Cooper Residential Homes Limited

Bethel/Bethesda 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection visits took place on 4 and 5 July 2017. The first visit was unannounced and the second was announced.

Bethel/Bethesda Residential Home provides care and support for up to 34 older people. At the time of our inspection 19 people were using the service.

There was a registered manager in place. It is a requirement that the service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we asked the provider to make improvements. We asked them to improve their practices in relation to safeguarding people from abuse and assessing risks. We also asked them to improve their practices in relation to their arrangements for monitoring the quality of the service and notifying CQC of significant events at the service. We asked them to display their most recent rating given by us as this was not in place and is a requirement. Following that inspection the provider sent us an action plan detailing what improvements they were going to make. During this inspection we found that some improvements had been made.

People felt safe living at Bethel/Bethesda Residential Home. Staff knew their responsibilities to help people to remain safe. They took action where they had concerns that a person was at risk from abuse or harm. Risks to people's health and well-being were mainly assessed and reviewed to provide guidance for staff. The registered manager told us they would make improvements to the care records where this was required. Staff took the appropriate action when an accident or incident occurred. The registered manager analysed any accidents or incidents to prevent a reoccurrence where possible.

The provider had not always checked the environment and the equipment people used to help people to remain safe. They were planning to implement further checks to maintain the security of the home.

Staffing numbers were suitable to offer people the care and support they required although we received mixed feedback about this. The organisation of staffing required improvements and the provider told us that they would undertake this. The provider carried out checks on the suitability of new staff to make sure that people were supported by those who had been verified as safe.

People received their medicines by staff who knew their responsibilities for handling them safely.

People received support from staff members who received training and on-going guidance on their work. New staff did not receive a formal induction when they started work. Staff generally felt supported by the

registered manager.

Where there were concerns about people's ability to make decisions for themselves, the registered manager had undertaken assessments to determine people's level of understanding. Decisions made in a person's best interest occurred in line with the Mental Capacity Act 2005. Staff understood their responsibilities under the Act.

People were not always satisfied with the food available to them. The provider had employed a new cook who had spent time asking people about their preferences.

People had access to a range of health care services to help them to remain healthy. Staff took action where there were concerns about a person's health or well-being.

People were cared for by staff who were generally kind. People's privacy and dignity was respected by staff. People were involved in decisions about their care. Information about advocacy services was not available to them. Staff knew the people they supported and encouraged them to retain their skills.

People received care and support that was mainly centred on things that mattered to them. They had opportunities to take part in activities that they were interested in. The provider was working with the local authority to improve activities for people who were living with dementia.

The environment and some staffing practices were not always helpful for people with memory difficulties. The provider was making changes to improve this.

People contributed to the planning of their care where they wanted to. People's care was reviewed although the recording of people's involvement was an area the registered manager said they needed to improve upon. People had care plans that were centred on them as individuals.

People and their relatives knew how to make a complaint or to raise a concern. The provider took action when one was received.

People and staff had opportunities to give feedback on the quality of the service. People and their relatives told us that some improvements had occurred at the service since our last comprehensive inspection. We found that further improvements were required.

The provider's quality checking of the service had not identified some of our concerns that we found during our visits. The provider had implemented and were developing a range of checks to drive improvement.

The registered manager was aware of their responsibilities. They had submitted the required notifications to CQC.

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 consistently safe.

People felt safe and were protected from abuse and avoidable harm by staff who knew their responsibilities for supporting them to remain safe.

Staff did not always have the guidance they required to help people to remain safe where there were risks to people's health and well-being.

The provider had safely recruited a suitable number of staff. The provider was planning to review the organisation of staffing to make sure staff were deployed suitably.

People received their medicines when they required them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who were trained and received on-going guidance about their role. Staff did not receive a formal induction when they started working for the provider.

Where people did not have the mental capacity to make decisions for themselves, the provider followed the requirements of legislation.

People were not always satisfied with the food offered to them.

People had access to health care services.

Is the service caring?

Good

The service was caring.

Staff were generally kind and they respected people's dignity and privacy.

Staff knew the people they supported and involved them in decisions about their care.

People were supported to maintain their abilities.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received support that was mainly centred on them as individuals. The environment and some staffing practices were not always helpful for people with memory difficulties.

People's care was reviewed although the contribution by people was not recorded.

People had access to activities that were being developed by the provider.

People and their relatives knew how to make a complaint and the provider took action when one was received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and staff had opportunities to give feedback on the quality of the service.

Staff received support and were aware of their responsibilities.

The provider had not carried out sufficient checks on the quality of the service. They had not always identified areas that required improvement.

The registered manager understood their responsibilities under their registration with Care Quality Commission. They were taking action to make the required improvements to the service.

Bethel/Bethesda 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 was a comprehensive inspection. The inspection visits took place on 4 and 5 July 2017. The first day was unannounced and the second announced. The inspection was carried out by an inspector and an expert by experience (ExE) An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, we reviewed the information that we held about the service to plan and inform our inspection. This included information that we had received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We contacted social and health care professionals and Healthwatch Leicestershire (the consumer champion for health and social care) to ask them for their feedback about the service. We received feedback and took this into account when making our judgements.

We spoke with five people who used the service and with six relatives. We also spoke with the nominated individual, registered manager, three senior care workers, three care assistants, an activities co-ordinator and a cook. A training professional was present when we visited and we asked them for their feedback.

We observed care and support being provided so that we could understand people's experiences of care. We looked at the care records of six people who used the service. We also looked at records in relation to people's medicines, as well as documentation about the management of the service. These included policies and procedures, training records and quality checks that the registered manager or provider had undertaken. We looked at two staff files to see how the provider supported and had recruited their

employees.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found that one person had made a serious allegation. The nominated individual told us that staff had not acted in line with the provider's policy to protect people from abuse. This was because there was a significant delay in staff reporting the allegation to a manager. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safeguarding service users from abuse and improper treatment. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

Staff knew their responsibilities for helping people to remain safe. This was because the provider had made available to them a process to follow should they have concerns that a person was at risk from abuse or avoidable harm. Staff could describe the types of abuse people might be subject to as well as their responsibilities. One staff member told us, "If I had concerns I would go straight to the manager, I would document it and get witness statements if needed. I could phone CQC [Care Quality Commission] if needed and I have phoned things through [to the local authority]." We saw that the registered manager had shared information without delay with the local authority where there were concerns about a person's health or well-being. We found that the provider's safeguarding policy required an update as it did not cover all of the different types of abuse that staff needed to be aware of. The provider told us they would make amendments.

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found that risks to people's health and well-being were not routinely assessed or reviewed. We also found that the provider was not doing all that was practicably reasonable to mitigate risks to people's health and well-being. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safe care and treatment. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made some of the required improvements.

Staff told us that one person could make accusations about them that were untrue. As a result of this they told us that the registered manager had given guidance to them on how to support this person. One staff member explained, "We are having to go in in twos as [person] complains about staff a lot. It's part of the care plan." We found that specific guidance for staff to follow had not been documented in the person's care plan or risk assessment. This was important so that staff had clear guidance about how to support the person. The registered manager told us they would arrange for a risk assessment to be completed. We also found that one person's risk assessment to move from one position to another was not clear about the type of equipment they required. The registered manager told us they would review the assessment. We found that there were other inconsistencies in people's care records. One person was described as requiring a soft diet in one part of their care plan. In another section of their care plan a pureed diet was listed. For another person they were described as requiring support to change from one position to another every four hours in one part of their care plan. This was to keep their skin healthy. In another section of their care plan this was

detailed as needing to be undertaken every two hours. The registered manager told us they would review the risk assessments and guidance for staff to make sure the correct information was available.

We found that other risks to people's health and well-being were assessed and reviewed. Where people were at risk of injury to their skin due to them not being able to move independently, measures were in place. A relative told us, "Staff change [person's] position in bed every two hours. [Person] has no sores or ulcers." Records we viewed confirmed this support occurred consistently. We also found that where people required encouragement to drink so they did not become unwell, staff were offering this support. One staff member told us, "Repositioning is definitely happening as it should be. If people need more fluid we try different things such as ice poles, bowls of ice cream and yoghurts." We found that staff were knowledgeable about the guidance available to them and we saw them following it when we visited. For example, staff assisted people to move from one position to another using equipment. They did this safely and in line with the assessments in place.

Some people, their relatives and staff told us that staffing numbers were not sufficient. One person said, "There is not enough staff." Another said, "No there isn't enough staff. At night there are two or three staff and they are on the other side of the home. I can hear them laughing and giggling but they don't come here [other side of the home]." A relative commented, "They could do with a few more staff. I feel sorry for them they are so stretched. Staffing is lower on the weekend. Staff cope very well." A staff member told us, "It's okay but we could do with one more. People don't have to wait too long. I don't think it's dignified when they have to wait."

We found that staffing numbers were suitable when we visited. We saw that people's call bells were answered quickly and people confirmed they did not have to wait for care and support when it was requested. One person told us, "During the day somebody is always around. They [staff] respond to the buzzer." We were given feedback that the allocation of staff to tasks that required to be undertaken could be improved. One staff member told us, "The ratio is good. We have a problem with leadership. Some staff take the back seat and there's no delegation. We have a shift planner but not everyone is doing the delegation." Another staff member said, "A few of them [staff] are a bit lazy. They could be doing more. There are enough carers, it's the way it's sorted." We gave feedback to the nominated individual and registered manager about the comments we received. They told us they felt that improvements to the arrangement of staff on shift could be improved and they would look to review this.

The provider had not always arranged for checks on the environment and the equipment people used to take place. We saw that equipment to help people to move position was serviced. We found that an electric bath required a service and the nominated individual told us they would arrange this when other equipment was due to be serviced. We saw that the safety of the gas, electricity and hot water temperatures had been checked. We also saw that the fire detection system was routinely tested. We found that fire signage to help people to locate fire exits were not always in place. The nominated individual had made improvements by our second visit. The provider told us that they were introducing weekly fire extinguisher checks to make sure they were effective should there be a fire.

The front doors to Bethel/Bethesda Residential Home were open throughout the day time when we visited. The provider told us that people were able to access the outside space when they wanted to and that staff supervised the communal areas. However, on two occasions during our first visit, the areas around the doors were not always supervised by staff. This meant that there was a risk that those not authorised to be in the home could enter. The provider told us they would look at their security arrangements to make sure that all people who entered the residential home were checked for the reasons for their visit.

People felt safe living at Bethel/Bethesda Residential Home. One person told us, "The carers make it safe. I have never seen bad behaviour by any staff." A relative said, "Staff come quickly if [person] rings the buzzer. [Person] can reach it. [Person] also has safety mats and a motion sensor in the room." They told us these measures helped their loved one to remain safe.

The provider had systems in place to support people safely should an accident or incident occur. We saw that appropriate action had been taken following a person falling including seeking specialist support to prevent a reoccurrence. The registered manager told us that they analysed all accidents and incident at the home to look at ways of reducing them. They said "I look for patterns but there aren't any at the moment." The provider had plans in place so that the service could continue to operate in the event of an emergency such as a fire. These detailed the specific requirement each person would need to remain safe which staff were knowledgeable about.

People received their medicines when they needed them. One person told us, "I get medication regular. Staff give them to me. They record it. They always ask me if I want any paracetamol." We observed a staff member administering medicines. We found that they did this safely. The staff member checked if people required pain relief. We heard them ask a person, "Have you got any pain or discomfort?" After each person had taken their medicines, the staff member recorded the administration in their medicine records. We viewed ten people's medicine records and found them to be completed accurately. The administration of medicines was in line with the instructions provided to staff by healthcare professionals. We found that medicines were stored safely and there were good systems to check that people had enough of their medicines available to them.

Staff knew their responsibilities when supporting people with their medicines. For example, staff knew what to do should they make an error. This was because the provider had made available to them a procedure to follow in the safe handling of medicines. We saw that staff had received training and their competency was checked to make sure they continued to work safely when handling medicines.

The provider followed its processes when recruiting staff. We found these to be safe. One staff member told us, "I completed an application form and did an interview. They asked for two references and the DBS [Disclosure and Baring Service] check is now completed." We saw that two references were sought for each new employee as well as the provider undertaking a DBS check before new staff started to support people. The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. This meant that people could be sure that only staff suitable to support them were employed.

Requires Improvement

Is the service effective?

Our findings

People had mixed views about the food available to them. One person told us, "I have said I would like better food." Another person said, "Food can be horrible. You can get a jacket potato with cheese or a jam sandwich for tea. Who wants a jam sandwich for tea?" Another person commented, "The food is okay but I don't like some things and leave it." Some people were satisfied with the food offered to them. One person told us, "Lunch was good today. The sweet was good." People's relatives felt that improvements were needed to the food available to their family members. One relative said, "The food does lead to some questions. A lot comes out of the can. There are very few fresh vegetables." Another told us, "The food today was cold and tasteless." People told us, and we saw, that a variety of drinks were available to them.

We saw that five out of the seven people sat in the dining room during a mealtime declined the main meal and chose an alternative of a jacket potato. We fed back the comments we received and our observations to the nominated individual and the registered manager. They told us that a new cook had just been appointed. We were shown questionnaires that people were supported to complete to ask them about their food preferences. We spoke to the new cook. They told us that they were developing the menu to be based on people's likes. They told us, "With the new menu I went around and asked people and listened to them. I also have ideas for how to improve the menu."

We found that people's food and drink requirements were detailed in their care plans and also within a folder in the kitchen to guide staff. Where there were concerns about a person not eating or drinking enough, staff recorded what people had eaten or drank so that they could monitor the amount. A staff member had devised a new chart to monitor this which was to include the amount of drink each person required each day. This was so that staff could prompt when this was required to assist people to drink more. Where specialist advice had been sought, we found that the guidance provided was being followed by staff.

The provider did not record new staff's induction when they started to work at the service. We found that new staff undertook key training but a record of an induction was not in place. The registered manager told us, "New staff have no formal induction but they do the mandatory training. They have supervision to check how they are getting on." They confirmed that staff were shown around the home and read the provider's policies and procedures. They told us they would record new staff's induction for those who were due to start at the service in the coming three months. They also told us that they were looking at the Care Certificate for any new staff that had no experience of working in care. The Care Certificate is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector.

We found that staff received on-going support and guidance from the registered manager. Care staff had supervision where they received feedback on their work. Topic areas covered included training requirements, key policies and procedures and service user discussions. This meant that there were opportunities for staff to reflect on their practice in order to look at how they could provide good care and support to people.

People were supported by staff who had received training to gain the knowledge and skills they required. One staff member told us, "They've got much better. Fire training is more often and my moving and handling has been refreshed." A training professional said, "The staff are sent on NVQ [National Vocational Qualification which is a nationally recognised qualification] courses and training. For example, fire safety. The owner is hot on that." Staff were complementary about the training offered to them. One staff member told us, "It's really good and if you're not sure you can ask for help to understand." We saw that staff completed training in topic areas such as helping people to drink well, fire awareness, care plan writing and assisting people to move position. The registered manager told us there were on-going plans to offer infection control, first aid and dementia awareness training to those staff who required it. We saw that some of these courses were due to start in September 2017.

People were asked for their consent before care or support was delivered. One person told us, "Staff ask permission before washing me and I can understand what they say to me." We heard staff say things to people such as, "Would you like me to help you?" and, "Can I just adjust that for you?" We saw that staff listened to people's choices and decisions about how they wished to spend their time and respected these. We saw that consent forms were completed where people could agree to their care.

The Mental Capacity Act (MCA) 2005 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. We checked whether the provider was working within the principles of the MCA.

We found that the provider was meeting the requirements of the Act. The registered manager had completed mental capacity assessments where there were concerns about a person's mental ability to make a specific decision. Such assessments were completed in areas including people's medicines and where bed rails were in place. Where a decision was required to be made in a person's best interest, this was undertaken with key people in the person's life. One person's mental capacity assessment and care plan had conflicting information. The registered manager told us they would update the information as the person's mental capacity fluctuated over time and the recording of this was not clear to guide staff. They also told us that they planned to make improvements to their recording to document that they had seen legal agreements for a representative to make decisions on a person's behalf where this was in place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider had made applications to the 'supervisory body' (the local authority) where they were seeking to deprive some people of their liberty.

Staff understood their responsibilities under the MCA. One staff member told us, "You're deemed as having it or not. If not, a best interest decision is put in place. And DoLS if there's a need. There was a best interest decision for a person about their medicines. The GP, psychiatrist and assessor were all involved." Staff knew that there were restrictions in place for some people and as a result, what action needed to be taken. One staff member said, "We have bed rails in place and there are crash mats for falls as well. It's all assessed. There's a DoLS in place for these if they can't decide for themselves."

People were supported to maintain their health. One person told us, "If [person] needs a doctor then reception calls them immediately." Another relative said, "We have seen doctors visiting here." We saw that staff took action where they were concerned about a person's health which included contacting a doctor.

We also saw that people had access to a range of healthcare services such as opticians, chiropody and a dietician's service. We saw that people had emergency grab sheets in place. These detail people's specific social and health care requirements for those who may not know their needs should a hospital visit or admission be required. A healthcare professional gave positive feedback about staff supporting people to remain well. They told us, "They follow the instructions we give." In these ways people's health was promoted.

Good

Is the service caring?

Our findings

People told us that staff were generally kind and caring. One person said, "Staff are caring. All of them." Another person told us, "I like the staff. They know how to care for me. I like them. I feel very safe here." A further person told us, "They [staff] are kind to me and gentle when they wash me." A relative commented, "Staff are caring. They talk to mum and involve her. They smile, show manners and listen." A training professional told us, "I see a lot of good practice, they do care. They are caring in their approach." We saw that staff spoke with people in a caring way and listened to people's concerns and worries. We also saw that people's rooms were personalised and contained things that mattered to them to help them feel at home.

We saw that there were times when staff were focused on tasks which meant that on occasions, people were not always spoken with and they spent periods of time without engagement from staff. For example, during a meal time we saw that only one staff member out of three was speaking with people for the first part of the meal. When the dessert arrived we saw that the dining room atmosphere was more relaxed and some conversations started to occur. On the second day when we visited, we saw that staff engaged with people more freely and we heard laughter and good conversations between staff and people. One staff member commented how staff were nervous about the inspection and this had affected some staff.

People were supported by staff who knew how to protect their dignity and privacy. One staff member told us, "I close the doors for personal care and gain consent to administer one person's eye drops in a communal area." We heard staff asking people discreetly if they required support to freshen up. When staff were assisting people with intimate care, they took care to make sure that doors were closed. When we visited we saw that staff knocked on people's doors consistently before they entered and spoke with people in a dignified and professional manner. We saw that people's care records were stored securely so that their private and sensitive care records were not available to those who should not have access to them.

People were supported to be involved in decisions about their care and support. One relative told us, "Staff drop into the room and have a chat with her about things. They involve her in activities in the home." Another relative said, "The staff here are caring and ask her what she wants." We saw that people's care records documented how people had been offered personal care or specific activities and the responses to these. People's decisions were respected and we heard staff upholding these when we visited. We saw that information on advocacy services was not available to people. An advocate is a trained professional who can support people to speak up for themselves. The nominated individual told us that they would look at providing information for people.

Staff knew the people they supported. One person told us, "The staff know me well and support me. I need help getting washed and dressed and they do it." Two people thought that staff knew them less well than when they had first moved into the home but were not unduly concerned about this. Staff told us how they got to know the people they cared for. One staff member said, "I know the people. I go in and sit with them or just observe. There are mini care plans for new people. I talk to the person and their family too." We saw that care records generally contained information on people's life histories and things that mattered to them. We also saw that people's hobbies and interests had been recorded to help staff when offering their

support. We observed the staff handover from one group of staff leaving their shift to another coming onto theirs. Staff were knowledgeable about the people they supported and carefully shared information about how each person had been that day.

People were supported to maintain their skills. People told us that they were encouraged to manage as much as they were able to for themselves. One person said, "Yes definitely I do as much as I can. I do everything I can." A training professional told us, "I saw staff supporting a person to walk up and down the corridor to help them to be more mobile. The person said they had enough and so they took them back to their room."

Requires Improvement

Is the service responsive?

Our findings

Where people had memory difficulties, we found that the provider had not always made adjustments to the environment and practices of staff to help people. For example, we saw that not all rooms were labelled with an indication of what each one was. This is important so that people can orientate themselves around the home. We also saw that a daily menu was not on display for people and that they were asked the previous day for the following day's food choices. Staff described this as unhelpful. One staff member told us, "The day before people are asked what they want. We have a lot of discrepancies as people forget or say they didn't order it." The registered manager told us they would stop this practice following our feedback and ask people on the day what they wanted to help people who had memory difficulties. They also said that they would look at displaying the menu using pictures to aid people's understanding.

People mainly felt that they had contributed to the planning of their care where they wanted to be included. One person told us, "On the odd occasions I have wanted to discuss care they have sat and talked with me." Another person said, "I haven't seen my care plan or asked for it. My relative asked to see all the information and she was given it and she read it." One person told us that they had not had any discussions about their care. During our last inspection we found that it was not always documented how people had contributed to the planning of their care. We found this still to be the case.We spoke with the registered manager who told us that care plans were discussed with each person where they wanted this to occur. They told us that they would make improvements to document this to show where people had been consulted.

People's care was reviewed by staff and this was documented in their care records. A relative commented, "The staff said last week that the care plan had been updated." Other relatives considered that staff kept them informed about their family members' changing requirements. Staff members told us that people were involved in reviewing their care when changes occurred. One staff member said, "Reviews are monthly by the person who has written the care plan. Residents are only involved if changes need to be done." During our last inspection we found that it was not always documented how people were involved in reviewing their care. We found this still to be the case. Although we saw that people's support requirements were reviewed, staff did not record when they had discussed people's changing needs with them. The registered manager told us that they would make improvements.

We saw that sometimes staff were sat in small groups whilst some people spent large parts of the day alone with little or no activity offered to them. We saw that the activities co-ordinator was absent during our first visit but was at work the following day. They told us they normally worked Monday to Friday and encouraged people to join in the activities. Staff told us that activities were being developed to make sure that people spent time in ways that mattered to them. The registered manager told us that the local authority's Quality Improvement Team were assisting staff in developing activities and approaches for people living with dementia to reduce the risk of social isolation.

Most people had opportunities to take part in activities that they were interested in should they choose to. One person told us, "I prefer my own company and stay in my room. Staff do invite me to come to the lounge." Another person said, "Occasionally I go to the common room and join in bingo, things like that. A

girl organises one thing every day for Monday to Friday. Nothing on weekends." A relative commented, "[Person] does chair exercises, joins in bingo and also goes to the flower and gardening club. She reads her paper, watches television. She does what she wants to do. Plenty of activities. She also goes to holy communion." We saw that some people were assisted to join in activities in the local area and pictures were on display of past activities that people had enjoyed. Notices of upcoming events that were planned were also displayed. We saw records of one to one activities for people who spent time in their own rooms. These activities included general chatting and hand massage.

People received support from staff that was mainly responsive to their preferences and support requirements. One person told us, "Yes you can sort of have choices. Such as activities. I can sleep anytime. I choose what clothes to wear." Another person said, "I prefer a bath and get one weekly. I could have more if I wanted. You have to pre-book it. I enjoy it. It's like a physiotherapy bath." Other people told us that they had choices on the food options and on the times they woke and went to sleep. We saw a staff member assisting a person to eat a meal. The staff member was making conversation with the person and assisted them at a pace that allowed the person to chew, swallow and taste the food. We also heard some staff speaking with people about things that mattered to them when they offered their support in people's own rooms.

The provider assessed people's care requirements before they were offered a place at Bethel/Bethesda Residential Home. This was so that they could be sure they could meet each person's support needs. We saw that pre-admission assessments took place. These detailed each person's key support requirements and were used to develop a comprehensive care plan for each person.

People had care plans that were centred on them as individuals. We saw that they mostly contained information on people's support requirements and routines that were important to them. This was important so that staff had the guidance they required when supporting people. We found that staff demonstrated a good understanding of the information within people's support plans and they followed the instructions they had been provided with.

People were supported to maintain relationships that were important to them. One person told us, "My relative comes to visit. She is good to me. She can come anytime" All of the relatives we spoke with told us they could visit their loved ones without undue restriction.

People and their relatives knew how to make a complaint or to raise a concern should they have needed to. One person told us, "I would raise it with the carer or owner." Another relative said, "We raised concerns about her fall on the floor. It led to equipment being available for [person]. We were listened to." We saw that the provider had a complaints procedure that was displayed for people and their visitors so that they knew the procedure to follow. The provider had received one complaint since our last visit in January 2017. We found that they took action to the satisfaction of the person.

Requires Improvement

Is the service well-led?

Our findings

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found that the provider did not always notify without delay significant events to CQC as required in the carrying on of a regulated activity. This was a breach of Regulation 18; notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements. They had submitted statutory notifications for significant events at the service. These help us to determine if the provider took the necessary action required.

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found that the provider did not display within the service the most recent rating by CQC. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; requirement as to display of performance assessments. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

During our visits we saw that the ratings poster from the previous inspection had been displayed in a prominent position. The display of the poster is required by us to ensure the provider is open and transparent with people who use the service, their relatives and visitors to the home.

At our previous comprehensive inspection carried out on 26 August 2016 and 1 September 2016 we found that the provider did not have comprehensive systems and processes to assess, monitor and improve the quality and safety of the service for people receiving care. We also found that the provider did not always identify and assess risks to people's health and well-being and that people did not always have accurate, complete and contemporaneous care records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; good governance. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made some of the required improvements.

The provider had introduced a range of quality checks to monitor the service. We saw that care plan audits were being introduced. Where these were in place in some people's care records, they had identified what action was being taken to make improvements. We found that one person's file did not have an audit and, as a result, the provider had not identified the areas we found that required improvement when we visited. The provider had not identified that certain parts of this person's care plan were not complete and that the support required to assist the person to change from one position to another was not current. We found that one person's specialist diet was documented incorrectly and that one person did not have a risk assessment in place that was required to guide staff. However, we found that people were receiving the support they required. This meant that it was a recording issue. The registered manager told us that all care records were being checked and they would make the required improvements.

We found that some of the provider's other quality checks had not identified that the fire signage was not

sufficient and that the actions required from a water survey in 2016 had not all been completed. The nominated individual showed us records detailing that the safety of the water supply had been recently tested and was satisfactory. The nominated individual told us they would make arrangements to improve their quality checking and to undertake the outstanding actions as a matter of priority.

We saw that there were other quality checks in place that were helping the provider to drive improvement. People's medicines and the management of it was checked weekly to make sure that the systems in place were being followed by staff. Where improvements were required of staff we saw that the registered manager was taking action. We saw that both senior staff and the registered manager were undertaking checks that included looking at staffing numbers, observations of the practice of staff and the cleanliness of the home. Actions that were identified were completed. We also saw that accidents and incidents were audited and people's call bells checked to make sure people received the support they required. In these ways, where the provider had checks in place, they were being used to make improvements to the service.

People, their relatives and visitors told us that some improvements had occurred since our last comprehensive inspection. One person told us, "They are trying to improve on little things. They have meetings." A relative said, "There was a new floor put in the lounge and dining room." A training professional commented, "It's progressing. They are focusing on the basics and I've seen them doing lots of work to improve." We received some feedback that further improvements were required. One relative told us, "The place is clean and comfortable. It could do with some modernisation." Another relative said, "I feel the home needs upgrading but it's more about the quality of care and it's quite good."

People had opportunities to give feedback on the quality of the service. We saw that residents meetings occurred where feedback was given to people about changes the provider had made based on the feedback previously received. We also saw that people were consulted about activities and food choices. People told us that some improvements had taken place and that one-to-one discussions had occurred with them to gain their views. Some people felt that their suggestions were not always listened to. We saw that questionnaires had been issued to people during 2017 to check people's understanding of safeguarding and making a complaint. This was following feedback received from people previously that they did not always understand these areas. The nominated individual told us that during 2017 they planned to issue quality questionnaires again to people and their relatives to seek their feedback and that they would take any necessary action.

The nominated individual and registered manager told us that they were committed to making improvements to the service. They told us how they were working with the local authority's Quality Improvement Team to gain support to address the areas that needed to improve. The provider had an open approach to delivering the service. They had shared the last comprehensive inspection report with people in the service user guide that was given to people who resided in the home. We found that the provider learnt from mistakes that had occurred. An example of this was that some medicines errors had occurred. We saw that the registered manager took action to retrain the staff member who had made the error and supervised them to make sure they were safe when handling people's medicines. This demonstrated good leadership.

Staff generally felt supported by the registered manager. One staff member told us, "The manager is very approachable. It always helps. The door is always open. It's improved. I'm quite happy working here." Another staff member said, "If I've got a problem the manager is approachable. They support me. If I have a problem I can talk to them. It's good support." Staff confirmed that they had opportunities to give suggestions to the registered manager about how the service could improve and that these were considered.

Staff knew their responsibilities. This was because the provider had made available to them a range of policies and procedures that they were knowledgeable about. For example, staff knew the action they should take if they were concerned about the working practices of a colleague. Staff also received supervision and guidance on their work as well as attending team meetings where the expectations of them were discussed. We found that staff were also knowledgeable about the provider's aims and objectives. We read that the provider sought to promote people's dignity and independence as well as providing care that was based on each person's specific requirements. A staff member described their understanding. They told us, "To provide a home from home. For people to develop new skills and for them to have social interaction. Also to maintain their independence for as long as possible." We found that the provider and staff were working to make improvements so that they could meet all of the specified aims of the service.