Bamfield Lodge Limited

Bamfield Lodge

Inspection report

1 Bamfield
Whitchurch
Bristol
BS14 0AU

Tel: 01275891271
Website: www.brighterkind.com/bamfieldlodge

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 3 November 2016 and was unannounced. The last full inspection took place in October 2015 and, at that time, three breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to need for consent, person centred care and good governance. These breaches were followed up as part of our inspection.

Bamfield Lodge is registered to provide personal and nursing care for up to 60 people. The service comprises of four units. The Crocus unit provides residential care. The Daffodil and Bluebell Units provide nursing care. The Snowdrop unit provides residential care for people living with dementia. At the time of our inspection there were 60 people resident in the home.

There was no registered manager in place on the day of our inspection. 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. The service is currently undertaking a recruitment drive to appoint a new manager.

At our previous two inspections we found that that people's records were not always completed consistently or correctly to monitor and manage their long term health conditions. The provider sent us an action plan telling us what they were going to do to become compliant. Although improvements had been made this area of their work requires further development.

At our previous two inspections we found that the care plans did not reflect people's individualised needs. The provider sent us an action plan telling us what they were going to do to become compliant. Insufficient improvements had been made. The quality and content of care plans continued to be variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement. This area of their work requires further development.

In October 2015 we found that people's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. Although we found sufficient improvements had been made staff knowledge of Deprivation of Liberty Safeguard authorisations required improvement.

Medicines were not managed safely. We saw gaps in some Medicine Administration Record (MAR) charts where staff had omitted to sign to confirm they had administered medicines as prescribed. The service was not following the provider's own policy in relation to covert administration. Topical medicine charts were in place, but these had not been consistently signed to indicate that people had their lotions and creams applied as prescribed.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. Staff were supported through an adequate training and supervision programme. People told us they felt safe living in the service.

People had access to on-going healthcare services. Records showed when people were reviewed by the GP, district nurse, tissue viability nurse, speech and language team and the dementia well-being team. Referrals for advice and support were made in a timely manner and when people's needs changed.

People told us the staff were kind, caring and respectful. Comments from people and relatives included, "The staff are all good" "They [the staff] are lovely to me" and "I'm pleased to be here, the staff are so kind." Throughout the day, we saw and heard kind, caring and respectful interactions between staff and people living in the home. Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

People spoke positively about the activities offered and told us the programme was varied and enjoyable. A range of activities was offered to people and the weekly programme was displayed on notice boards.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Where issues of concern were identified they were taken forward and actioned. People and their relatives and friends told us they knew how to make a complaint.

The acting manager was well respected by staff, people and their relatives and they saw him regularly. The acting manager communicated with day and night staff about operational issues that needed to be addressed. The provider sought feedback from people so that they could evaluate the service and drive improvement.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not managed safely.

Risks to people using the service were managed appropriately so that people were protected from harm.

Records showed that a range of checks had been carried out on staff to determine their suitability for work.

Staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not protected people against the risk of poor or inappropriate care as inaccurate records were being maintained.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Staff were supported through an adequate training and supervision programme.

People had their physical and mental health needs monitored and had access to healthcare professionals according to their specific needs.

Is the service caring?

Good

The service was caring.

People told us the staff were kind, caring and respectful.

People appeared calm and relaxed in the presence of staff.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans did not reflect people's individualised needs.

Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

People spoke positively about the activities offered and told us the programme was varied and enjoyable.

A complaints procedure was in place and the acting manager responded to people's complaints in line with the organisation's policy.

Is the service well-led?

Requires Improvement

The service was well-led.

The acting manager was well respected by staff, people and their relatives and they saw him regularly.

The regional manager visited the home regularly and compiled a monthly visit report. Clear action plans were evident and timescales given to areas in need of attention.

People were encouraged to provide feedback on their experience of the service.

Bamfield Lodge

Detailed findings

Background to this inspection

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

This inspection took place 3 November 2016 and was unannounced. The last full inspection took place in October 2015 and, at that time, three breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to need for consent, person-centred care and good governance. The service was rated as 'requires improvement'. The inspection was undertaken by three inspectors.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas.

We spoke with 10 people that used the service, three relatives and 11 members of staff. We also spoke with the acting manager, the regional support manager and the regional manager.

We reviewed the care plans and associated records of six people who used the service. We also reviewed the medicines administration records (MAR's) of the people who lived at the home. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

Medicines were not managed safely. We saw gaps in some Medicine Administration Record (MAR) charts where staff had omitted to sign to confirm they had administered medicines as prescribed. We saw three charts with missing signatures on three different dates. One of these had three consecutive gaps on 21, 22 and 23 October 2016. We checked the medicine dispensing system in use and the medicines were not there. Although we were told they had been administered, the staff member should have signed to confirm this had happened.

Some people using the service were having their medicines covertly. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medicines by administering it in food and drink. As a result, the person is unknowingly taking medicines. The provider's policy detailed the process that should be followed if covert administration was being considered, including a best interest discussion with carers, relatives, the person's GP and a pharmacist. We looked at the documentation in place to support covert medicine administration for two people. For one person there was evidence of a best interest discussion taking place, but the date this had taken place was 30 July 2015. The documentation contained nothing to indicate that a pharmacist had been involved in the discussion. It had been documented that a review was due on 30 October 2015, but there was no evidence to show that this had taken place. We were informed by the acting manager that the person was not having their medicines crushed, but when we observed the medicine round, the nurse did crush the medicines and administered them. The majority of the person's medicines had been prescribed in liquid form, but four were not. The MAR chart instructed staff to crush one of the medicines, but did not have this instruction in relation to the other three. Although one was a capsule and couldn't be crushed, the others were tablets and the nurse confirmed they did crush them. Another person was also receiving their medicines crushed and given covertly. No best interest decision making process had been documented and there was no evidence of pharmacist input. Crushing medicines without a pharmacist approval could adversely affect the way a medicine affects the person and also means it is not being administered according to its licence. The service was not following the provider's own policy in relation to covert administration. This placed some people at risk of receiving medicines in an unsuitable form.

Topical medicine charts were in place, but these had not been consistently signed by staff to indicate that people had their lotions and creams applied as prescribed. For example, one person had been prescribed a cream three times a day to be applied to their leg. However, the chart showed that for the five days prior to our inspection the cream was applied only once on four days and twice on one day. Another person had been prescribed an ointment three times a day but for the five days prior to our inspection the chart had not been signed at all on two days, signed once on two days and signed once on one day. We saw other charts that had also not been signed by staff as frequently as they should have been. This meant there was a risk that people were not having their topical medicines applied as prescribed.

Medicines audits were being undertaken. We looked at the latest internal audit dated 20 June 2016 and the latest pharmacist advice visit dated 20 October 2016. Although the pharmacist audit identified the issues we noted in relation to covert and crushed medicine administration, this had not been identified in the internal

audit. The missing signatures on MAR charts had also been noted during the pharmacist audit, but not identified during the internal audit. Although we saw "Missing signature audit tools" at the front of MAR charts, these had not been completed to highlight the missing signatures that we had noted.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were stored safely. PRN (as required) protocols were in place to inform staff when people might require additional medicines such as pain relief. In addition, there were homely remedy protocols in place which had been countersigned by the GP to indicate when "over the counter" medicines could be administered without a prescription.

Risks to people using the service were managed appropriately so that people were protected from harm. The majority of the care plans we looked at gave clear guidance and information to staff on how to reduce risks to people whilst also supporting their independence. Examples of risk assessments that we saw were falls risk assessments, mobility risk assessments, skin integrity risk assessments and malnutrition risk assessments. Where risks had been identified, the information within the plan was clear and had been reviewed monthly. For example, in one of the plans we looked at, the person had been assessed as medium risk of falling. The plan detailed exactly how staff should support the person when assisting them to move from the bed to chair in order to prevent a fall. We saw that one person had bed rails in place. There was a risk assessment completed in relation to the use of the rails and that there was a consent form in place. However, there was no explanation within the plan for why bed rails were considered necessary. We discussed this with the acting manager during our inspection and they agreed that this information should be added.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms clearly identified the nature of the incident, immediate actions taken and whether any further actions were required, such as updating the person's care plan and risk assessment.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults.

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. The service did not use agency staff and unexpected absences were in the main covered by existing staff. One member of staff told us; "Staffing levels are better than they were and are generally maintained. There are less people when they call in sick." People commented positively about the staffing levels and people who had lived in the service for some time told us that staffing had improved in recent months. One person told us, "There are always staff popping in for something or for a chat. They even sort out my flowers." A relative commented, "There always seems to be staff around, they don't seem short." One person commented that, on occasion, they thought staffing might be a little short at night. They said sometimes, but not often, their call bell may take a little longer to be answered. They told us this didn't happen often. Another person told us, "Always staff about if I need and at night just need to press my buzzer." The service is also currently undertaking a recruitment drive to appoint a new home manager.

The staff we spoke with had a good awareness and understood their responsibilities with regard to safeguarding people from abuse. They were able to explain how they would recognise different types of abuse and the actions they would take if they suspected a person was being abused. One member of staff told us, "I wouldn't hesitate [to report if they suspected abuse] and I know the manager's would follow it up" and "The phone numbers for whistleblowing and for safeguarding are up in the staff room." Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

People were cared for in a safe and clean environment. Staff knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons were available and we observed staff using it prior to assisting people with personal care.

People felt safe living in the service. Comments included, "My family used to worry about me when I was at home, but they know I'm safe now" "Oh yes I feel really safe" and "You hear such awful things [about care homes] but I have to say, I'm pleased I'm in this one." One relative told us, "She's doing well since she's been here, safer than at home."

Personal Emergency Evacuation Plans [PEEP} were in place in people's care plans. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

Requires Improvement

Is the service effective?

Our findings

At our previous two inspections we found that people's records were not always completed consistently or correctly to monitor and manage their long term health conditions. The provider sent us an action plan telling us what they were going to do to become compliant. Although improvements had been made, this area of their work requires further development.

The documentation in place in relation to how staff dealt with behaviour that could be distressing to others using the service and to staff, was not robust and did not provide the level of detail required to demonstrate that staff were knowledgeable about how to deal with these incidents. For example, in one person's care plan it had been documented "can become highly agitated and may exhibit challenging behaviour. Has a behaviour chart in place". The guidance for staff on how to deal with this behaviour and how to keep themselves and other people using the service safe was to "offer reassurance". There was insufficient detail to clarify the meaning of providing reassurance for this particular person. There was no recorded detail of what might trigger the agitation or how staff should assist the person to de-escalate it. Although behaviour charts had been completed by staff, the only trigger that seemed to have been identified was documented as "being here". In addition, it had been documented that staff could administer medicine to relieve the agitation, but did not detail what steps should be taken prior to giving the medicine.

In another person's care plan it had been documented that they "can become aggressive during personal care". But the guidance for staff was limited to "needs simple instructions" and "when becomes distressed, offer a drink or sandwich". Again, the information was limited and did not provide staff with enough detail on why the person might become distressed or enough detail on how to assist them.

Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. We looked at the records for one person where staff had documented within the care plan that the person was unable to eat and drink independently. The guidance for staff was "needs full assistance and staff to encourage to eat and drink." The plan also informed staff the person should be encouraged to drink 1500mls per day. The fluid intake charts for this person did not reflect the guidance within the plan. On 2 November 2016, it had been documented that the person had drunk 700mls in total. This intake, which was less than half the daily target, was not referred to within the daily record for that day. It was therefore unclear how concerns in relation to the person's fluid intake were escalated or acted upon. We looked at the chart for another person having their fluid intake monitored. Their care plan did not give staff any indication of the target fluid intake during a 24 hour period. The fluid intake for 1 November 2016 had been recorded by staff as 790mls, but in the daily review notes, staff had documented "eating and drinking well". The acting manager informed us that a "fluid champion" had been introduced who was responsible for checking people's fluid intake. Despite this there was no evidence that the information had been noted and escalated to a senior member of staff. The lack of information meant there was a risk that people might not have enough to eat or drink.

Wound care plans were in place and these were clear and well written. However, the quality of the wound photographs was not always good. In one care plan we looked at the photographs of the person's wound

were clear. They had been dated and it was easy to see the improvement over a period of time. However, in another person's plan the photographs were very blurred and it was not clear how staff would know what the wound had previously looked like. We showed these pictures to the acting manager who agreed that the pictures were not clear.

There continues to be a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Staff told us they had received DoLS training. Most of the staff we spoke with had a basic understanding of what was meant by DoLS. However, most staff were not able to tell us who had DoLS authorisations in place . Staff not having full knowledge of the DoLS authorisations could undermine people's rights. This area of their work requires further development.

Staff had received MCA training and understood they needed to obtain consent from people before they provided support with personal care or treatment. For example, a member of staff asked one person, "Are you ready [to get up] yet, if not I'll come back in a while if you like." The person had eaten breakfast in bed and the member of staff was checking they were ready to be supported to get up. Care plans contained decision specific mental capacity assessments.

People told us they made choices and decisions about their care. They told us they decided when they got up, where they spent the day, where they had meals, and when they went to bed. One person told us, "They [the staff] try to persuade me to spend time in the lounges with the others but I prefer to stay mostly in my room. I'm never bored."

Staff were supported through an adequate training and supervision programme. Supervision is where staff meet one to one with their line manager. We reviewed staff records which demonstrated that recent staff supervision had been conducted. This meant that staff received effective support on an on-going basis and development needs could be acted upon.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, infection prevention, health and safety, food hygiene and safe handling of medication. The training records demonstrated that staff mandatory training was up to date. Staff were in the main positive about the supervision and training they had received. One member of staff told us, "I love it here. I've had good training and was really helped to settle in when I started." Some staff thought they would benefit from more challenging behaviour training. One member of staff told us; "Staff are not equipped to deal with challenging behaviour. It would help if staff are better trained."

People had access to on-going healthcare services. Records showed when people were reviewed by the GP, district nurse, tissue viability nurse, speech and language team and the dementia well-being team. Referrals for advice and support were made in a timely manner and when people's needs changed.

Good

Is the service caring?

Our findings

People told us the staff were kind, caring and respectful. Comments from people and relatives included, "The staff are all good" "They [the staff] are lovely to me" and "I'm pleased to be here, the staff are so kind."

Throughout the day, we saw and heard kind, caring and respectful interactions between staff and people living in the home. For example, we heard one person say to a member of staff, "I don't want to be a nuisance." The member of staff replied, "You're never a nuisance. It's a pleasure to be able to help."

We observed the breakfast and lunchtime service. Staff were aware of the people who liked to eat the same breakfast each day. One person told me, "They ask me, just to check, and I have porridge every day." We saw people offered choices of cereals, porridge, toast and full cooked breakfasts. Another person commented, "I didn't want what was on the menu and they cooked me a cheese omelette."

We saw that people were not rushed and where they needed support, this was done sensitively and with kindness. One person who had lost weight was encouraged to eat at lunch time. The care staff and the catering staff were aware of the person's weight loss and tried to persuade the person to eat a meal. Alternatives were offered and the catering team tried to persuade the person by offering their known favourite foods. The person continued to decline the meals on offer and agreed they would eat the dessert. The catering and care staff gently encouraged the person throughout the meal time.

We did note one exception to the predominantly caring nature of the staff. We observed one staff member who assisted two people with their meals with no interaction, other than "open your mouth." They did not inform people what the food was, did not ask if they were enjoying it, and proceeded to assist them with their dessert without informing them they were doing so. In addition, they left food uncovered whilst they went to get something and did not ask the person if the food was at an acceptable temperature. We discussed this with the acting manager during our inspection and they said they would address this with the staff member.

We heard a member of staff kindly reassuring a person who was unsure where they usually spent the afternoon after they had eaten lunch. The member of staff spoke quietly to the person and told them, "If you like, I'll come back for you when you've finished and see if you want to go back to your room or if you would like to join in the bingo." The person looked relaxed and reassured and continued to eat the rest of their meal.

Staff told us how they provided care and support that was kind and respectful and how they made sure people's dignity and right to privacy was maintained. Staff gave examples such as, "I always make sure they [people receiving care] are treated with respect. Small things like checking we do things the way they want" "Always make sure doors and curtains are closed and that people are warm enough" "It could be my nan and I know how I would want her to be cared for."

People appeared calm and relaxed in the presence of staff. Staff took time to stop when they were passing

people, sometimes just to check they were comfortable.

We observed staff were kind and patient with one person who declined to get dressed and was sitting in the communal lounge partially wrapped in blankets. The person insisted staff bring all of their clothes from their bedroom into the communal area so they could choose what to wear. Staff accepted the behaviour of the person, which could be challenging at times, and respectfully and courteously responded to the person's and requests.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people choice and encouraged independence. One member of staff told us; "[Person's name] is lovely. Her communication is affected by her dementia. She has a wicked sense of humour and picks who she likes. She responds to some people better than others. You must pay attention. She's very particular and likes to take her time and not to rush. She will tell you if her clothes are not folded properly."

The activity staff told us they really tried to get to know people well, and they had recently introduced a 'wishing well' into the home. The idea was that people could make a wish. For example, one person expressed they had always wanted to go skiing. They were not physically able to do this. The activity staff were exploring ways this could be provided through a games console.

Requires Improvement

Is the service responsive?

Our findings

At our last two inspections we found that the care plans did not reflect people's individualised needs. The provider sent us an action plan telling us what they were going to do to become compliant. Insufficient improvements had been made. The quality and content of care plans continued to be variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Documentation within care plans was not of a consistently high standard and was not always person centred. For example, in one person's plan it had been documented that their personal hygiene needs were that they "would like to feel clean at all times" and "staff to give a choice of clothes". There was no information in relation to whether the person preferred a shower or bath or a strip wash. There was no detail of how they liked to dress, whether they liked to wear jewellery or make up. The life history section for this person was also not completed. In the same person's plan within the medication section, it had been documented that they were prescribed a pain relieving patch, but there was nothing documented to say where the person experienced pain or why.

When people had been assessed as being at risk of choking, speech and language therapist (SALT) advice was sought. However, it was not clear how this information was shared with staff, including kitchen staff. For example, one person had been reviewed by the SALT team on 31 October 2016. Their recommendation was for the person to have a smooth diet and normal fluids. In addition the recommendations stated "maximise nutrition with supplements by adding butter/cream/whole milk". We asked the kitchen staff what information they had been provided with in relation to this person's dietary requirements; they were unaware that butter, cream and/or milk should be added to this person's meals

People were not consistently involved in their care plans or in the reviews. Although the plans we looked at had all been reviewed monthly, there was no evidence to show whether people had been asked if they felt the plan met their needs. There was also nothing to indicate if relatives had been invited to be involved in care plan reviews. However, it was clear from care records that relatives were kept well informed about people's care. For example, it was documented when staff contacted relatives to inform them about people's wellbeing.

We were told by the acting manager that the service is at the preliminary stages of introducing a regular 'resident of the day' system which will focus on a particular person on a rotational basis. The family of the person will receive an invite to attend the service to speak in person about their family member. The person's care plan will be audited and will spend time to speak with key departmental heads such as the acting manager, the chef, housekeeping and maintenance staff to ensure the service is sufficiently meeting their needs. Owing to the system not being fully implemented people told us they were not routinely involved in formal care plan reviews. They told us they had yet to be invited to go through their care records with staff.

There continues to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people had been assessed as being at high risk of pressure area breakdown, care plans detailed how staff should prevent this happening. When people had air mattresses in place, there were photographs in people's rooms of the correct mattress setting. This system was working well and all of the air mattresses that we checked were at the correct setting. When care plans instructed staff to change people's position regularly, position charts were in place. These were all up to date and showed that people had their positions regularly changed in order to minimise the risk of pressure sores developing. In addition, SSKIN bundles were in place which is a nationally recognised five step model for pressure ulcer prevention.

People spoke positively about the activities offered and told us the programme was varied and enjoyable. A range of activities was offered to people and the weekly programme was displayed on notice boards on each of the three floors. One person commented they could not read the programme displayed and would prefer their own copy to be delivered to their bedroom. Where people chose not to, or were unable to participate in group activities one to one support was provided in people's rooms. The activity staff told us about the support they provided for one person who was not able to join in the group activities. They told us they found out the person's favourite song. They told us they recorded the song and either played it or hummed or sang it gently to the person when they visited them in their room. They told us the person responded positively and their enjoyment was evident.

An activity folder provided details of the activities people had participated in and their reactions, responses and feedback were noted. This information was written into people's individual records each week and reviewed each month.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Where issues of concern were identified they were taken forward and actioned. People and their relatives and friends told us they knew how to make a complaint. One person spoke positively about the acting manager and told us they were confident any concerns they had would be promptly addressed. They told us, "We can speak with him and we know he will take action."

The service had received a number of compliments. A family member recently commented; "It was a great comfort to all the family to know that she was looked after by such caring and dedicated people."

Requires Improvement

Is the service well-led?

Our findings

This is the third inspection that Bamfield Lodge has failed to fully meet all the regulations. There have also been repeated breaches of the same regulation at these inspections. These include good governance and person-centre care. Since the previous inspection in October 2015 the service has failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. Examples of areas where they failed to implement the actions stated in their plan included; "With the new documentation will be improved audit procedures to raise the standards of completion and content"; and "At this time they (the people using the service) will be consulted on all aspects of their care and will sign the care plan at that point. If they are unable to so a best interests/care plan review meeting will take place and their chosen representative will assist with this process."

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their audit systems had not identified that the continued breaches of the regulations had failed to be sufficiently rectified. Their action plan stated all the actions would be completed by 28 February 2016.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager recently left the service. The acting manager (formerly the deputy manager) was well respected by staff, people and their relatives and they saw him regularly. Most people we spoke with were also aware of the regional support manager providing additional support to the home on a regular basis. Comments included "He allows me to use my initiative and he makes me feel involved"; "If I have any concerns about anything, I go to the acting manager. He's very good; he knows what he's doing"; "I really like him and he's approachable. He genuinely has an open door policy."

The acting manager communicated with day and night staff about operational issues. Agenda items identified action points which needed to be taken forward such as absence call protocol; breaks; induction and manual handling procedures. Staff in the main felt listened to. One member of staff told us; "This is the best company I have ever worked in. The team are genuinely caring. We work really well as a team. We are person centred."

The acting manager also held daily meetings with the heads of departments. The meetings covered a number of operational issues such as arising concerns with people in the service, maintenance, menus and activities. This ensured that each team were aware of any issues that needed to be dealt with on each day. It also allowed the acting manager to feedback any issues arising from their daily management report which involved a tour of the service and a sample review of care plan records.

The regional manager visited the home regularly and compiled a monthly visit report. The visits were used as an opportunity for the regional manager and acting manager to discuss issues related to the quality of the service and welfare of people that used the service. Work was progressing in person centred care

planning and the recent regional manager's report identified that further work was required on the management of medicines.

To ensure the safety of the service regular fire, water, health and safety checks were undertaken. Where improvements were required they were undertaken within the designated timescales set by the management team. Health and safety committee meetings were held to discuss issues and actions regarding such issues as recorded incidents, review of the home audit, fire prevention and training updates.

The provider sought feedback from people so that they could evaluate the service and drive improvement. A recent resident and relatives meeting had been held which enabled an open forum for discussion and enabled people to express their opinions. Future activity plans were discussed such as new external performers and birthday events. People confirmed that they were happy with the menu changes and the on-going progress of the service.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. Annual customer surveys were conducted with people and their relatives or representatives. The service received 30 responses. Some personal care issues were raised by people. The majority of people said they would recommend the service to others and rated the service as good. One person commented; "Overall I feel Bamfield is an excellent care home. The staff are wonderful."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always completed consistently or correctly to monitor and manage their long term health conditions. The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.