Beech Lawn Care Ltd

Beech Lawn Nursing and Res 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Beech Lawn on 18 November 2014, the inspection was unannounced. We last inspected Beech Lawn Nursing and Residential Home on 18 August 2014. At that time there were no concerns in the areas we looked at.

Beech Lawn is a care home for older people who require nursing and personal care. It provides accommodation for up to 44 people. At the time of the inspection there were 37 people living at the home.

There was no registered manager at Beech Lawn. The matron, who had been in post since June 2014 and was working as a nurse on regular shifts at the home. The matron had an application in process to had an application in process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff working at the home understood the needs of people they supported. Visitors reported a good

Summary of findings

relationship with the staff and management who were approachable. However, we noted it was not recorded in care records when people and their families were involved in the planning and review of their care.

The matron had not been in post long and was keen to develop the service. However she was required to work on the floor for much of the time and was limited in how proactive she could be in identifying and dealing with issues. There were quality assurance systems in place to monitor the service but risks were not always identified or action taken to minimise risk.

The matron had not identified the concerns found at this inspection. Staff did not attend regular updates of training such as safeguarding adults and infection control. People's care and medicine records were found available in corridors and lounge areas and were not kept securely.

The atmosphere was friendly and staff and people living at the home were relaxed in each other's company. People told us they liked being at the home and were happy living there. People told us the staff were "very good" and "very kind," they had no complaints.

The premises comprised of three wings. The original house had been extended in 2007 – 08 to add a new nursing care wing. People who used the home for residential care only had their bedrooms in the upper floor of the original building. There was a choice of areas for people to spend time with visitors, take part in activities, or spend time on their own. We saw many people were cared for in bed and did not leave their bedrooms. There was an enclosed outside courtyard for people to enjoy.

During our inspection we observed people looked well cared for and their needs were met quickly and appropriately. Staff addressed people politely and respectfully using their preferred name. We saw staff speak with people as they provided care and as they passed by throughout the inspection. People told us, "I am quite happy here," and "We just sit and watch the television and chat."

The matron and staff had developed positive contacts with other professionals who ensured effective care delivery for people whenever they needed or wanted it.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. Although people said they felt safe at the home, their medicines were not managed safely and safe recruitment processes were not followed at the home.

Risks to individuals living at the home were identified in the care records and managed.

There were sufficient numbers of staff to meet people's needs.

Requires Improvement

Is the service effective?

The service was not effective. Staff did not attend regular updates of their training.

Where people did not have the capacity to consent, the provider did not act in accordance with the legal requirements.

People saw health and social care professionals when they needed to and staff followed their advice. People were supported to maintain a healthy diet.

Requires Improvement

Is the service caring?

The service was caring. People were supported by staff who were friendly, caring and respectful.

People told us staff were patient and kind.

Staff respected people's privacy and supported their dignity

Good

Is the service responsive?

The service was not responsive. Information in care files was not always accurate and did not direct staff when to provide care.

Activities were available to people at the home, however, these were only provided on certain days and did not always relate to peoples hobbies and interests.

People received care in a timely way and staff were not rushed.

People were aware how to raise any concerns they may have with the service.

Requires Improvement

Is the service well-led?

The service was not adequately well-led. The matron had only been in post for six months and was in the process of addressing some issues. However, the matron had not overcome the concerns found at this inspection prior to our visit.

There were no central records held in relation to staff training or supervision and therefore these issues were not monitored.

Requires Improvement

Summary of findings

Accidents and incidents at the home were not audited.

People's records were not kept securely.

Beech Lawn Nursing and Res 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 checked 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.

We visited Beech Lawn on 18 November 2014. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in older people's care. The inspection was unannounced.

During the inspection we spoke with the matron, the clinical lead, eight staff, 10 people who lived at the home, two relatives and an external healthcare professional. We spoke with two relatives after the inspection on the telephone. Many people at the service were unable to communicate with us as they were living with dementia.

We looked around the home and observed care practices on the day of our visit. We looked at four records which related to people's individual care. We also looked at three staff files and records in relation to the running of the home. We reviewed information held by the Care Quality Commission about this service and the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Is the service safe?

Our findings

People told us they felt safe living at Beech Lawn and had no worries about the safety of their possessions. However we found that not all aspects of the service provided was safe.

We looked at the arrangements in place for the administration of medicines. There were not robust arrangements for the recording of controlled medicines that were received into the home. We checked the stock of controlled medicines held against the records kept and found two items had not been recorded in the index of the book of controlled medicines, so it was not clear these medicines were present in the home. This meant the stock could not be accurately checked. Controlled drugs must be managed in a specific way as required by law. These medicines had been received by the home in October 2014, and were found entered under the name of the person for whom they had been prescribed. This error had not been picked up at controlled drug audit checks carried out by the nurses. This meant the audit was not effective.

There was some good practice in managing medicines. Handwritten entries on the medicine records were signed by two people to reduce the risks associated with transcribing information. This was in accordance with the medicines policy held at the home. Some medicines required cold storage and Beech Lawn had a fridge specifically for this purpose. We noted the maximum and minimum temperature of this fridge was recorded daily. This helped ensure that medicines which needed to be kept in a fridge were kept safely. The Care Quality Commission had received notifications about four medicine errors that had occurred at the home before this inspection. This meant the home was identifying errors. Notifications are information the provider must give to the Care Quality Commission regarding events that have an affect on the running of the service and people living there.

The training record did not contain any information about when staff had attended medicine administration training. A week after the inspection we were told all nurses, with the exception of two night nurses, had undergone this training in 2014. The two night nurses were not booked to undertake this training. It is important all staff who administer medicines receive regular training to help ensure they are safe to carry out this task.

However, we found that the home was not managing medicines safely. People told us they received their medicines at the appropriate times. The records did not clearly show when each person had received, or had not required, their medicines. There were 10 gaps in the medicine administration records (MAR) for the period 13 to 18 November 2014. A further four gaps appeared in one person's records for a medicine that was prescribed to be taken when required (PRN), with no indication if it had been offered or refused. We checked the medicine packs for each person who had a gap on their MAR chart and saw all the medicines had been removed from the packs for the doses as prescribed. We were told by the matron; "They (the staff) will have given the medicine but they forget to sign, it is a problem." We saw regular medicine audits took place at the home. Missed signatures on MAR charts had been raised as an issue in June 2014, October 2014 and November 2014. Following the October 2014 audit a process for accounting for missed signatures was begun. The audit stated; "I (a lead nurse) will take on the job of accounting missed signatures and each missed signature will generate a medication error form. The form will be kept within the medication error file." We checked this file and found one form had been completed. We were not given evidence to show that this process was being monitored or what action was being taken against staff who did not sign MAR charts having given medicines.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the files for some new staff. Staff had Disclosure and Barring Service (DBS) checks to check their suitability for working with people living in the home. One staff file, for a person who started working in August 2014, did not contain any references. The matron told us they had taken verbal references over the phone. Nothing was recorded to this effect in the file. Another new care worker who had started working at the home on the day of the inspection was 'shadowing' experienced staff. This staff member was seen attending to people at the home, unsupervised. There was only one reference in their file, and we were told after the inspection this was actually, "the wrong reference from the previous employer" and the reference held related to another person. Their file did not contain any proof of identification; this meant the home could not be certain of the person's identity. The matron accepted this was an oversight.

Is the service safe?

Another member of staff, who worked during the inspection, was a bank care worker. This is a person who is called upon by the home, when necessary, to cover sickness and holiday periods, and does not have set hours. This staff member worked regular hours at Beech Lawn and did not have a staff file available for review. The provider did not operate effective recruitment processes to ensure people were protected from the risk of being supported by unsuitable staff.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they felt they could approach staff with any worries they may have and one person told us, "The staff are very acceptable. All very kind, not pushy at all." The relatives we spoke with agreed with this view. We saw staff responded to people in a kind, patient manner and treated people with dignity and respect.

Staff told us they had not had recent safeguarding adults training but were clear about how to raise any concerns they may have to the matron. Other staff knew where they could raise their concerns when the matron was absent. We saw there were; "Say no to abuse" posters available to people, on noticeboards in the home and in the matrons office. This would assist staff with raising any concerns they may have to agencies outside of the home.

The care records contained detailed risk assessments which were specific to the care needs of the person. For example, there was guidance for staff on how often a person needed to be supported when walking, "Walks with frame, does try but requires help. Risks of falls. (The person) will ring the bell when needing help, use handling belt and provide Zimmer frame." Another risk assessment correctly told staff a person required two staff to move safely. Risk assessments had been regularly updated to reflect any changes in a person's needs. Each person had been specifically assessed for moving and handling equipment, with clear guidance for care staff on the size and type of equipment required by the person to move them safely.

We asked people if they felt there were sufficient numbers of staff to meet their needs. Feedback was mixed. They told us; "Not really, rushed off their feet sometimes," and "Yes on the whole." Visitors and staff told us they felt there were enough staff, although one member of staff said; "We could always use extra help," and; "It's ok until someone goes off sick." The matron told us the home was fully staffed at the time of this inspection. We heard call bells ring and noted the bells were answered promptly. We saw from the staffing rota there were seven care staff and two nurses on in the mornings with a shift change at 2pm. Then five care staff worked through until the two night carer workers and one night nurse came on duty at 8pm. The nursing staff worked eight hour shifts from 8am to 8pm to support the care staff throughout the day. Staff told us that although there were numbers of staff on duty, the workload was not manageable and people did not always have their individual needs met. Dependency assessments were not used to help ensure there were sufficient numbers of staff available to meet people's needs at all times.

There was a programme for servicing equipment such as hoists, stair lifts, fire equipment and alarm systems. We were told new slings, to be used with hoists, had been recently ordered to ensure there were enough to allow each person to have their own sling for their personal use. The home had a handyman who carried out repairs and we saw the staff used a book to report any work that needed to be done. The handyman checked wheelchairs and beds and also did the electrical testing of appliances. A recent fire service check of equipment at the home had resulted in some additional external lighting, additional alarm sounders and heat sensors, being fitted. There was an ongoing plan of maintenance to the home. The premises were adequately maintained and equipment was safe to use.

Is the service effective?

Our findings

Care staff knew the people they supported and were aware of their individual needs and preferences regarding their care and support. However, staff did not receive training to support them to carry out their roles effectively. The information contained in the provider information return (PIR) was not accurate. It stated 55 staff had attended safeguarding adults training in the last 24 months. The matron did not have a central record of staff training that had taken place and when it was due for updating. This was addressed by the matron following the inspection. A training record was created from the certificates of attendance in staff files and was sent to CQC the day after the inspection. We saw from this that 37 members of staff had not received necessary safeguarding adults training updates since 2012. Updates were required by staff in areas such as health and safety, infection control, and first aid. Staff had not attended regular updates of training in areas stated as mandatory by the homes policies, such as health and safety, infection control, and first aid. The matron told us the need for this necessary training would be addressed immediately by supporting staff to access the training. There was no programme of regular individual supervision for staff in place at the home. The matron told us they were planning to introduce one. This meant staff were not provided with one to one time with the matron when issues relating to their work and their ongoing development could be discussed.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The matron worked regularly as a nurse on shifts and provided support to the care staff as necessary. All staff had been given an appraisal in May 2014. Staff meetings took place occasionally, we saw the minutes of the last meeting which took place in October 2014. There was an induction process which new staff told us they found very supportive when they joined the home. Staff underwent a period of shadowing experienced staff before they worked alone. Staff said they felt they could access the matron or the clinical lead nurse at any time if needed and felt well supported.

We discussed the requirements of the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLs) with the matron and other staff. The MCA provides a legal framework for acting, and making decisions, on behalf of individuals who lack the mental capacity to make particular decisions for themselves. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. One person's care file contained evidence of a mental capacity assessment and a best interest decision meeting. This meeting had taken place to reach a decision on behalf of a person at the home and had appropriately included the views of the family and GP in reaching a decision.

Staff had attended Mental Capacity Act training according to the training record we were sent, however staff we spoke with were not clear on this legislation. None of the staff we spoke with, including the matron were clear on the associated Deprivation of Liberty Safeguards. There were people at the home who were not free to leave, and were under constant supervision. Therefore applications to the local authority should have been made for authorisations for their necessarily restrictive care plan. This had not been recognised by the matron.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information in care plans was not always clear and accurate regarding people's capacity and decision making. One care file stated the person was a bachelor and had no children. On the pre-admission assessment it stated, "Daughter will handle all finances," and indicated a "welfare attorney" had been appointed. There was no detail of this in the care plan. Another care file stated on 27 August 2014; "Now unable to make choices for herself, poor communication," then later in the same file on 08 October 2014 it was stated; "Ensure decision making is listened to and staff are respectful of decisions made." There was no evidence of a mental capacity assessment in this person's file to take into account this change. In two people's care files we saw they had been assessed as having capacity to make their own decisions, however, in both files it stated each person required bed rails and "This does not deprive (the person) of their liberty." However the Deprivation of Liberty Safeguards does not apply to people who have capacity and we did not see evidence these people had been asked to consent to the use of bed rails. We also did not see any evidence of involvement of the person, or their representatives, in decision making or care plan reviews. People had initially signed in agreement with receiving care

Is the service effective?

when they first arrived at the home. People were not invited to sign in agreement with their own care plan reviews, or to consent to their photograph being displayed in their care and medicine records.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

We looked at four care files. Information in these records was handwritten and contained a variety of assessments that supported a plan of care and guided care staff to meet people's needs. Information did not clearly inform staff when to provide specific care. In two care files it stated people were at risk of developing pressure ulcers sores and needed "regular" position changes. The plans did not clearly state how often care staff should move these people. We reviewed two turn charts in people's bedrooms. According to the charts the frequency and number of times people were repositioned varied widely from every three hours to over six hours. Staff were not clear about how often each person was to be re-positioned. Neither of these two people had any pressure damage at the time of the inspection. We were told by the clinical lead and matron that care staff did not always record when they provided care to people. This lack of recording and information places people at risk of receiving unsafe care.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We attended the staff handover at 2pm as part of our inspection. The clinical lead discussed each person at the home with the care staff who were beginning their shift, highlighting any changes that may have occurred. During the handover staff demonstrated that they knew people's needs and knew how they liked to have their care provided. Any change in people's needs was shared amongst staff so that the person received the same approach from all the staff.

One person told us; "They (the staff) get things right." Family members told us; "I am very happy indeed, they include me in everything they do, they provide good care and are impressive in the way they handle some of the challenges that (the person) has presented them with," "They are very good at communicating with me", and "It is a great weight off my mind that she is there, we were told it was a good place before we went and they were right".

People's comments about the food were varied. They told us the cook knew what they liked and disliked. Comments included; "The food is variable generally speaking, not too bad. The cooks are very good and make the best of what they have to work with. I have no complaints about the food," "I enjoy the food well," "Food alright, enough and always hot," "Food very good, we get a choice and there is always plenty" and "I have a choice and there is always something I fancy".

People were aware that when the evening drinks were brought around they could also have biscuits and sandwiches and meals were kept back for those returning to the home after mealtime. We saw there were records kept by the kitchen staff about the meal choices made by people, their dietary requirements and how their food should be presented. For example, if a person required their food to be pureed or not.

We observed lunch being served in one of the two dining areas. Lunch was a social occasion with up to six staff available in the dining room to support people with their meal if required. Staff chatted and joked with people in a relaxed manner. Staff sat with people who required support with their meals both in the dining areas and in their own bedrooms. Some people were having their food and drinks monitored due to concerns about their intake. We saw these records were completed regularly by care staff. There were assessments that monitored people's risk of malnutrition.

Whilst people did discuss their health with staff they were unaware of their care plans. People were confident that their health needs would be met, and had all experienced being visited by external healthcare professionals in the past. One visitor was familiar with the care plan for her relative and had been kept informed of changes in their health. We saw in people's care files records of healthcare professional visits, such as district nurses, chiropodist, tissue viability nurses, dentist, audiologist and GP's. One visiting healthcare professional told us "They always call us appropriately now for people who need our advice and treatment, it has got a lot better since the new matron has been there" and "We have no concerns about the care in the home and find the staff to be effective."

Is the service caring?

Our findings

People living at the home were supported by kind, caring and compassionate staff. People told us they were treated with respect. Doors and curtains were closed when care was being provided by staff. Comments included; “The staff are very good, we get on very well” and “The staff are marvellous, don’t interfere and do what we want.”

Family members told us the staff were very attentive and kind, “I am very happy with the care they provide,” “no issues whatsoever, very good,” and “They (the staff) keep me well informed about my mother, I work in the industry so I know how important that is, they are great.” Staff responded in an understanding way to their family member’s needs. One told us “(the person) is not easy sometimes and they (the staff) have been very patient and got good results.” Another told us “I think this is a very good home, I was told to look at it and try to get (the person) in there, when I did so I was very pleased, and have continued to be very happy with the care and kindness they show to (the person) .” People were able to have visitors at any time. During the inspection we saw family members and friends spending time with people in the lounges and in their own rooms.

Staff were observed communicating well with people throughout the inspection. The atmosphere at the home was happy and relaxed. Staff laughed and joked with people as they provided them with support. Some people were not able to leave their rooms and were cared for in bed. We saw staff regularly visiting these people to see if they needed anything and having a chat with them.

Everyone we spoke with told us they were happy with their care and support and spoke positively about the staff and the matron. People told us they received their care in a timely manner, and when they rang their bell for assistance, staff appeared quickly. People told us they were given plenty of time to make choices and decisions for themselves and were not rushed by staff. People were supported to maintain relationships with friends and family. Visitors were welcome to the home at any time. Comments included; ”They (the staff) like to come and talk to me” and “They (the staff) come up and sit on the bed and I tell them stories of my life which I exaggerate a bit”.

People’s preferences and dislikes were clearly seen in their files, and this information guided staff to provide care to people in a individualised way. For example, “Likes cherry aid”, “Likes to sleep on his back,” “Likes to hold a cup” and “Sometimes when poorly (the person) will require feeding.” This helped ensure people received their care in the way of their choosing. Many of the people living at the home were living with dementia and had difficulty initiating conversations and communicating with staff. Life histories are important for staff to understand the background of the person and how it impacts on who they are today, and can support staff with meaningful conversations and activities. However the two life histories we saw in other peoples care files contained useful detailed information about the person’s previous work life and their hobbies. We did not see life histories in two of the care files we reviewed.

Is the service responsive?

Our findings

People were assessed prior to moving into Beech Lawn to help ensure their needs would be met once they arrived at the home. People were spoken with about their needs and preferences and a care plan was drawn up over the first few weeks following their admission. Care plans contained sections on people's health needs, routines, communication needs and personal care needs.

Care staff were able to refer to a shortened version of a person's care plan held on a sheet in the person's room. This ensured staff had easy access to relevant information regarding a person's care needs. Care plans were reviewed regularly. Any changes to a person's needs were transferred to the information sheet held in the person's bedroom. However, the care reviews did not involve the person or their representative and were indicated only by a date and signature of the nurse. There was no record of discussion with the person or their representatives. One care plan had been originally hand written 2 May 2013 and re-dated 11 times without a change being made to the original care plan. There was no indication of how the review took place and who was involved. It is good practice for people to be given the opportunity to be involved in their own care plan and subsequent reviews of their care.

People were not provided with sufficient opportunity for meaningful activity that met their needs

The home had an activity co-ordinator who worked on Monday, Wednesday and Fridays. Social activities for people only took place on these days. They arranged a variety of activities for groups of people and on a one to one basis for people in their rooms. Staff told us; "We don't have time I wish we did," and "We try our best but we are very busy." One person who lived at the home told us; "Nothing much goes on here." The activities on three afternoons a week included bingo, dominos, whist, quizzes, crib, hand exercises, plays and occasional visits from outside entertainers. These activities were not linked to people's hobbies or interests. Several people said they were looking forward to a forthcoming visit from the Looe Fishermen's Choir. Several people said that they preferred to stay in their rooms rather than join in any activities. Others mentioned being taken out by friends and relatives and one lady said she was looking forward to going to a relative's house on Christmas Day. The matron advised that there were opportunities for religious services on two occasions every fortnight. A volunteer from Age Concern visited the home to provide befriending support for people who did not have any visitors.

People told us there were no residents' meetings held to seek their views and experiences of living at the home. The matron confirmed no residents' meetings took place. People told us they saw the matron regularly and could speak with her at any time. Staff told us they spoke with people all the time about their experiences of care and support at the home.

The home had a complaints procedure and this was available in all bedrooms for people to access should they need to raise a concern. The policy outlined the timescales within which complaints would be acknowledged, investigated and responded to. The matron told us there had been one formal complaint received and this had been responded to appropriately and resolved. The home had received compliments recently, the PIR stated inaccurately they had received 12, but the file we were shown by the matron contained two. The matron was not aware of the details of the PIR. Families of people at the home told us they felt able to raise any concerns with the staff and were confident they would be responded to.

Is the service well-led?

Our findings

The matron had not been in post long and told us she was keen to develop the service. However she was required to work on the floor for much of the time and was limited in how proactive she could be in identifying and dealing with issues. There were quality assurance systems in place to monitor the service but risks were not always identified or action taken to minimise risk. The systems in place to ensure the delivery of good quality care required improvement. Information received from the provider prior to this inspection did not reflect the inspection findings. For example, the PIR stated; "staff undertake yearly training and updates" and "55 staff attended safeguarding adults" training in the last 24 months. The training records we were sent showed many staff had not undertaken this training since 2007 with the latest training having taken place in 2012. The service did not have an effective way of monitoring staff training.

Systems for the storage of people's personal information were inadequate. Daily care files were kept on a window sill in a dining area of the home, together with a file containing the personal emergency contact details of each person's families/ friends and their healthcare professionals. Medicines records containing people's photographs were stored on a shelf in a corridor of the home, this information could be accessed by anyone walking past. This meant people could not be confident their personal information was kept securely.

This is a breach of the Data Protection Act 1998. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the beginning of the inspection we asked for information from the matron about the people who lived at Beech Lawn, specifically about which people required regular re-positioning and were having their food and fluid intake monitored. The matron gave us information that was not accurate. We were told there was only one person who required regular positional changes, during the inspection we found there were a number of people who required this care. The matron was not familiar with the needs of people at the home .

A quality assurance survey had been sent out to people in October 2014. The responses to this survey were not available to us at the time of the inspection. The matron was not aware of the outcome of this survey. We were told the provider held the responses and was in the process of collating them and that they would provide a report when this had been completed.

The matron did not have robust processes for monitoring and assessing the service provided at the home. We had concerns about the management of medicines at the home. We discussed this with the matron who was not aware the actions taken following the regular medicines audits had not been effective in addressing the errors found in the administration of medicines .

Accidents and incidents that took place at Beech Lawn were recorded. However, the records of many incidents were found held together in the accident record book and had not been separated out into each person's personal file. This did not ensure the confidentiality of people's information. The service had not audited accidents and incidents and did not have an overview of these events. This did not ensure any trends or patterns would be recognised, addressed and thus reduce the potential risk of re-occurrence.

No central records were held in relation to staff training or supervision. The training of staff was not being monitored to ensure updates were arranged when required. The matron had identified such issues in the home and had sought the advice of Cornwall Council learning, training and development unit to support the home with staff development. In addition they had joined a group of other service providers in Cornwall to share knowledge and gain support for the home .

The call bell system generated reports which could be used to monitor call bell response times. The matron told us they were only used if there was a concern raised about a delay in answering a bell. The system was not used routinely to monitor call bell response times. The matron told us she was always aware when call bells sounded and would respond herself if they were not answered promptly

All the above is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home laundered people's clothing on the premises. The laundry had a system where clothing was collected from people's rooms, washed, dried and returned to baskets which had their room number on them. There were not enough baskets for each person to have their own and

Is the service well-led?

some people had their laundry piled together in one basket containing a few people's clothing. There was a large amount of unnamed clothing stored in the laundry. One person told us; "When something goes missing it usually turns up eventually." This system did not ensure people had their own clothing returned safely after washing. The matron told us they would ensure more baskets were purchased so that there were enough so that each person could have their own.

The matron provided a monthly report to the provider who visited the home regularly to support the staff and the matron. This provider report detailed changes in the number of people at the home, staffing changes, purchased equipment and highlighted issues that required the attention of the provider. The matron told us the provider was responsive to issues that required attention.

The matron had set up a programme of weekly staff surgeries and advertised them to staff to take the opportunity to spend time with the matron and discuss any issues that were important to them. We were told staff had not felt the need to take up this opportunity. Staff told us they were happy working with the matron who they felt provided them with adequate support. In addition staff meetings were held. The minutes of staff meetings did not contain the names of staff who had attended, however, there was no process for passing information shared at the meeting with staff who were not present at the meetings. This meant some staff may not be aware of information relevant to their role.

The matron joined Beech Lawn in June 2014 and was applying to become the registered manager. Staff told us; "things have improved a lot since the matron arrived" and "She is very good and getting things organised." People who lived at the home were complimentary about the matron and said that she was very approachable and helpful. A visitor considered this to be a welcoming and friendly home where the management was open to receiving comments from relatives

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not carry out analysis of incidents that resulted in, or had the potential to result in harm to a service user. Risks were not identified and responded to.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not ensure that records were kept securely and did not maintain an accurate record in respect of each service user. 20 (1) (a) (b) (i)(2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person must protect service users against the risks associated with the unsafe use and**

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Action we have told the provider to take

management of medicines, by mean of the making of appropriate arrangements for the obtaining, recording ,handling, safe keeping, dispensing, safe administration and disposal of medicines. 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person must have suitable arrangements in place in order to ensure staff are appropriately supported to enable them to deliver care and treatment by receiving appropriate training, professional development, supervision and appraisal. 23 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse. 11 (2) (a)