Bamfield Lodge Limited

Bamfield Lodge

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

Bamfield Lodge provides nursing and personal care for up to 60 people. The home comprises of four units, located over three floors. The Crocus unit provides residential care. The Daffodil and Bluebell units provide nursing care. The Snowdrop unit provides care for people living with dementia. At the time of our inspection there were 57 people living in the home.

The inspection took place on 26 September 2017 and was unannounced. The last inspection report was published on 2 December 2016. At that inspection there were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches, some of which were repeated from the previous inspection, related to medicines management, person centred care, record keeping and quality assurance.

This comprehensive inspection was brought forward due to a number of safeguarding concerns being raised that related to the safety, care and treatment of people living in the home. The local authority safeguarding team and the police were currently involved in investigations which were on-going at the time of our inspection.

There was no registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. One of the provider's registered manager's from another care home had been providing management support for the home. On the day of our inspection one of the provider's senior support managers started in post, on a full time basis.

At our previous three inspections we found that peoples' records were not accurately completed and that care plans did not always reflect peoples' individual needs. We issued requirement actions. The provider sent us an action plan telling us what actions they were taking to become compliant. At this inspection we found that improvements had been made. However, further improvements were needed.

We found medicines were not always safely managed. Risk assessments and risk management plans were in place but were not always accurate and up to date. Safe staff recruitment procedures were completed. Sufficient numbers of staff were not always deployed to meet peoples' needs. Staff were not always provided with sufficient support, supervision and training.

There was a lack of consistency in the process followed when people lacked the capacity to consent and make their own decisions. The managers and staff were not aware who had authorised Deprivation of Liberty Safeguards in place. This had been identified at our last inspection as an area for improvement.

Staff demonstrated a kind and caring approach and they treated people with dignity and respect. Staff knew

people well and were able to tell us about people's likes and dislikes, choices and preferences. These were not always reflected in the care records. People were provided with a range of activities and entertainment on a daily basis.

There was no registered manager in post. Most people were not aware of the management arrangements in the home. Staff expressed concerns with regard to the lack of consistent leadership and management.

Sufficient actions had not been taken in response to the breaches of regulation identified at the last inspection. People were not receiving safe care and treatment. The provider's quality assurance systems did not identify, or actions had not been taken, to consistently address the shortfalls we found.

We made a recommendation with regard to staffing.

We found repeated breaches in two of the regulations at this inspection. We found a further breach with regard to staff supervision and training. Full information about CQC's regulatory response to any concerns found during inspections is added to the report after any representations or appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always safely managed although improvements had been made to the management of covert medicines.

Risk management plans did not always identify or mitigate risks to people's safety.

Staff were not always sufficiently deployed to enable people's needs to be met.

Staff had received trained in safeguarding people from harm and abuse.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff performance was not always monitored on a regular basis.

There was a lack of consistency in the process followed when people lacked capacity to consent and make their own decisions.

People's health care needs were not always fully met.

People had access to health care professionals.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and respectful and we saw people being treated with warmth and dignity.

Staff knew what peoples' individual needs, wishes preferences and choices were.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised and did not always reflect people's changing and current needs.

People were provided with a range of activities and entertainment.

A complaints procedure was in place that was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well- led.

There was no registered manager in post. Interim arrangements were in place.

Systems were in place for monitoring quality and safety. However, the audits had not always identified the shortfalls we found or planned actions had not been fully completed.

Bamfield Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Bamfield Lodge on 26 September 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of the type of service inspected.

Before carrying out the inspection we reviewed the information we held about the care home. We looked at notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with nine people who lived at the home and five visitors. We observed the way staff interacted and engaged with people.

We spoke with the regional manager, the senior support manager, the registered manager from another service providing support to the home, and 13 staff that included registered nurses and care staff on night duty and day duty, catering, housekeeping, activity and agency staff. We observed how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at eight people's care records. We looked at medicine records, staff recruitment files, staff training and supervision records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, we received further information that we had requested.

Requires Improvement

Is the service safe?

Our findings

Care plans contained risk assessments for areas such as falls, moving and handling, skin integrity and nutrition. Where risks had been identified, the care plans varied in how well they guided staff on how to reduce the risks. There was an inconsistency, and work had been undertaken to make improvements for some people's records. However for others, the care records did not always give sufficient detail to confirm risks were safely managed. In addition, the staff we spoke with told us they did not always provide the care people needed.

We looked at the records for two people who had been assessed as at high risk of falling. One care plan informed staff to, 'Remind to use zimmer when mobilising, ensure sensor mat positioned correctly, assist when leaving the unit, ensure wearing correct footwear and a clutter free floor.' However, for the other person their records stated, 'Now has 30 minute observations and I will order a sensor mat'. There was no other guidance about how to reduce the risks for this person.

Some people were assessed as being at high risk of developing skin damage. Most of the care plans provided guidance about how these risks should be reduced and management plans were in place. However, some of the plans did not provide accurate information. For example, one person had been assessed and it was recorded they used a pressure- relieving mattress to minimise the risk of further skin damage. We checked and the person did not have a pressure- relieving mattress in place. For another person who had two 'skin flap' injuries and one pressure ulcer recorded in September, the treatment plans and updates were unclear and inconsistent. An incident record completed on 17 September 2017 by a member of staff stated, 'Pressure sore found on bottom.' There was no record or update of the treatment of the pressure ulcer since this date in the person's care plan. We bought our concerns to the attention of a registered nurse. They checked the record and agreed there was no further care entry for the pressure ulcer. They then checked the person and told us the person's pressure ulcer had healed.

Accidents, incidents and falls were recorded and entries were made into the provider's electronic 'Datix' system. Following our visit we requested, and received additional detail of the follow up treatment or actions taken for all incidents, accidents and falls that had occurred up to six weeks before our visit. The reports included entries for five people with unexplained skin tears. The follow up action for each person was the same, in that it included the informing of next of kin, update in care plan, communicate lessons learned to staff and monitor resident. There was no record of any further investigations being undertaken to establish the individual causes of the injuries sustained.

Some people were unable to use call bells to call for assistance. We also saw people who were able to use their call bells, but they were not always within reach. For example, one person told us they had seizures on occasions. They told us, "I have these blackouts, I think you call them seizures, I can't do nothing about it." They told us they had a 'buzzer' on their wall. They pointed to it and told us they couldn't usually reach it. They told us they usually shouted for help when they needed it. We saw there were other people whose records stated they needed checking on a regular basis to make sure they were safe. The records were not always fully completed to confirm the safety checks had been completed.

Some people were having their food and/or fluid intake monitored. A member of staff was a designated 'fluid champion.' Their role was to check the charts were completed each day. For most of the records we looked at, people had received the targeted amount of fluids they were recorded as needing over a 24 hour period. We found further improvements were needed. For example, for one person, the records showed they had no fluids between 5pm until 8.30am the following day. For another person, their records showed they had no fluids from 5.15pm until 9am the following day.

At our last inspection, medicines were not always safely managed. We issued a requirement action and the provider sent us an action plan telling us what they were going to do to meet the requirements of this regulation. At this inspection, we found some improvements had been made. However, these were not consistent and there continued to be shortfalls in the safety of medicines administration.

Medicines received into the home were checked and the amounts were recorded on the medicine administration record sheets (MARs). Most medicines were suitably stored in locked cabinets and cupboards in designated rooms. We did note one tub of prescribed fluid thickener was not suitably stored. It was on the top of a microwave oven in the dining room in the area of the home where people were living with dementia. NHS England issued a 'Patient Safety Alert' in 2015 due to the risk of death from asphyxiation by accidental ingestion of fluid thickening powder. The powder should be suitably stored. We brought this to the attention of the member of staff that was present at the time.

The amount of medicines left over from previous months were not always recorded. This meant accurate stock level checks could not be completed. This shortfall was also noted on the regional manager's audit for August 2017. Arrangements were in place for medicines that required cool storage or additional security. Medicine storage rooms and refrigerator temperatures were recorded on a daily basis to make sure medicines were stored at suitable temperatures. Records were maintained for medicines no longer required.

Where people were prescribed variable doses of a medicine, the amount they were given was not always recorded. For example one person was prescribed paracetamol, 250mg/5mls, two to four spoons to be given. They were given the medicine on 20 and 24 September, but the amount given was not recorded. This meant the effectiveness of the medicine could not be accurately assessed. Another person had paracetamol suspension written by hand on to their MAR. The entry was not dated or signed. This was not in accordance with the provider's policy that stated, 'The hand-written MAR should be checked for accuracy and signed by a second trained member of staff before it is used.'

We found further improvements were needed for one person who had their medicines crushed. A pharmacist had signed to confirm their agreement the medicines were suitable for crushing. However, the care records provided conflicting guidance about what the medicines were mixed with. In one record it stated the medicines should be crushed and mixed with food, and in another record it stated the medicines should be crushed and mixed with 'suitable fluids.'

Where people were prescribed non medicated creams, arrangements were in place to confirm the application instructions. The care staff were required to confirm they had applied the creams on topical MARs. We found these charts were not fully completed. For example, for one person, a cream was prescribed to be applied three times each day. The topical MARs had been completed to confirm the cream had been applied as prescribed for six days in September. That meant there were 20 days where the records had not been fully completed.

A daily 'drug administration error audit tool' sheet was in place. This instructed staff 'at the end of the shift

go back and double check you have signed or coded every drug' This was to make sure there were no gaps on the MARs and they were fully completed. The check for 17 September showed the check was completed and had identified one person had not received one of their daily medicines. The checklist had a section to confirm when the error was reported to the person in charge and when the error was rectified. This section was not completed. The audit tool had not been completed on 23 and 24 September. On 24 September we noted gaps on the MARs. Two medicines had not been signed to confirm they had been given.

The above were breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people, relatives and staff we spoke with expressed concerns that there were not always sufficient staff in each area of the home to meet peoples' needs. Peoples' comments included, "I think they could do with some more (staff)" and, "Well, we have been sitting here chatting, have you seen anyone (staff)?" Relatives told us, "No, definitely need more (staff). I have noticed on a weekend especially, there is no one around" and, "We have had to walk around several times trying to find a staff member to help one of the old ladies, so no, I don't think they have enough."

The staff we spoke with expressed concerns about staffing levels, with comments such as, "It feels like we're always short staffed" "If we don't have time to get everyone up, we have to leave people in bed" and, "It makes us feel rubbish when we can't meet people's needs."

On the morning of our visit, we heard call bells ringing almost constantly from 6am until 8am. We observed night staff working and trying to make sure peoples' needs were addressed. At 6.45am we heard a male member of staff on the phone to staff on another floor. They were working alone on the floor and they were asking for a female member to provide support to one person. The male member of staff told us it was known this person preferred female staff to provide personal care. There was no female member of staff available to provide the personal care requested by the person until approximately one hour later. Throughout the day of our visit, we heard staff commenting about staffing levels and how they were not sufficient and peoples' needs were not always being met. In one area of the home, three people had their lunch in the dining room. We were told by staff there were usually approximately eight people. The staff we spoke with told us more people had decided to stay in their rooms. We spoke with one relative at 12.30pm. They told us, "The staff were telling me today that the night staff didn't do much last night, so they are really busy. My relative has only just been got out of bed."

We spoke with the regional manager and the management team about staffing levels. They showed us the dependency tool used to determine the numbers of staff needed. We checked the rotas and saw that on most occasions the home was staffed at the levels determined by the dependency tool. However, we saw staff struggling to meet people's needs. Staff, people and relatives all commented that staffing was not always sufficient and people's needs were not always met.

We recommend the provider reviews the numbers and deployment of staff to make sure sufficient staff are available to consistently provide care, support and treatment for people using the service.

Where moving and handling equipment was needed to move a person safely, care plans provided details of the type of hoist and the size of sling that was required. Where people had fallen, falls diaries were completed. Records showed that falls were reported and body maps were completed to show where bruises or injuries had been sustained. Where people needed monitoring after a fall the records stated the frequency of observations that were needed.

We observed medicines being given to people by registered nurses and senior care staff that had received appropriate training, and this was safely completed. We saw staff supporting people to take medicines in their preferred way. For example, we heard one member of staff say, "I have your morning tablet for you, is this ok? Would you like to take it as usual, from a spoon and with some water?" We also heard staff describing what the medicines were for.

Some people were prescribed medicines to be taken when needed, such as, for pain relief. We heard people being asked if they needed these medicines. For example, we heard one person being asked, "How are you? Do you need you painkillers?" Protocols were in place to describe the types of pain the medicines were prescribed for. We saw that staff signed the MARs after they had made sure people had taken their medicines.

We found improvements had been made in the administration of medicines for people whose medicines were prescribed to be taken covertly. This means medicines are given to people without their knowledge after a best interest decision has been made. There are clear guidelines and the provider had policies in place to agree the circumstances in which covert medicines could be given. The records showed the guidelines were being followed and records were completed.

No one in the home self-administered their medicines although arrangements were in place if people were assessed as safe to do so. Protocols were in place for people to be given 'homely remedies.' These are 'over the counter' medicines the GP agreed could be given to people for a specific limited period of time, without a prescription.

People who were able to fully express their views told us they felt safe in the home. Comments included, "Yes, no worries from me" "This is a safe place" and, "They have a night staff who checks regularly. I hear him open my door sometimes in the night." We also received positive comments from relatives such as, "The staff are brilliant, always there when we need them. I know I can go home without a worry."

The staff we spoke with told us they understood their responsibilities for protecting people from avoidable harm and abuse. Staff told us they knew how to report concerns. A member of staff told us, "We report it to the nurse in charge, they log it in Datix, and then I think it goes to the safeguarding team," Staff were familiar with the term, 'whistleblowing' and said they felt confident to raise any concerns about poor care practices. Comments included, "I would definitely report any worries I had to management, and if it wasn't resolved I would go higher" and, "I'm happy to speak up."

Safe recruitment processes were completed. Staff completed an application form prior to employment and provided information about their employment history. Previous employment references had been obtained by the home together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella checks, electrical safety, lift maintenance and hoist checks had been completed. Systems were in place to ensure that fire safety was adhered to. A fire risk assessment had been completed and records showed that regular safety checks were undertaken. People had personal emergency evacuation plans that provided details of how they should be supported to leave the home in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff told us that because there was no registered manager in post, there had been a lack of consistency in the support and supervision they received. Comments included, "I haven't had one (a supervision meeting) for ages, maybe six months or so" and "I had one a few months ago." The senior support manager told us staff should receive supervisions on alternate months, one of which would include an annual appraisal. We checked the summary for 75 staff. Twenty eight had received supervisions in accordance with the provider's policy.

The senior support manager told us about the range of training provided for staff. This included training they described as mandatory that included health and safety, first aid, moving and handling, food safety, mental capacity and safeguarding. We spoke with staff who told us they had access to training, and most staff described the training as 'Good.' However staff told us they did not always receive training to enable them to understand people's specific illness needs. One member of staff told us they had asked a number of times for epilepsy training. They told us they would not know what to do if a person had a seizure, They said they would, "Ring the emergency buzzer and wait for the nurse to come."

This lack of appropriate supervision and training for staff was a breach of Regulation18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an induction programme when they started in post. The programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably and correctly trained to provide care and support. One member of staff told us, "I had the best induction I've ever had when I started here."

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.

In the records we looked at, where people had capacity, consent to care had been obtained. Where people were unable to consent, best interest decisions had been made. Some records did not provide evidence of best interest decision meetings having been held, least restrictive options considered and how certain decisions had been made. For example, one person had bedrails fitted to their bed. There was no evidence that consent had been obtained and no evidence to support the best interest decision that was made to use the bedrails.

Other records did provide information about how decisions had been made and who had been involved. For example, we looked at the records for one person who did not have the capacity and was unable to provide consent to receive their medicines. A best interest decision making meeting had taken place. It was noted to be in the person's best interests after consideration was given to the potential effects of not taking their

medicines would have on the person. The records concluded it was the least restrictive option and in the person's best interests to receive their medicines covertly.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

On the day of our visit, none of the staff we spoke with, including the senior managers, were aware of people who had current DoLS authorisations. The senior support manager provided the information after our visit that six people had current and authorised DoLS in place and that several other applications had been made to the local authority. We spoke with staff during our visit and they were not aware of any authorisations in place and therefore not aware if any conditions were attached to the DoLS. We looked at the conditions that had been in place for one person. The DoLS had expired in August 2017. One of the person's conditions was that they needed to be checked to ensure their safety every 30 minutes. This was recorded in the care plan in November 2016. However, all subsequent records stated the person needed hourly checks and hourly checks were stated on the monitoring records.

We spoke with people who gave mixed feedback about the quality and choice of food available. Comments included, "The food's very nice yes" "Depends who's cooking" "It's ok most of the time" and, "Sometimes the meat is tough, even the chicken. I would like more cups of tea too. I used to drink a dozen cups a day when I was home." In one of the dining rooms people were supported and staff were attentive to people's needs. For example, we heard staff say, "Try a bit" "Is it nice?" and, "Have a bit more." In another dining room, there was little engagement with people. We saw one person was bought into the dining room at 12.40pm, and sat alone until another two people were brought in just before lunch was served at 1.20pm. There was little interaction with people throughout the meal service.

We spoke with the catering staff who told us they were aware of people's dietary requirements, and that people's likes, dislikes, preferences, needs and choices were all recorded on 'food passports.' They told us these records provided up to date information for each person in the home.

People's weights were recorded and significant weight loss or gains were noted. There was also a nationally recognised tool used to calculate people's risk of malnutrition or obesity. When a person had been identified as having a significant weight loss or gain, additional actions were recorded if required. We saw the GP had been contacted and their advice was recorded. We also saw that speech and language therapists (SALT) had been involved and their advice recorded.

People were referred and had access to external healthcare professionals. District Nurses provided additional support for people living in the home who received personal care. The records showed people had received support from visiting speech and language therapist (SALT) assessors, wheelchair services and from social workers.

Good

Is the service caring?

Our findings

We received mixed feedback from people when we asked if they felt staff cared about and for them. Comments included, "When they have time" "Yes, I feel they are caring" "Depends who's talking to you" "Oh yes they are a good bunch here" and, "Some are and some aren't, as I expect you get anywhere." We spoke with relatives who told us, "They are so caring here, you can tell from the way they talk to you" "They are amazing here, I think they truly care." One relative said, "I think they are caring, but have some bad habits. One example is they are so task driven." We fed back the comment made about task driven care to the management team.

The relatives we spoke with told us they were made to feel welcome when they visited the home. They told us there were no restrictions and they were able to visit at any time.

We watched interactions with staff, and people looked relaxed and comfortable in their presence. For example, one member of staff called out, "Knock knock" as they knocked on a person's door before entering. They then said, "Morning, it's me. How are you, did you sleep well last night."

We listened to a conversation a member of staff had with one person who had called for help. The person asked the member of staff if they should be getting up. They had difficulty hearing the member of staff's response, so the member of staff supported the person to put in their hearing aid. They then provided reassurance to the person that it was still early and there was no rush for the person to get up.

The staff we spoke with told us they believed they were caring and respectful. Feedback from staff included, "One thing you cannot fault is the quality of care here" "The care is good, staff treat people with care and empathy" and, "Staff do care." Staff also told us they knew how to make sure people's preferences and choices were respected. For example, one member of staff said, "I always make sure people are clean and smartly dressed. I know some of the women like to wear make-up, so I always offer it to them."

We heard a member of staff providing reassurance for one person when they were distressed. The person told the member of staff they didn't want anything because they were, "Too upset." They said this was because they thought their husband had gone out in the car. The member of staff tried to gently reassure the person they shouldn't worry. The person replied, "I do worry all the time." The member of staff bent down and spent time talking with the person. They gently touched their shoulder whilst trying to console and reassure them.

We watched another member of staff who told us they loved working in the home and it was, "The best place I've ever worked in" as they moved between bedrooms and offered support to people. They were cheerful, kind and caring. They were compassionate with a person who had become disorientated. We heard them telling the person, "We're alright here aren't we, and of course, I'm your friend so we'll look out for each other" then, "If I pop and get you a cup of tea, that always makes us feel better doesn't it." The person seemed reassured by this and smiled at the member of staff. The member of staff returned a few minutes later with the promised cup of tea.

Records of compliments the service had received this year were not collated. However, we read one card received in September 2017 that read, 'Thank you for all your help.'

Requires Improvement

Is the service responsive?

Our findings

We saw improvements had been made and some of the care records we looked at were person centred. However there was an inconsistency in that care plans that were not always responsive and personalised to peoples' individual and current needs. They did not always provide enough guidance for staff on how to meet people's needs. For example, in one person's plan it had been recorded that they could become frustrated and agitated. There was no further detail about what triggered their frustration and agitation. The guidance for staff was limited to "use distraction techniques", but did not give any details of what these were. For another person, their records stated they were often 'confused and distressed' and staff were to 'give reassurance.' There was no further guidance for staff with regard to how they provided reassurance for this person, who it was recorded also sometimes said, 'You won't hurt me will you.' The person had been referred to the dementia well-being service.

Some care plans did not provide the details need to make sure peoples' specific care needs were met. For example, the records for a person with a catheter stated, "Staff to take care of the catheter and change the leg bag weekly". There was no further detail about what the care was or what staff needed to look for or how they would recognise if the catheter was not working correctly.

Life history and 'My life' records were inconsistently completed which meant staff did not always have access to information about people's lives prior to moving to the service or information about their choices and preferences. One member of staff said, "The care plans should tell staff about people, but they don't." However, the staff we spoke with told us, and generally demonstrated a good knowledge of people's needs. They also told us they didn't always feel able to work in a person centred way because of the staff shortages they told us they experienced on a regular basis.

We looked at care plans where people's assessed needs and desired care outcomes had not always been updated to reflect changes to their care needs, choices or preferences. Whilst reference to changes were often made in the updates sections, the actual care plans were sometimes out of date. For example, one person needs had changed and there had been a significant change to how their medicines were being given. The care plan was written in June 2016 and had not been re-written or added to, to provide details of the person's current needs.

The regional manager sent us an action plan updated following our visit. This updated action plan confirmed a plan was in place to update the care plans. The action plan stated that five updates had been completed and a further 11 were due to be completed by 15 November 2017.

Most of the people and relatives we spoke with told us they were kept up to date, but we did not speak with anyone who said they had been actively involved in reviewing their care plans.

Some of the care plans we read showed that care was personalised and in response to people's identified needs. For example, in one person's care plan the nutrition section provided detail of the person's food and drink preferences and the person liked a non-slip placemat to be used. In the personal care section the

records described the clothes the person preferred to wear. In the emotional section, the triggers that could make the person become agitated had all been listed. In another care plan for a person who was blind, the records described the support the person needed at mealtimes. Guidance for staff included "Cut food up, guide her hand to the plate, and let her know what the food is."

Another person's care plan described how to support a person with their mobility, taking into account their level of independence. The records stated, 'Staff to encourage her to use her zimmer frame at all times when she wants to walk as she doesn't always remember. Staff always place zimmer frame next to her.'

We spoke with the activities coordinator who explained their role and told us about the activity provision within the home. They told us, "My passion is to make every day special for the residents." An activity programme was available on display in the corridors. A wide range of activities were provided and these included quizzes, bingo, memory lane reminiscence sessions, dancing and singing from external entertainers and arts and craft sessions. The was also a joint venture with a local college, a sports programme designed to keep older people as active as possible. One relative told us they thought there could be more 'dementia focused activities' and commented, "I think sensory play is something lacking here, a lot of the lower capacity residents could really benefit from it."

'Residents and relatives' meetings were held each month. The meetings were organised and led by the activities coordinator. Records of the meetings, the activities provided and the one to one sessions were all compiled in the activities folder.

Most people and relatives we spoke with told us they would feel comfortable raising a complaint or speaking with a manager if they had any concerns. Comments included, "I would talk to the person in charge, yes I would" "I'm not sure actually. I think I would just tell my relative" and, "I have not yet had to do so but if I did I would have no problems talking to the staff."

One relative told us, "I worry about the communication here and if the complaint would be passed on. We were contacted about my [name of person using the service] needing a CT scan. That was a month ago now and we have heard nothing since."

We checked the complaints records and spoke with the regional manager about recently raised complaints, or complaints they were actively involved with. We were provided with detail about three recent complaints and how they had been investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

This is the fourth inspection that Bamfield Lodge has failed to fully meet all the regulations. There have also been repeated breaches of the same regulations at these inspections. These include good governance and medicines management. There was no registered manager in post. The last registered manager de-registered in November 2016. A manager had been in post since this time. However, they had not registered with the Commission, and they left the home in August 2017. The provider's website displayed the rating from the last CQC inspection, published on 21 December 2016, which services are required by law to do. They also stated actions they had taken in response to the inspection and they included the following statement, 'The home now has an experienced Registered Manager in place and a strengthened management team which includes a Deputy Manager and new Head of Care. The new structure is designed to ensure high quality care standards throughout the home'. This statement provided incorrect and inaccurate information.

A registered manager from one of the provider's other homes had been providing management support to the home for the four weeks leading up our visit. They were supported by the regional manager who visited the home each week. One of the provider's senior support managers started in post on the day of our visit. Their role was to take full time management responsibility for the running of the home, until a new manager was appointed.

Most people we spoke with were not aware of the management arrangements for the home. Comments included, "He's been here for a while now, but I never see him any more" "I don't think we have a manager right now" and, "I don't know who it is, I'm sorry." One person commented about the registered manager from one of the provider's other homes, "She's very nice. Always says hello to me."

We spoke with relatives and they told us, "I think the staff are getting a bit fed up of being passed to different managers all the time" "The staff have stopped caring (about who the manager is) and just kind of do what they have always done" "The last manager didn't last long, I don't expect the next one to either" and, "They (managers) come in with great ideas and passion. That soon goes though."

An annual survey for people using the service and relatives was completed in 2017. Bamfield Lodge scored highly for staff friendliness and approachability, being treated as an individual, entertainment and being treated with dignity and respect. The lower scoring areas related to food choices and quality, security of belongings and activities outside of the home. The most frequently noted comments made related to the ratio and availability of staff.

We spoke with staff who expressed concerns about the lack of consistent leadership and management support. They said, "We're all tired. The care staff have kept this place going, but we get no thanks from management" "It's a joke. We've had such a high turnover of manager's and new staff don't stay" and, "I just get on with it. The lack of manager doesn't bother me." One member of staff told us, "This is a great place to work, the best care home I've worked in."

We looked at records of staff meetings. The last meeting was held in July 2017 and noted what was working well and what was not working so well. Since this time, there were no group meetings. However, the registered manager that had been providing support from another home had small or one to one meetings with staff. One member of staff told us, "She's been really good and is very supportive. She listens and wants to get things sorted." Staff had the opportunity to provide feedback in staff surveys that were completed on an annual basis. We saw the scores from the most recent survey showed an overall lower level of staff satisfaction at Bamfield Lodge compared to the provider's other care homes.

We spoke with the managers about quality assurance systems that checked the quality of the service provided and helped to ensure risks to people's health safety and welfare were monitored. These included planned monthly audits of care plans, health and safety, activities, meal service, and medicines management. However, the systems had not identified some of the shortfalls we found. There had also been an inconsistency in following up the actions required. We were told this was due to the changes in the management and leadership of the home.

We read the notes for a night audit check completed in June 2017. One comment stated that staff were 'not taking breaks and short of staff.' Another comment referred to the home being very quiet on the night of the check. There were no further notes to confirm the staffing concern had been followed up or looked into.

A Home Action plan was in place. This was updated on 3 October 2017, and sent to us after our visit. This identified and had actions planned to address some, but not all of the shortfalls identified during our visit. The improvement actions stated in the plan the provider sent to us after our last inspection had not been sustained and we found repeated shortfalls.

The lack of an effective quality assurance programme to drive improvements and mitigate risks to people was a repeated breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The managers understood their responsibilities with regard to the notifications they were required to send to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive sufficient support, supervision and training.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not always assessed and actions were not consistently taken to mitigate any such risks. Medicines were not always safely managed

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not consistently mitigate risks or make improvements to people's health, safety and welfare.

The enforcement action we took:

We imposed additional conditions on the provider's registration