fully accessible floors and a good size garden. People's bedrooms were appropriate to their needs and personalised to their taste. There were several well - appointed communal areas throughout the premises which enabled people to have privacy with visitors and family members somewhere other than their bedroom.

The needs of the people using the service had changed over recent years and the service now supported more people who were living with dementia. We found the environment required improvement to support the needs of people living with dementia. This was in relation to signage, décor and supporting them to find their way around the building, and to identify where various rooms were located. We discussed this with the

management team, who acknowledged that supporting the needs of people living with dementia was a challenge for the service currently and that work was required in this area.

The service and other healthcare providers worked together to meet the health-related needs of people who used the service. We saw from records that people had support to access health care from community health professionals such as opticians, GPs and chiropodists, and the complex care team.

Requires Improvement

Is the service caring?

Our findings

Although staff were kind and gentle in their approach, they were not deployed effectively to ensure people's needs were met in a timely manner. This had a negative impact on people's experience of care at the service. People, relatives and staff we spoke with during the inspection told us that the staff were very busy and did not have time to chat with people. One person said, "They just don't have the time to chat." They told us that care was frequently delayed or rushed because staff had too much to do at busy times of day. This left many people waiting an unacceptable amount of time for basic care, such as support to get up at the time they preferred. A relative told us, "[Relative's] commode has still not been emptied sometimes when we come at lunch time. We put that down to short staff." This did not demonstrate respect for the person or protect their dignity.

However, people told us that most staff treated them with respect and promoted their privacy and dignity when supporting them with personal care. One person said, "They are very respectful; they do cover me up when washing me. I get washed in bed," Everyone we spoke with confirmed that staff respected their privacy and did not intrude on their private space. One person confirmed this by saying, "I'm not bothered who comes to help me they are all nice; they always knock on the door. I leave it open but they still knock." The newly updated care records we looked at had clear prompts for staff to remind them to respect people's privacy and dignity at all times.

People and their relatives told us that staff were kind and carried out their role with compassion. People said, "They are all very caring towards me; I have no complaints; I wouldn't change a thing. I stay in my room and they always come to say hello (name), are you ok? do you need anything? I am well looked after." and, "I am totally dependent on these people here, they are very kind and gentle." and, "They are awfully good to me."

During the inspection we found that staff engaged with people in a caring and respectful manner. Although staff were busy and exchanges were brief, there was warmth and genuine interest shown towards people and staff clearly knew each person well. People told us that staff took advantage of any opportunities to have chats with them whenever possible, and often when providing assistance. One person said, "We have a good chat when I am in the shower."

People were supported to maintain their independence and to be involved with the day to day running of the home if they wished. One person explained how staff supported them when needed but ensured they continued to do as much for themselves as possible. They said, "They let me keep my independence as much as I can. I wash the parts I can reach and they help with the rest. They show me different things from my wardrobe and I choose what I want to wear." Before lunch we saw one person setting the tables. They later told us, "I like to set the dining tables at mealtimes; they know that's my job and they like me to do it."

People we spoke with said they were supported to make decisions about their care, such as whether or not they wanted a shower, what they wanted to drink and what they wished to wear.

People were supported to maintain contact with friends and relatives, and relatives we spoke with told us they felt welcome and involved in their relative's care. We saw a number of visitors during the day and noted that they appeared comfortable and relaxed when speaking with staff.

Requires Improvement

Is the service responsive?

Our findings

Before this inspection we received concerning information about the quality of the care plans at Beaumont Park. This related to lack of detail, personal information and in some instances, a lack of care planning in relation to specific care needs people had including health conditions. At this inspection we found that some significant improvements had been made to care planning documents although some work was still required to ensure that adequate guidance was in place to support staff to know how to assist people in relation to some care needs. The interim manager told us that they had also been concerned that the quality of the previous care plans were not good and were very task led and not focussed on the individual person they were written for. The concerns raised with us had also been shared with the provider, who in response had undertaken to review and rewrite the care plans for every person who used the service. At the time of the inspection, this work was almost complete, with just two or three care plans still to be rewritten.

The updated care plans we looked at were person-centred and gave staff very detailed information on what care people needed. The documents were divided into sections covering areas of need such as communication, eating and drinking, mobility, personal care and needs related to specific health conditions. The information included details of what people could do for themselves and how they liked care to be provided such as, which soap to use, or whether or not the person liked to use a flannel. There was also a heading entitled' What a good day looks like for me', which detailed how staff could know when they had met the person's requirements in relation to that particular need.

Although the care plans were a clear improvement on the previous documents, we found some areas where more detail was required to ensure staff understood how to work responsively to people's needs. For example, the care plans we looked at for people living with dementia did not clearly state what type(s) of dementia the person was diagnosed with, or how it impacted on them. Different types of dementia can present in very different ways and staff would have benefitted from understanding how each person they worked with, who was living with dementia, was affected by it.

We found that some people who were prescribed antipsychotic medicines did not have care plans in place to guide staff on supporting people to manage their behaviour, and the role of antipsychotic medicines in this. The interim manager started to put these in place as soon as we raised this matter with them. One person did have such a care plan, but it was not sufficiently detailed in relation to strategies staff should try before resorting to antipsychotic medicine as a last resort. We discussed this with the interim manager who confirmed this plan was 'a work in in progress'. The care plan instructed staff to record strategies that had successfully reduced the person's distress, noting any known triggers leading up to incidents. Once the information was gathered the interim manager said they would be able to write more detailed care plans. However, we found that staff had not always recorded this information in consistently. Strategies staff used, if any, were not always clearly recorded. When we spoke with staff about this they did have some strategies that they used, but they did not all use the same approach, and it was not always written down.

The lack of clear guidance about this had an impact on one person during our inspection. A person had become distressed and an agency member of staff had administered PRN antipsychotic medicine to them

without consulting staff who knew the person well. In the absence of any clear written guidance the staff member made this decision based on the knowledge that this medicine was prescribed for the person to be given when distressed. Staff who knew the person were able to tell us how they might have been able to assist the person to feel calmer without the use of medication, but this information was lost because it was not written down. This put people at risk of inconsistent care and over use of anti-psychotic medicines.

The service had an established activities team who had developed a good programme of events and activities to support people to maintain their interests and hobbies. The activities coordinator made links with external organisations who supported the provision of interesting and diverse events over the year such as, singers, musicians, live animals and reptiles brought in for people to hold. Children from a local school also came in to visit people. People and relatives we spoke with felt there were opportunities to participate in enough activities to maintain people`s interest and to feel stimulated during the day. One person said, "I love the activities, bingo, quizzes - we have singers come in and he will say 'this one is for (name) it's your favourite, Elvis. I just watch the board for dates and what's happening."

People told us they enjoyed regular days out in the garden, weather permitting, for cake, ice cream and tea, and to check on the home-grown tomatoes and bedding plants that they helped to grow. People also had opportunities to go out on trips to town for coffee or a meal out. People told us staff tried to ensure they were able to participate in activities if they wished to. One person told us, "The staff are good they always come and ask if I want to go to the activities."

The activities coordinators were aware that many people who lived at Beaumont Park were cared for in bed for much, if not all the time and were not able to join in the group activities. To reduce the risk of isolation they provided a number of one to one sessions with people in their rooms carrying out activities, such as reading, playing music and companionship.

The provider supported people well to have, as far as possible, a dignified and pain free end of their life. The provider's care planning systems contained a section about people's needs and wishes for the end of their life. This had been completed in most of the care plans we looked at and included details about people's wishes at the end of their life; who they wanted involved, where they wanted to be cared for, and any religious or spiritual considerations they wanted followed. The interim manager told us that the service took time to explore this with people and their families and gave examples of when good end of life care had been provided. they emphasised that the needs of the family were also considered and supported as far as possible. For example, the service had recently supported a person to come to the service from hospital to support a dignified end to their life. They had supported the person`s family as well and provided the opportunity for them to stay overnight in line with the person's wishes. Within people's care records, a current decision regarding resuscitation was recorded, and where people did not want to be resuscitated, the appropriate Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) authorisation was kept on the person's file.

The provider had an up to date complaints policy and procedure and people we spoke with knew how to make a complaint should they find it necessary, although some were unsure about who the current manager of the service was. One person said, "I don't know who the manager is because I think the last one left. The staff are all really approachable though and I could raise anything with them." Another person said, "I would talk to whoever is in charge. I can speak up for myself if I need to." There was a record kept of each complaint received and we saw that each one had been investigated and responded to in line with the provider's policy. This record enabled the manager to monitor complaints and identify actions that were required to make improvements to the service.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to assess and monitor the quality of the support provided and these had been used to identify shortfalls and make improvements to the service. The interim manager completed regular service audits, such as audits of medicine system, records and training. These systems fed into a service development plan. Members of the provider's senior management team maintained a visible presence at the service and we saw that they regularly monitored the quality of the service through visits and through oversight of the electronic monitoring systems completed by the interim manager every month.

However, we found that the provider not taken sufficient action to address some of the issues we identified at this inspection. The provider had recognised that a full complement of staff had to be retained, despite the service not being full, to support the people living at the service who had complex and high support needs. However, they had not taken any further action to ensure that the staff were deployed in a way that met people's needs in a timely way. No analysis had taken place to identify particularly busy times of day, or how best to use the staff on duty to meet people's needs.

Effective action had not been taken to address how crucial development work, such as the rewriting of all care plans, had impacted on the day to day care provided to people. The increasingly high care needs of people using the service was recognised, but again, information about this had not been used effectively to inform staff numbers at particular times of day. The pre - admission assessment had not been used effectively to ensure the needs of new people coming to live at the service could be met, taking into consideration the needs of people already living at the service. The regional director said that a new dependency tool was being developed by the provider.

Although the manager and provider carried out regular audits of the service, taken effective action to resolve these issues in relation to staff deployment. They had also not identified a lack of training for staff in relation to people's health conditions or the need for work to be carried out to create a more dementia friendly environment. The lack of positive behaviour support including clear guidance on the use of antipsychotic medicines demonstrated that best practice in this area was not being followed. This had also not been identified by the provider's quality monitoring systems and processes. We concluded that the lack of identification and analysis of underlying issues at the service may have contributed to the increase in incidents of poor care and acts of omission reported to the local authority safeguarding team and us over the last six months.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acknowledged that a number of incidents of poor care or acts of omission had taken place and were committed to improving their practices so these issues did not occur in the future. The interim manager was working with staff to address issues of poor practice and record keeping, and clear standards were being set to ensure staff understood what was expected of them. Staff we spoke with welcomed this

and told us that the improved care plans helped them to understand people's needs better. The provider's safeguarding lead had robust systems in place to monitor safeguarding incidents and to carry out thorough, honest investigations when it was required.

From our discussions with the interim manager and the senior management team, it was clear they acknowledged the shortfalls in the service over the last six months. They demonstrated a clear commitment to making improvements and were responsive to feedback, addressing some issues found at the inspection immediately. For example, we identified that one person living with a chronic health condition had not been referred to a specialist healthcare professional. The clinical lead responded to this immediately and made the referral by the end of the day.

During the last six months, the local authority had been providing regular support to the provider to enable them to bring stability to the service and make the necessary improvements. The management team worked cooperatively with the local authority and developed a service improvement plan to address the issues that required improvement at the service. They have kept us informed of this process and the progress they have made. We inspected the service at this time because we were concerned that the provider may not have made sufficient progress towards making the necessary improvements. At the inspection we found that clear improvements had been made. However, further work was still required to ensure care provided was consistently good and changes were embedded fully within the culture of the service.

Record keeping, although better, still required improvement to ensure care was fully documented. The interim manager told us that the current systems required staff to complete more forms than was necessary, which took up valuable time and led to staff failing to complete records reliably. They told us that a review of the recording system was planned to reduce paperwork while maintaining essential records.

Records showed that people had opportunities to provide feedback on the service through a number of means including surveys and resident's meetings. On the day of the inspection there was a focus group taking place, attended by people who used the service and key members of staff including the interim manager. People were able to voice their opinions and seek immediate responses from the manager. We saw that minutes from these meeting were taken and that actions were followed up.

During the inspection we observed people who used the service interacting with the interim manager. It was clear that they had a visible presence in the home and that people felt comfortable to speak with them.

Staff were mostly positive about the support they received from the management team and the provider, although some staff we spoke with felt that the workload they undertook was not always fully acknowledged by management. Staff felt that the interim manager had made positive improvements to the service and that teamwork had improved as a result. One member of staff said, "People (staff) here pull together as a team." Another member of staff said, "I am supported and motivated by the manager. She is approachable and interested. Yes, she is responsive, and she does what she says she is going to do."

Staff meetings took place on a regular basis and staff told us they had the opportunity to contribute to discussions and to share their views about the service and how improvements could be made.

The interim manager told us that they aimed to ensure they worked together in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure the provision of joined-up care.They sent us notifications of reportable incidents as required by the legislation.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Issues contributing to staffing deployment issues and incidents of poor care were not analysed or acted upon effectively to make improvements to the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively to ensure people's needs were met safely in a timely manner