Bupa Care Homes (CFChomes) Limited

Beacon Edge Care Home

Inspection report

Beacon Edge
Penrith
Cumbria
CA11 8BN

Tel: 01768866885

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20 April 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 19 and 20 April 2017 and the inspection was unannounced.

At our last inspection of Beacon Edge Care Home in November 2016 we found breaches of the regulations in relation to person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, good governance and staffing. We rated the service as "Inadequate" and the service was placed into special measures. Following this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

Beacon Edge Care Home is registered to provide accommodation for people who require nursing and personal care for up to 33 people, some of whom may be living with dementia.

Accommodation, at the time of our inspection, was provided in single rooms all on the ground floor of the home. There are potentially 5 bedrooms on the first floor, but these were not in use as bedrooms at the time of our inspection. There are bathroom and toilet facilities throughout the home as well as two communal lounges and one dining area. At the time of our inspection there were 24 people using the service.

The service should have a registered manager but has not had one since July 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection, in November 2016, we found that medicines were not handled safely and people's health was at risk of harm. During our inspection on 19 April 2017, we saw that some improvements had been made with regards medicines. However, not enough progress had been made to ensure that all people were receiving their medicines safely and were protected from the risk of harm.

The care records that we reviewed showed that risk assessments, including assessments in relation to falls risk had taken place. We found that they had not consistently been reviewed and updated. We found that people using the service continued to experience falls, bruising and injuries.

We found improvements to the care plans of people who could at times display inappropriate behaviours. Advice and support from health care professionals had been sought and included in the care planning process. However, we observed that the advice had not always been followed by the staff supporting these people.

We noted that staff recruitment protocols, induction and staffing levels had improved since our last inspection. We also found that staff received support and supervision with regards to their work. However, there remained gaps in staff competency checks and aspects of staff training and development.

People were not always supported to have maximum choice and control of their lives but staff tried to support them in the least restrictive ways. DoLS authorisations had been applied for or were in place where relevant. The policies and systems in the service supported this practice.

At our last inspection we found that people had not always been adequately supported with eating and drinking. At this inspection we found some improvements, particularly around the deployment of staff at meal times and communication with the catering staff. However, concerns remain with the dining experience for people and the management of people at risk of malnutrition.

At this inspection we observed that staff treated people in a friendly and caring manner. People told us that they thought the staff cared about the people they supported. Health and social care professionals commented that people were looking better cared for and appeared more relaxed. We observed that the nurses in charge of the shift were well organised and demonstrated a professional manner. We also observed that staff were not always mindful of protecting people's dignity, particularly during moving and handling processes nor were they effective in communicating with people who had limited verbal communication skills.

At the time of this inspection people had limited access to social and leisure activities because the activities co-ordinator was not at work. We observed staff trying to provide one to one activities with more able people and there was a musical entertainer in the home at the time of our visit. Activities were confined to the communal areas.

Staff and relatives told us that they had been kept up to date with the proposed changes and sale of the home via meetings with the managers. People were optimistic about the proposed changes.

At the last inspection of the service we found that the service did not have an effective system in place to monitor and improve the quality and safety of the service. The provider had given us a plan of the actions they intended to take to help make sure the service improved, although some of the timescales for achieving compliance with the regulations were too long. At this inspection we found that there had been some improvements made. However, we found that quality monitoring systems had not been robustly and effectively applied.

We found continuing breaches of the regulations in relation to safe care and treatment, safeguarding people from abuse and improper treatment, staffing, meeting nutritional needs, person centred care and good governance.

Additionally, we have made a recommendation about supporting people to access meaningful activities. At our last inspection we made some good practice recommendations but the provider had failed to acknowledge these.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments had not consistently been reviewed and updated as people's needs changed.

Accidents and incidents were not consistently managed, recorded or reported as appropriate.

Although some improvements had been made to the ways in which medicines were managed, there were still times when people did not receive their medicines as their doctor had prescribed.

There were a sufficient number of staff deployed at the home. This helped to ensure people's needs were met in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Nutritional assessments, monitoring and record keeping were poorly managed.

Staff had been provided with training to help update their skills and knowledge. Supervisions and appraisals had commenced but there remained gaps in the processes for checking staff competencies.

Improvements had been made to help improve staff understanding and application of the Mental Capacity Act 2005, particularly in relation to the deprivation of liberty safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff approached people who used this service in a friendly and kind manner. We found that people looked better cared for and appeared more relaxed.

We observed that people did not always receive dignified care.

Staff had been provided with information about care planning for end of life care but had not received any specialist training on this subject.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual care plans had mostly been reviewed and rewritten.

Care and support was not always provided as described in people's individual care plans.

Where advice had been sought from health care professionals, this had not been followed with any consistency.

Is the service well-led?

Inadequate

The service was not well led.

There is no registered manager at the service.

The provider had developed an action plan to help bring about improvements, but these had not been implemented expediently.

The principles of good quality assurance were inconsistently applied. This has impacted on the provider's ability to drive improvements.

Beacon Edge Care 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.

The inspection took place on 19 and 20 April 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors, a pharmacist inspector 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.

Prior to the inspection we reviewed the information we held about this service, for example information from the local authority, clinical commissioning group and health and social care professionals. We also reviewed the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During our inspection of the service we spoke to 11 of the people using the service, six relatives and eight members of staff, including the manager and regional director.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of four people who used this service. We looked at the medication records and management of medicines for 11of the people who lived at the home. We also reviewed the staff duty rosters and the recruitment records of one recently appointed member of staff. We looked at the meeting minutes from recent staff, residents and relatives meetings as well as a selection of the quality audits that had been carried out at the home.

We asked the manager to send us further information after our inspection visit. The information requested was in relation to survey results, quality audit reports and information about notifications. The manager sent

this information as requested.

Inadequate

Is the service safe?

Our findings

Two visitors to the home told us about concerns they had experienced. One person said; "Some of my relative's items have gone missing. Some clothes have disappeared, their dentures (but these have now been found) and then their glasses went missing. They had to have new ones." The other visitor told us; "When I've been in I have seen some staff being a bit rough at times with moving residents about. My relative has suffered bruising, which I was told had been caused by the hoist."

At our last inspection of this service we found that there were a significant number of people reported as suffering skin injuries and unexplained bruising. The provider sent us an action plan detailing how they would make sure improvements were made with regards to the safety of people using this service. The provider told us that; "Care plans will be fully updated with changes to condition, risk or intervention as soon as possible on the same shift after the event."

At this inspection we found that people continued to suffer from bruising and skin tear injuries. We observed that one person in particular had considerable bruising and skin tears. We reviewed the care plans and risk assessments of four of the people who lived at the home and we observed the delivery of care in some of the communal areas. We found that general risk assessments and falls risk assessments had been undertaken. However, we found that they were not always up to date, relevant to the setting or followed by staff.

We checked the information we held about the service (notifications) and spoke to the local authority about the injuries. The Regulations state that such matters are to be reported to CQC "without delay." We found there were some accidents and incidents that the provider had not reported to us in a timely manner. We discussed our continuing concerns with the local authority safeguarding manager about the accidents and injuries at Beacon Edge Care Home.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. People who lived at the home were not adequately protected against the risks of harm or injury because the provider had not done everything reasonably practicable to mitigate the risks.

We reviewed the records of four people who could at times display inappropriate behaviours. We saw that advice and support had been obtained from the community mental health team. Some of their advice had been included in people's care plans. However, we observed that staff did not consistently follow this guidance to help support people safely at these times. Records showed that some of the injuries people suffered had been sustained during periods of unsettled behaviour. We found that little improvement had been made since our last inspection of this service.

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. People who used this service were not properly protected from the risk of harm or abuse because the systems and processes in place were not effectively utilised.

Following our last inspection, the provider also sent us information about the actions they had taken to ensure medicines were handled safely. At this inspection we looked at how medicines were managed for 11 of the 24 people living in the home. We found that although some improvements were evident, insufficient progress had been made to ensure people were receiving their medicines safely.

We found that medicines were not obtained safely. One person had run out of the pain relief medicines the day before our inspection. This meant that they had not been able to have any pain relief for almost two days.

We reviewed the records about the receipt, stock and administration of medicines. They showed that medication could be accounted for and that most people were given their medicines as prescribed. However, some people were not given their medicines safely. A system had been put in place to record the time people had been given doses of Paracetamol to help ensure a safe time interval between doses. The records had not been accurately maintained and could not show that there was always a safe time interval between doses. Similarly, systems to ensure medicines which needed to be given at specific times with regard to food were not followed. Medicines not given at the right time compromises the effectiveness of the medicine and the safety of people using the service.

At the last inspection people missed many doses of their medicines because they were asleep or because they refused them. At this inspection we saw that some nurses went back frequently to reoffer medicines until people were happy to take them resulting in fewer missed doses. However, this practice was not consistently carried out by all nurses. This meant that some doses were still missed.

At the last inspection, people who needed to be given their medicines covertly, by hiding it in food or drink, refused and missed doses of their medicines because nurses did not give it covertly. At this inspection we found that these people took their medicines more often because nurses had been given training on how to administer medicines covertly. However there was still no information recorded to guide nurses what to do when one person had refused all their food and drinks. Nurses had not arranged for one person to have their newly prescribed pain relief medication as a liquid which meant it could not be hidden in their food or drinks. They refused most of the doses of pain relief which may have left them in pain.

People who were prescribed medicines to be given 'when required' now had information recorded to guide nurses to ensure medicines prescribed in this was could be given safely and consistently. This included using pain scores for people that could not tell nurses if they were in pain. However we saw that these scoring sheets were not always used so it was not possible to tell if nurses had properly assessed their need for pain relief. Some people were prescribed laxatives and the information stated that staff should monitor their bowels, however there was no information as to the monitoring that should take place. The manager told us that this information was not passed on between nurses on shift changes so nurses may be unaware if people needed laxatives. The manager reviewed this matter at the time of our inspection and introduced a system to capture this information. This helped to make sure people were given laxatives safely and consistently.

Improvements had been made about the information available for staff to refer to when administering creams. However we saw that when there was a choice of number of times a cream could be applied there was still no information to guide staff to choose how often a cream should be applied. We also saw that guidance was missing for some creams. The records about creams showed that even when the guidance was in place creams were not applied as prescribed. This may cause people's skin integrity to be at risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 – Safe care and treatment. People who used the service were placed at risk of harm because the systems and processes in place did not effectively promote the proper and safe management of medicines.

At our last inspection of the service we observed that call bells were frequently activated by people using the service, with poor responses from staff. We were told at that time that many people had sensor mats in their bedrooms, which activated when they moved or suffered a fall. At this inspection we observed that call bell activation had reduced significantly and that response times from staff had improved. However, we also noted that most people spent less time in their private bedrooms and more time in the communal living areas, where staff could monitor people more easily. We found that some of the bedroom doors had been locked to prevent people from entering. We asked the manager about these arrangements. We were told that people were able to make the choice of where to spend their time. However, this was not documented in the sample of care plans that we reviewed and we did not observe staff asking people about where they would like to be.

We observed that the staffing levels and staff deployment appeared to meet the needs of the people using the service. However, we had received information that this was not always the case, particularly at night. We spoke to the manager about this matter, who assured us that the actual staffing levels matched those recorded on the staff rotas.

We reviewed the recruitment records of one recently employed member of staff. We found that the recruitment processes and checks had mostly been carried out appropriately. There was some information missing from the documents at the time of our inspection. The manager was asked to send this information to us following the inspection, which they did.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke to during our inspection confirmed that they had started to undertake various training courses. One member of staff told us that they had completed a week of induction training when they first started to work at the home. They said; "I am happy with the induction I received and the nurses here were all very supportive." Another staff member told us; "We work well together and help each other out." We spoke to two other members of staff who also commented on the training they had received. They felt that they were "up to date" and that the training was "good." They particularly commented positively on the training they had recently received with regards to dementia.

One of the nurses we spoke to told us that they had requested some specialist training to update their skills but this had not been provided. The nurse told us; "I am worried about losing my skills. I am looking for some bank staff hours at the hospital to help update my skills (nursing)." Another member of staff said; "Training is ongoing, problem is sometimes we are short staffed and it doesn't happen." We discussed this matter with the manager and regional director. The regional director told us that BUPA were increasing their clinical skills training for nurses, to help address gaps in skills.

The staff records we looked at showed that staff had recently undertaken updated training. However, there were still gaps in the training records, particularly around fire drills, 'Person First, Dementia Second', communication skills and managing behaviour that challenges. The manager told us that the fire trainer had recently left the home but that arrangements were in place to ensure this training would be fully completed by all staff by the end of May 2017. The manager also told us that the specialist communication training had not yet been arranged for staff.

We noted during our observations that staff did not have the specialist skills to help them communicate effectively with people living with dementia. We observed that people who had good verbal communication skills received more attention from staff. For example people who could speak were asked about having their nails done or asked about participating in other activities. People with limited verbal communication skills were not offered or encouraged to participate in such activities. We observed some of these people to be sat in the lounge or dining room looking around or dozing in their chairs.

Following our last inspection the provider submitted an action plan detailing the improvements that would be made around staff training and competency checks. The action plan stated that all nurses would have medication competency assessments by 15 March 2017. At this inspection the manager told us that out of the eight nurses employed in the home only four nurses had had their competency checked. Two of the remaining nurses had not been checked at all. The manager told us they could not show us the competency records for two nurses because they had given the records to the nurses to reflect upon at home. The NICE guidance (Managing medicines in care homes) is clear that staff who are administering medicines must have the necessary training and be assessed as competent. Staff who do not have the skills to administer medicines safely should not be administering medicines to people.

In addition to this, we also found that staff had not received training to help them support and care for

people who may be coming to the end of their life. The provider told us in their action plan that they were trying to source this type of training for staff but there were no timescales to indicate when this would be achieved. The action plan also stated that staff had been provided with the appropriate documentation and plans for caring for people coming to the end of their life. However, there were no indications to confirm staff would know how to use this documentation correctly.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing, because staff had not had appropriate support, training and professional development to enable them to effectively carry out their duties.

At our last inspection of this service we found that staff had not received supervision regarding their work. We found at this inspection that there had been some improvement in this area and that the provider was meeting this legal requirement.

Records showed that staff had attended supervision and appraisal meetings with their line managers, although there was some confusion about this. One member of staff said they hadn't attended a supervision meeting, whilst another stated they had received an appraisal of their work with their line manager. A member of staff with responsibility for carrying out supervisions was very clear about the staff supervisions they had carried out.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection of this service the provider had taken an inconsistent approach to the application of the principles of the MCA and DoLS at the service. People had been deprived of their liberty and applications had not been applied for in all cases. This was a breach of the regulations.

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had reviewed their protocols with regards the MCA and DoLS and that the provider was meeting this legal requirement.

We found that related assessments and decisions had been properly taken and that the provider had followed the requirements in the DoLS. Applications for DoLS had been submitted appropriately to a 'supervisory body' for authority to do so and where applications had been authorised the provider was complying with the conditions applied to the authorisation.

At our last inspection of the service we found that people who used this service did not receive adequate support with their nutritional needs. At this inspection we found that some improvements had been made but we were not assured that people were properly supported with eating and drinking. We spoke to people who used this service, the staff, including the cook and social care professionals about eating and drinking. We carried out observations over the lunchtime meal and also reviewed the nutritional records of four people who used this service.

At our last inspection we noticed that the meals served at the home were crammed into a short space of time. At this inspection the manager told us that better staff allocation over the meal time periods had improved the meal time spacing. However, the improvements were not significantly noticeable. The only flexibility we observed around mealtimes was the choice of foods for breakfast and that people were able to get up and take this meal when they liked. We saw people still having breakfast at 10:45, given lunch at 13:00 and tea at 16:30, with tea and cakes in between.

One of the people who used the service commented; "I like the food and we have some nice puddings sometimes." Another person just said that the food was "OK."

Staff spoken to made the following comments; "Residents are weighed monthly," and "If they (people) go under weight someone from speech and language would be involved or the dietician if needed." The cook was able to discuss people's special dietary needs with us. They had information in the kitchen regarding everyone's personal requirements, allergies, likes and dislikes.

We also looked at the summary report from the recent visit (March 2017) by the BUPA Admiral Nurse. Admiral nurses are specialist dementia nurses who give expert, practical, clinical and emotional support. They had identified that there was limited access for individuals to independently gain access to drinks and snacks outside of mealtimes. We observed that this situation had not been addressed during our inspection of the service.

During our inspection we observed staff helping people to eat their breakfast and/or their lunch. There were some inconsistencies regarding the support people received, particularly people who needed intensive support with eating and drinking. Some people were observed to be fed by staff rather quickly and with inappropriate cutlery such as large metal spoons. Little was done to make the meal time experience a more personal and enjoyable experience for people using the service. We observed that conversations between staff and the people they were supporting was focused on the 'task' of eating. The manager did enter the dining room and made sociable conversation between the tables. We noted that people responded positively to the manager.

We observed that people who were still sleeping, were pushed through to the dining room from the lounge, two of whom remained sleeping throughout our observations. This was poor practice, particularly for people living with dementia. We also saw some good practices during our observations. One particular member of staff dealt extremely well with one person's aggressive outburst at the dining table and provided reassurance to help calm the situation. Other staff were seen encouraging people to eat and drink. We heard one person say they didn't like part of their meal and staff immediately offered them an alternative, which they accepted.

Social care professionals had raised concerns with regards to the standard of monitoring and recording people's nutritional status and intake. We reviewed this during our inspection. We found that one person had lost 4kgs in weight over a period of one month. They had been assessed at high risk of malnutrition and a referral to the dietician had been made. However, we found that staff had not followed the clear guidance contained in this persons care plan. They had not been weighed as frequently as they should and their care profile recorded that they were not at risk of malnutrition and that the kitchen did not need to provide a fortified diet. We checked their food and fluid intake diary. This had been poorly maintained and it was impossible to tell whether this person had been supported and encouraged to take a good, nutritious diet or whether alternative foods had been offered when meals had been refused.

At our last inspection we had found serious concerns with the way in which thickeners had been used. At

this inspection we noted that some improvements had been made. This was particularly noticeable in the guidance available for staff to refer to when making people drinks that needed to be thickened to stop them from choking and developing chest infections. However, we saw that staff did not refer to the guidance when making drinks and we saw one person's drink had not been thickened enough. This placed this person's health at risk of harm. The records about the use of thickeners were not accurate because they were not always made by the person thickening the drink. The acting manager told us that they would take immediate steps to make sure people were given their drinks thickened correctly and that accurate records would be made.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Meeting nutritional and hydration needs. People who used the service were placed at risk of receiving inadequate support with their nutritional and hydration needs because the provider did not follow a robust strategy that met the individual needs of people who used this service.

Beacon Edge Care Home provided care for people living with dementia. At our last inspection of this service we made a recommendation that the service considered appropriate advice and guidance, based on current best practice, with regards to the environmental design at the home and the specialist needs of people living with dementia.

At this inspection of the service, we did not observe any improvements to support that this recommendation had been followed up by the provider.

Requires Improvement

Is the service caring?

Our findings

During our inspection of this service we spoke to some of the people who used the service and their relatives who were visiting.

One visitor told us; "I feel so helpless at times my relative just wants to come home but I would have no support could not manage. My relative tells me they have had some poor sleep." Another relative told us; "Our family are very happy with the care here our relative came here straight from hospital and we could not have coped otherwise."

Although we received some mixed views about the service from relatives, we found that they felt staff were mostly loyal to Beacon Edge and their relatives. We found that people were mostly complimentary about the staff who cared for their relatives and friends.

One of the people that lived at Beacon Edge told us; "These girls (staff) are nice they treat me well." Another person said; "Some staff are good others don't want to know." This comment was in relation to obtaining help to go to the toilet.

A member of staff commented; "We know our residents well, most have been here quite a while, we get to know what they like and don't like." Another staff member said; "Some people have been here a long while. We care about the people we support."

We observed staff treating people with kindness and respect as well as participating in friendly conversations. During our inspection of the home, we observed that people generally appeared comfortable in the company of the staff on duty.

Health and social care professionals told us that they thought people were "looking better cared for" and "appeared more relaxed." We also noted this during our inspection of the home.

We spent some time in the nurses' office. During that time we observed that the nurse in charge led the shift very well. The nurses gave the impression that they were well organised and dealt with daily tasks in a caring but effective and professional manner.

We observed staff helping people with their mobility by the use of the hoist. Staff provided explanations about the process to the people they supported and this helped to alleviate any anxieties the person may have had. However, staff were not mindful of protecting people's dignity. More attention could have been paid to ensure their clothing provided coverage to protect the dignity of individuals.

We also observed staff helping people with their medicines. The nurse provided explanations about the medicines to the people they were supporting and demonstrated a kind, warm and encouraging manner towards them.

At our last inspection of the service we observed that staff did not have the skills to support people or communicate with people who became challenging or demonstrated inappropriate behaviours. We made a recommendation that the provider found out more about training for staff, based on current best practice, in relation to supporting the specialist needs of people living with dementia. Staff told us that they had received some training with regards to dementia awareness and that they valued this training. Their training records confirmed that the provider had encouraged staff to participate in this type of training.

The manager also showed us an example of the work that had been carried out to help manage the behaviours of one person in particular. We reviewed their care plan, which confirmed what the manager had told us. However, we observed a member of staff encouraging the behaviours of this person rather than following the guidance in the care plan. We also observed staff spending time with people who could verbally communicate but ignoring others who could not. Staff still lacked the skills to effectively communicate with, and support people living with dementia.

We observed that the manager at the home demonstrated good skills and made simple but effective differences to the demeanour of people living at the home. We observed the manager coming into the lounge saying "Good morning" in a cheery way to everyone in the room. The same happened at lunchtime when the manager visited every table to check people were alright. We noticed that everyone perked up and a smile came on their faces.

At our last inspection of this service we found that staff had not received any training specifically designed to help them support people coming to the end of their lives. Registered nurses at the home were unable to manage syringe drivers, often used to administer anticipatory drugs when people were very poorly and coming towards the end of their life.

The provider had told us in their action plan that this type of training was "in the pipeline" but there was no target date set for this to be achieved. We made a recommendation in our last inspection report about this. We recommended that the provider found out more about training for staff, based on current best practice, in relation to supporting people at the end of their life. At this inspection the manager told us that staff had been provided with information about end of life care but the provider had not sourced this training for staff.

The manager told us that there was no one requiring end of life care at the time of our inspection. However, there were gaps in the skills of the nursing staff. This meant that the service was not adequately prepared to support people when they required this specialist care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of this service we found that people's care and support plans had not been developed specifically to meet their individual needs and expectations. Information had not been accurately recorded and care had not been provided in a person centred way.

The provider had sent us an action plan outlining how these shortfalls would be addressed and by when. The provider had set a long timescale for getting these important documents up to date and we had discussed our concerns about this matter with them. Individual care plans should provide information and guidance to staff about people's support needs, preferences and expectations. If these documents are not up to date and reflective of people's needs, people using the service are placed at risk of inappropriate and unsafe care

Health and social care professionals commented on the care plans of people who used this service. They said that they had seen some improvements in the standard of information recorded but felt that there were still improvements to be made. They raised concerns about the length of time it was taking. Some people felt the care plans contained too much information, making them difficult to read and work through. Some of their areas of concerns were around the accuracy of food and fluid monitoring, evaluations of the care plans and some conflicting information recorded in daily notes and care plans.

At this inspection we found that care plans had mostly been reviewed and rewritten. We could see that checks were starting to be made on the accuracy of the information recorded in the care plans. However, because this process had only recently commenced it was difficult to assess whether the care plans were consistently and effectively meeting the needs of people using the service. Of the care plans we reviewed we found that where people had been refusing aspects of their care particularly support with personal care, assessments had been carried out appropriately so that staff could act in the best interests of the person requiring support. We found that information was not always as up to date as it should have been and that staff did not consistently deliver the care and support as recorded in these documents. For example; two people should have been wearing their glasses to help their behaviours and help prevent falls. We observed that these two people did not wear their glasses all day. The manager told us that these people often refused to wear them. This was not documented in their care plans nor were there any strategies to help staff to encourage people to wear their glasses.

Another person had been reviewed by the community mental health team to help staff manage some of their behaviours. We found that although information had been included in the person's care plan, staff had failed to follow the guidance. This included the completion of behaviour monitoring records which were intended to help identify patterns and trends. It was important that this type of information was accurately recorded in order to help the community mental health team devise management plans to keep the person safe.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Person centred care. People who used this service did not receive appropriate care and treatment

that met their needs and preferences.

The relatives we spoke to during our inspection told us that if they had any worries they were able to discuss those openly with the staff. They also told us that if their relative was unwell or had some difficulty staff would ring and inform them and that they were able to visit as they liked.

The service usually employed an activities co-ordinator, but this member of staff was not at work at the time of our inspection. The manager was not sure how long the activities co-ordinator would be absent for. In the interim period the manager told us that care staff were being encouraged to carry out activities with people living at the home. We did observe some staff providing one to one activities during the day, for example jigsaw puzzles, reading the newspaper and a member of staff painted one person's nails. However, this support was observed to be restricted to people who could verbally communicate and respond.

A musical entertainer came to the home in the afternoon, encouraging people to join in with singing and playing musical instruments. Relatives were also encouraged to join in and everyone appeared to be enjoying this. One person told us; "I like a sing along but cannot remember the words, I like a dance too." Their relative added; "She really comes alive at these times." Most of the people who lived at the home were brought into the lounge for this. Activities were confined to the lounge areas and activities for people who wished to stay in their own rooms were limited.

We recommend that the service seeks advice and guidance, based on current best practice with regards to supporting people to access meaningful activities within a safe environment.

There was a complaints process in place at the home. The people we spoke to told us that they knew who they should raise any concerns with. We found that there had been no complaints made about the service since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that the service was not well led. A registered manager had not been in post since July 2016. There had been four different managers at the home since that time.

At the time of this inspection the service did not have a registered manager but was being overseen on a day to day basis by a regional support manager. This manager was in attendance at the home on the days of our inspection.

Staff and relatives told us during the inspection that they had been kept up to date with the planned sale of the home and the changes for the service. They were optimistic about them. However, none of the people who used the service could recall being informed of the changes.

One relative told us; "We feel there could be some improvements here having met with the new (prospective) owners here, they seem to have some good ideas."

The staff also commented about the service and the proposed sale and changes of ownership. One person said; "It (the home) is in need of change." Another told us "I had become very disillusioned with BUPA Management, they don't listen to ideas or anything, this place needs investment, they are not interested hopefully the new owners will listen." However, another member of staff, although happy that there were going to be changes at the home, felt that "Things are better organised now."

At this inspection we found that the provider had systems and processes in place to help monitor the quality and safety of the service. However, we found that the systems were not robustly applied or effective and did not ensure that the service met all of the legal requirements. We had made some good practice recommendations following our last inspection. At this inspection we found that the provider had not acknowledged the recommendations in driving improvement throughout the service.

At our last inspection of the service in November 2016, the BUPA Admiral Nurse was carrying out observations and checks on staff practice during the service of the lunchtime meal. Their report at that time identified the outcome as poor (48%). The report stated that a revisit to the home would be carried "out in one month" i.e. December 2016. At this inspection we asked to see the follow up report from the Admiral Nurse regarding the revisit. The manager told us that the Admiral Nurse had not been back as planned and had not visited the home until 30 March 2017. We asked the manager for a copy of the most up to date report. The manager sent us a summary of this, which provided us with limited information. However, the summary identified that some improvements to the environment had been noted and provided some information as to where other improvements could be made. For example; improving access for individuals to independently gain drinking and snacks outside of mealtimes, improvements to the décor and tonal differentiation and improvements to support people in finding their way around the home.

At our last inspection of the service the manager told us that satisfaction surveys were being distributed in readiness for the annual quality survey. The manager gave us a copy of the latest report, at that time and

dated December 2015. At this inspection we asked the manager for information about the quality survey results. The manager provided us with the same report as at the previous inspection. We asked people about feedback surveys. They said that these had been done "some time ago."

Although we were given no evidence that the specific annual quality satisfaction surveys had taken place and been evaluated, we saw that some surveys had recently been completed. The comments received had been positive and included: "The staff are extremely friendly and approachable"; "My relative always looks clean and looked after."

We found that relative and resident meetings had occurred. Additionally, staff meetings had been held. At the meetings the provider had discussed the outcomes of CQC inspections and up dated people with the proposed changes that were taking place at the home. The meetings had provided a platform for people to have their say on the service. We also noticed that there was a Relatives Communications Book on the bottom shelf of table where the visitor signing in book was kept. We reviewed this book and found that it had not been used. The last entries were made in September 2014 and November 2016. We asked a staff member about the book and were told; "The relatives just come and see us if they want anything." We returned this book to the top of the table near signing in book but before we left the book had been placed back on the bottom shelf. However, people were also able to make comments and suggestions via the 'manager's suggestion box' located in the main corridor of the home.

We observed that the manager held daily departmental meetings with the staff and carried out daily walk rounds of the home. A "Resident of the Day" system had been implemented. This meant that a different person each day would be nominated as the resident of the day. Their care plans and risk assessments would routinely be reviewed as part of this system to help ensure they were up to date and completed with accurate information. A system had been put in place for the twice daily auditing of people requiring their dietary intake to be monitored. However, during this inspection we found that although audits had taken place, gaps remained in the monitoring and recording systems, which placed people using this service at risk of harm and inappropriate care.

We saw that the regional director had carried out monthly audits of the service from February 2017. The provider used a RAG (red, amber, green)rating system where red indicates concerns and green is satisfactory. The audit that had been completed following our last inspection had been given a rating of 37% (red/amber). This audit had identified serious shortfalls in the quality of the service. The next audit carried out in February 2017 showed some improvements and the rating had improved to 45% (amber). The March audit continued to identify further improvements had been made at the home. However, this document also recorded that there remained concerns with regards to care planning documentation and medication management. The final audit report available at the time of our inspection was dated April 2017. This audit identified a reduction in the improvements being made to the quality and safety of the home. The reason for the reductions in improvements had not been recorded.

We checked the information we held about this service against some of the records kept at the home. For example; accident records and people's daily notes. We found that the provider had not always notified us of accidents and incidents as required. The local authority safeguarding manager reported similar issues with regards to delays in alerts from the service. We are dealing with this matter outside of the inspection process.

Following our last inspection the provider gave us a detailed action plan. The provider had also shared their action plan with the local authority and clinical commissioning group (CCG). We spoke to the provider about their action plan as some of the timescales for achieving compliance with the regulations were too long, a

concern shared by the local authority and CCG. However, the provider did not amend these despite the concerns.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance. Systems and processes were in place to monitor the quality of the service but had not been robustly applied. This had impacted on the effectiveness of the provider's governance arrangements in driving continuous improvement.