Ringdane Limited

The Beaufort Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 May 2016 and was unannounced.

The Beaufort Care Home provides accommodation for up to 29 people who require nursing or personal care. Most of the people living at the home have complex medical conditions requiring a lot of care and support or highly specialised nursing. 19 people were living at the home at the time of our inspection.

We last inspected the home in November 2015 and found there were two breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

These breaches were in relation to insufficient numbers of suitably qualified, experienced staff to meet people's care and treatment needs and staff did not always receive the appropriate support to enable them to carry out their duties competently. The provider did not continually assess, monitor and improve the quality of the service.

We issued the provider with a warning notice in relation to how they monitored and assessed the quality of the service and asked them to provide us with an action plan outlining the improvements they intended to make. At this inspection we found some improvements had been made but further improvements were still required.

There was no registered manager in post. 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.

There was a new manager in post who was in the process of registering with us. They had started working at the home at the beginning of April 2016. The provider had also recruited a new deputy manager and there was a new area manager in post.

Some people and relatives were unhappy with the care provided, and expressed concerns about the length of time they, or their relations, had to wait to receive care. Staff were committed to providing a good standard of care but we observed there were delays in attending to the needs of people and call bells were not responded to promptly. People did not consistently receive baths and showers when they wanted them.

At our previous inspection in November 2015 the home had been reliant on agency nurses to provide nursing care in the home. At this inspection we found the provider had recruited permanent nursing staff and the use of agency staff had reduced. However, the occupancy level at the home had increased and we found there were not enough care staff to provide care and support to people at the times they needed it.

At our last inspection in November 2015 we found a breach in the regulations as quality checks had not been completed consistently to identify when improvements were required. At this inspection we found regular quality audits of the home were conducted to monitor and improve the care provided by the service. Analysis of incidents and accidents were carried out to minimise the likelihood of them happening again.

People did not always receive their medicines as prescribed and on some occasions the correct equipment to deliver medicines had not been ordered.

Improvements had been made so that permanent staff had received training required to undertake their work safely. However the provider had not kept an accurate record of staff training needs. We found staff had started to receive sufficient support and supervision to help them work effectively

The manager understood their responsibilities and the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards (permission needs to be sought when a person who does not have capacity has their liberty restricted).

Staff were kind and caring when providing personal care. However, staff interaction with people was mostly when supporting them with care tasks. We saw limited engagement between staff and people at any other time of the day. Relatives were not always confident their family member's dignity was maintained. Some relatives felt their family members did not receive the personal care required to promote their dignity.

The provider employed an activities co-ordinator, but some families were concerned their family members were left in their rooms for long periods which could lead to social isolation.

Care plans and assessments contained information that supported staff to meet people's needs; however some had not been updated when there had been a change in people's condition. People and their relatives were not consistently involved in the planning of care being provided.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not receive consistent care from staff at times when they needed it. People did not always receive care and treatment that met their individual needs and ensured their safety and welfare. Staff understood what action to take if they had any concerns people were being abused. People did not consistently receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Permanent staff had received training to deliver effective care, however staff training records were not up to date. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported with their nutritional needs but food was often cold and drinks not always provided in reach of the person. People were referred to a range of healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not consistently receive personal care that met their individual needs. Individual staff members mostly interacted with people in a caring and respectful way but did not always have time to engage with people outside of delivering care. People's privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to pursue their hobbies and interests.
Care and support was not always provided in a way people preferred. People and their relatives were not consistently involved in the planning and review of care provided. People and

relatives were given opportunities to share their views about the care and support received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had recruited a new manager, deputy manager and nursing staff. However the provider had not ensured there were sufficient numbers of care staff to support the needs of people. The provider and management had improved systems in place to monitor the quality and safety of service provided but medicine audits were not robust enough. Staff felt supported and able to share their views and opinions about the service.

The Beaufort 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 May 2016 and was unannounced. The inspection was carried out by two inspectors, an expert by experience and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

We reviewed the information we held about the service. We looked at information received about the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local authority commissioners who funded the care for some people at the home. They told us they had identified some areas for improvement and were closely monitoring the home in relation to these.

During our visit we spoke with eight people who lived at the home, three relatives, five care staff, two nurses and two non-care staff. We also spoke with the manager and the area manager.

We observed staff interactions with people and the support they delivered in the lounges and dining area.

We reviewed the care plans of three people. We also looked at other records such as medication records, recruitment files, complaints records and quality assurance records including meeting notes.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2015, there were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs .This was a breach of Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 - Staffing. The provider sent us an action plan outlining how they would improve. We checked to see if improvements had been made.

At this inspection we found the provider had taken some actions to improve staffing levels. They had recruited permanent nursing staff to the home and there had been a reduction in the number of agency nurses used. At the time of our visit there was only one agency nurse employed, and they had worked at the home on a regular basis and knew people who lived at the home. The provider was in the process of employing an additional registered nurse following completion of suitable pre-employment checks. This means there would be sufficient numbers of nursing staff to meet peoples nursing needs. One member of staff commented, "It's much better now there is a proper manager and deputy manager in place and permanent nurses."

However, since our last inspection, the number of people who lived at the home had increased and although there was an additional care worker on duty in the mornings on occasions, for example when staff rang in sick, there were not enough staff to provide support and care to people. One person said, "I never saw a face in here all morning, not until they brought my lunch, breakfast was the last time I saw a staff member."

People and their relations expressed concerns about the length of time people had to wait for staff to support them going to the bathroom. During our visit we observed it took 65 minutes from a person's initial call for assistance, until staff finally supported them to go to the bathroom as requested. This was because staff were too busy providing other people with support to meet this person's needs

People cared for in bed, who needed staff support to reposition their bodies to reduce the risk of skin damage; did not always get the support within the agreed timescales to reduce the risk. For example, some people required assistance from staff to be repositioned in bed and receive personal care on a four hourly basis. One person's charts we looked at showed they frequently had to wait five hours in between repositioning. This means that the person's skin could become sore if they were left in the same position for too long. One member of staff told us, "In the morning it can be very difficult to get time to do the first repositioning for people."

We were concerned that the correct times were not being recorded on the charts. We had been looking at a chart in a person's bedroom at 1.15pm. We left because staff needed to carry out personal care. When we went back in to the room later and found staff had recorded the personal care given at 1pm.

All staff we spoke with felt there were not enough staff to provide care and support to people. Staff told us most people required two staff to help them with personal care. When there were five members of staff working, the fifth member of staff was not able to help with personal care because people's needs were too

great to support them on their own.

Staff told us sometimes they did not have enough time to shower or bath people regularly and commented that when staff rang in sick, at short notice, it was not always possible to cover the staff absence. On the day of our visit, the number of staff on duty reflected the staff rota. However there were not enough to meet people's needs. Staff told us when there were staff absences which could not be filled, it had been "Horrendous" and staff were, "Shattered by the end of the day."

Staff were usually not available to attend to people in the communal lounge unless they were passing through the room to get to the conservatory or garden. We were made aware of a person falling in the lounge after our inspection visit and staff had not been present. They had been assessed as requiring close supervision by staff to prevent falls. This person was taken to hospital with a serious injury.

This was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing .

We discussed our concerns about staffing with the new manager and the registered manager from another of the provider's homes who was at The Beaufort to provide support. One told us, "The staff have struggled with the increase of residents, we know how busy the staff are, we can hear call bells constantly going and staff rushing around."

They both acknowledged our concerns regarding staffing levels and the new manager told us they had already been in contact with the provider's area manager to discuss this. The provider used a dependency tool to determine the number of staff required to care for people, however this only indicated the minimum levels of staff that were required to support people.

The new manager told us there had been occasions when staff would report as being unwell for duty shortly before their shift was due to begin which left no opportunity to replace them. They had addressed this at the staff team meetings and issued a firm notice to inform staff this would no longer be tolerated. They also told staff they would have to directly inform the manager in advance of any absence so cover could be arranged.

We spoke to the provider's area manager immediately following our visit. They informed us they would be addressing staffing levels as a priority and would review the staff duty rotas to assess whether there were enough staff on duty to meet the care and support needs of people who were currently living at the home. They also assured us that they would reduce new admissions to the home to one person a week and senior manager authorisation would be required for all new admissions in order to assess whether the person's individual needs could be met. This was to ensure there would be sufficient numbers of staff to meet the needs and dependency of people living at the home.

The provider had a 'resident's experience team' and their role was to provide support to homes where areas of concern or additional training needs were identified. The area manager informed us one member of the team would now be allocated to support the home and reassess the dependency needs of all people living there to ensure they were correct. This meant the dependency tool would have accurate, up to date information entered to ensure the appropriate numbers of staff were available to support people.

Medicines were stored safely, and in line with legal requirements. However we found the administration and management of medicines was not robust enough and some people did not receive their medicines when they required them.

Shortly before our inspection we were informed by the provider of an error recorded in the stock levels of controlled drugs. These are drugs that due to their strength need to be closely monitored. We had also been informed of another incident in February 2016 when a person did not receive their medicines for seven days as the home had run out.

We checked people's medicine administration records and found some people had not been given their medicines as prescribed as there were none in stock. One person who regularly required an injection did not receive it for three days because the wrong needle for the syringe had been ordered. One person told us, "I had the doctor visit a couple of weeks ago and they said I had a chest infection and would prescribe antibiotics but I never had them. It was the same last night I couldn't have my prescribed medication because they had run out." We asked the manager about this and they confirmed some people had not received their prescribed medicines, they also acknowledged correct stock levels of medicines had not been accurately monitored and this was being addressed.

Each person had a medicines administration record (MAR) which showed when medicines had been given. Some people had medicines prescribed on an 'as required' basis (PRN), for example, pain relief drugs. However, medicine plans to inform staff of when and why people might need these, were not consistently in place.

One person was on stronger medicines which can cause side effects and people using them should be closely monitored. There was no medicine plan to explain this to staff. However the medicines plans that were in place contained clear and comprehensive information.

We asked people if they received their medicines on time. One told us, "You get tablets through the day but not always when in pain." They told us this was because they often had to wait for staff to be available for them to request pain relief. A number of people were prescribed PRN pain relief but their records did not tell us how their pain levels were monitored or assessed by staff. This is important, especially for people who cannot communicate, to ensure they are kept free of pain and comfortable.

Some people were prescribed special creams, but we could not determine whether staff were applying the creams to them. The nursing staff did not sign on the MARs that these had been administered to people and the care staff, who were responsible for their application, had not recorded this was being done. One person needed their heart rate monitoring before they were given their medicine so they could safely receive it and we saw on one day this was not carried out.

We saw two people, who were cared for in bed, receiving their medicines. They were supported to sit up before taking their medicines so they would be safe, and the nurse explained what their medicines were for. Some medicines needed to be given at certain times before meals however there were no arrangements in place to ensure these instructions were followed.

This was a breach of Regulation 12 (2) (g) (f) HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The new manager informed us that they had taken steps to address the issues we had identified. They told us a nurse was now responsible for the daily checking of stock levels for medicines and a new medicines audit form had been devised. The area manager informed us after the inspection visit that a tool for assessing peoples pain levels would be introduced into the home and PRN protocols would be put in place for people who required them.

Some people told us they felt safe living at The Beaufort, they said, "Safe, yes very much so," One relative we spoke with told us, "I feel my relative is safe there, she has been at other homes and I haven't felt she was safe there. I do now."

Most people were able to use a call bell which had been placed near them in their bedrooms. However, two people could not reach their bells. One of the people needed to use a medical device and was unable to. They became distressed because their call bell was out of reach at the bottom of their bed.

We spoke to this person's relative who told us they had previously visited their family member and found them in a similar situation with no access to their call bell, they told us, "Last week the call button was unplugged at the wall so mum couldn't get help if she wanted it."
Another person told us, "I could do with a call button, usually I have to shout when I think I can hear staff passing." Call bells were heard in constant use during our visit. They were answered in varying time frames.

There was a procedure to identify and manage risks associated with people's care. Staff knew the risks and how these were managed. Risk assessments for falls, the use of bed rails, moving people, sore skin and nutrition were in place; however some of these did not contain enough detail. We found one had not been updated following an incident that had required immediate treatment for a person and we bought this to the attention of the new manager. They told us this would be reviewed immediately.

Professional Healthcare advice had been followed by staff. For example, people identified as at risk of choking when eating or drinking had drinks thickened with a substance to reduce their choking risk. One person was seen supported to eat their lunch and the staff member told us they did not speak to the person whilst supporting them to eat as this placed the person at risk of choking if they tried to talk back.

Some people were unable to eat or drink and had a percutaneous endoscopic gastroscopy (PEG) tube in place. (This is a tube that allows liquid food to be given directly into a person's stomach). A PEG feed is used when people are unable to swallow food or fluids. There were no 'nil by mouth' notices displayed in their rooms and no guidance in people's notes on how to correctly position them when they were receiving their special feed via their PEG. This is important so staff would be aware the person could be at risk of choking if they were given anything by mouth or incorrectly positioned. Staff however were aware of the people who were nil by mouth.

Staff had knowledge of adult safeguarding procedures and knew what to do if they suspected any type of abuse. Staff said they would refer their concerns to the manager and if necessary to someone more senior. One member of staff said, "If we suspected any abuse there is a policy we follow and a chain of action to take."

The provider's recruitment process minimised risks to people's safety because checks were made to ensure staff who worked for the service were of a suitable character. Staff told us and records confirmed, Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safe recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

We saw there was an emergency evacuation file in the main reception area; however this was not fully up to date with the current people, or contact details, of the current manager. This information would be required by emergency services if the home needed to be evacuated. We brought this to the attention of the new manager.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The manager told us information was recorded onto a 'tablet computer' and that this could be done by any member of staff. The manager would then analyse the information and put action plans in place to make improvements such as updating people's risk assessments or referring them to healthcare professionals for support.

Maintenance checks such as water temperatures had been carried out by the maintenance person; however these had not been countersigned by any manager for several months to confirm all necessary safety checks had been carried out. The new manager had already identified this and was addressing it.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in November 2015, staff told us they did not feel supported in their roles because they did not receive appropriate on going supervision to make sure their competence was maintained. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The provider sent us an action plan outlining how they would improve.

We found the provider had made improvements, and staff told us they now received supervision (one to one meetings) on a regular basis. The new manager told us they expected supervision would be carried out monthly and planned to prioritise supervision to staff who were new to the home to ensure they received appropriate support. They went on to say, "I also want to work alongside staff so I can observe the care they are giving."

At our last visit, staff had not been provided with annual appraisals where they could discuss their developmental needs and set personal objectives for the forthcoming year. However, during this visit we saw a timetable which identified when staff were due to meet with the new manager for their next supervisions sessions and annual appraisals. One member of staff confirmed to us they were due to have their appraisal meeting shortly with the new manager.

At our last inspection we identified that some agency nursing staff did not have the clinical skills required to meet people's needs. This had resulted in poorer care for people who required nurses to use a syringe driver and PEG tubes. A syringe driver helps reduce symptoms of pain by delivering a steady flow of injected medication continuously under the skin. The provider had recruited permanent registered nursing staff to the home following our inspection and reduced the use of agency nurses.

The provider had ensured all the nursing staff were trained to manage people requiring the use of syringe drivers and this training had been provided with support from a local hospice team. There was no-one receiving this treatment at the time of our inspection.

We asked people if they felt staff had the correct knowledge to support them, one commented, "I don't like the hoist but staff are very reassuring they talk to me all the time."

Care staff told us, when they started working at the home, as part of their induction they worked alongside more senior and experienced staff. This meant they could observe them working and learn from them. However, one care staff member work told us they only had two days of an induction and shadowing and felt they needed more in order to feel confident in carrying out their role. We spoke to the nurses on duty who told us they had not received an induction course when they started working at the home however they had completed the provider's mandatory E-learning (computer training) training.

We were told that training was planned to provide staff with further skills and knowledge. The provider was taking steps to register staff on an online training programme which would be mandatory for all staff. This covered all essential training areas such as health and safety, safeguarding, infection control and the mental

capacity act. The staff training record was not fully up to date. Some staff were still not able to access the online system however we saw that the new manager was addressing this and clear direction had been given to staff that they had to complete all the mandatory sessions before the end of May 2016. Staff told us, "To be honest we haven't done a lot of training. When we do it is mainly E- Learning (computer training)." The new manager had been in their post for one month we asked if they had received an induction course. They confirmed they had been allocated a position on the available next course which was due to start shortly.

The supporting registered manager, who was present during the inspection, told us they were a qualified trainer for the "React to Red" programme. This is training offered by the local tissue viability team (nurses who reduce the risks of skin problems) with the aim of educating care staff about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. They told us they would be offering support and training to staff at the home. One of the senior care staff was a qualified moving and handling trainer. This means that staff were able to receive practical 'hands on' training and support when moving and handling people safely.

The new manager informed us the provider had recently commenced new staff on the Care Certificate. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people.

The provider had successfully assisted one member of non-nursing staff to complete additional training to enhance their skills called the CHAPS (Care Home Advanced Practitioner) program. This qualification meant they were able to carry out additional duties such as updating care plans and giving medicines to people. One of the nurses informed us the provider was supporting them in preparation for revalidation which is a new process all registered nurses must complete as part of their registration.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. 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.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments were in place and reviewed regularly. Capacity assessments for individual decisions involved the person, their family and appropriate healthcare professionals. We found staff followed the principles of the Act when providing people with support and respected the right of people with capacity to make decisions about their care and treatment.

Staff knew they should gain people's consent before they provided care and support. We heard one member of staff asking a person for permission before going to carry out personal care. We asked staff what they would do if a person refused support. They responded, "If people don't want to comply with their plan of care we make sure they are safe, someone else may do better and go back later to talk to them and reassure them."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The manager understood their responsibilities under the

legislation. They had identified that some people could have some restrictions on their liberty and submitted the appropriate applications to the authorising authority.

Some people were unhappy about the some of the food provided and the temperature it was served at. Comments included, "The food is lovely, but it's always the same all the time. But if you ask for something different you can have it. I wanted mushy peas when I first came here and they didn't do them, but they went to the shop and got some how good is that." One person complained that soups were not warm enough when they received them, they told us, "My daughter brings in soup and the kitchen heat them for me but when I get them they are only just warm never hot." A relative we spoke to told us, "The food is freezing sometimes and it's always the same."

We were told lunchtime started at 1pm. The cook told us lunch was ready for care staff to take to people at 1pm; however staff did not start to serve it to people until 1.40pm. This was because they were still busy providing personal care to people. At 2.45pm six people had not received their meal.

The majority of people who lived at The Beaufort required assistance with eating their meals and we observed staff took their time supporting them. One staff member told us, "We make sure people have time to eat their dinners." They told us supporting people with their meals took a lot of time and they did not want to rush them as some were at risk of choking. However this impacted on their other duties and limited them being able to spend time with people. This also meant some people would have to wait longer to be supported by staff for their meals. Prior to our inspection the provider informed us a relative had complained that their relation had experienced delays in getting their meals.

We had mixed views from people about whether they had enough to drink. They told us, "Staff are always offering you drinks," but one person told us, "Drinks come without asking but some staff put them on my table which is over there out of reach. Even when they bring the table nearer it is still not near enough." We saw this person's drink was on their bed table which was out of reach. Prior to our inspection visit we had been contacted by a concerned relative who told us their relation was not provided with regular hot drinks and staff were not always available to fill up their empty glass.

We saw most people had drinks available to them however a member of staff commented they felt people did not always have enough to drink as they often saw drinks being thrown away. They also told us people often complained their food was cold.

We discussed this with the new manager who told us this would be addressed immediately. We saw from a recent team meeting that staff had been reminded to ensure that they offered drinks to people.

Food was cooked fresh on site and menus were devised by the cook. People were not involved in menu planning, but could order whatever they wanted if they didn't like the menu. The cook explained, "If someone wants something we don't have, I'll nip to the shops. "They went on to tell us they would go into people's rooms each morning to find out what they would like for their meals that day. For those who unable to communicate they found out about peoples likes and dislikes from family members. Some people who had difficulty eating a normal diet were provided with a soft pureed diet and others provided with fork mashable food to make swallowing easier for them.

There was a list of people who required special diets and pureed meals in the kitchen and a likes and dislikes board. Where people were at risk of malnutrition their meals were fortified with cream, butter and milk and they were given fortified drinks.

Some people had their food and fluid monitored to ensure they ate and drank enough to maintain their health and well-being. However some of these were not fully completed and the description about the amount food eaten was not clear. Some fluid charts did not contain information about how much fluid a person should be drinking. Staff would need this information to make sure the person was having enough to drink.

Care records showed people were referred to appropriate health and social care professionals. These included the person's GP, dietician and the speech and language team (SALT). However some recommendations suggested were not consistently followed.
Relatives told us the service referred people to external healthcare professionals where a need was identified.

We saw one person had long toenails asked the nurse why a chiropodist had not seen the person. They informed us there had been a referral made however following a discussion between the chiropodist and the person's family they had not been back. Staff had tried to cut this person's nails but we found further attention was needed.

Requires Improvement

Is the service caring?

Our findings

There were mixed views from people and relatives that staff were kind and caring. One person told us, "All the staff are lovely but I have my couple of favourites. They are like my family really, they go out of their way to try and keep you happy and out of a lot of pain. Even when they are understaffed they still try and do everything for you." A relative told us, "I know they don't get to take their breaks and they have many dedicated staff but they don't have much time, people here have high dependency needs."

One person told us a staff member on night duty never spoke with them, and made them feel they were not wanted. Another person commented, "Some staff are caring some are not so, I tell them if I think they have not spoken to me kindly." Following our inspection, we discussed some of the concerns expressed to us with the area manager and they told us they would address them as a priority.

During our inspection visit we heard staff speaking kindly to people and saw they were respectful, however as staff were busy we saw little interaction with people outside of receiving support.

On the day of our visit, all but two people who lived at the home were cared for in bed. Care staff ensured people's privacy was protected when providing personal care and closed bedroom doors. However during our inspection we found one person had removed their bed clothing and was exposing their body, their bedroom door was open, and we covered them up to protect their dignity. One relative told us, "My son visited last week and said [person] had no clothing over her and was completely exposed, now that is not nice for my son to see his grandmother like that. That's not protecting her privacy and dignity."

People did not always receive baths or showers when they wanted them. One person told us, "I can't remember having a bath or shower, perhaps it's not convenient for the staff, they did more for me in the early days." One relative we spoke to told us they had been concerned that their relation was not having baths or hair washes and asked staff why; they told us the response they received was, "It's more hygienic to do bed baths." Another relative we spoke to told us, "My relative has only had three baths in six months; I even offered to staff that I would come in to do it. [Person] worries that they smell."

Staff told us they did not always have time to provide people with more than one wash a day. They said people did not always get the showers they wanted because there were not enough staff to support them to take them to the shower.

We discussed this with the new manager, they told us these concerns had already been identified and they were in the process of addressing them. They were looking to reorganise staff duties on the night shift in order to allow further time for the day staff to assist people with bathing and showering. They also told us once the staffing levels were appropriate this would provide more time for personal care to be delivered. During our inspection visit we saw people appeared well cared for and their bed linen was clean.

We observe staff communicated with people effectively and used different ways of enhancing that communication by touch .They bent down to speak with people who were sitting and used gentle

reassuring tones when talking.Interactions between staff and residents was warm and compassionate but limited to when personal care was being provided. Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. We saw this when one person became agitated after lunch, and a member of staff sat with them until they fell asleep.

The home provided care to people when they were reaching the end of their lives. Plans were put in place to make sure people received treatment which would reduce pain and make them more comfortable. However we found some people were not fully involved in making choices about how they would like to receive their care. For example one person's end of life plan stated that the aim was to, 'up hold the person's wishes and preferences' but the plan did not state what these were. This means staff would not be aware of how this person wished to be supported as they approached the end of their life.We discussed this with the new manager who told us they would discuss this with nurses to ensure the plan was reviewed and accurately reflected the person's choices.

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. Relatives we spoke with told us they were able to visit their family members when they wanted or where invited to by their relation. One relative told us, "I visit nearly every day."

Requires Improvement

Is the service responsive?

Our findings

Most people who lived at The Beaufort remained in bed because of poor physical health, however one member of staff told us if the home was short staffed this impacted on people being able to sit out of bed. We asked people what they thought of activities on offer in the home, one person told us, "There is no support, very little interaction, the rooms down stairs are nice but I don't go down very often. The only time I get out is when my daughter takes me." During our inspection we saw two people sat in the lounge with very little engagement from staff.

Relatives we spoke to also expressed concerns that people spent a lot of time in their room with little interaction, they told us, "I have mentioned before about helping [person] out of bed and into her chair as this only happens on Christmas day and even that didn't happen this year. I never see other residents in chairs or sitting in the garden they all seem to be in bed." Another relative told us, "I have asked why [person] is in bed so much, I worry she has no-one to talk to." They went on to tell us staff had told them they did not have sufficient numbers of chairs in the lounge area and this meant not everyone who was able to could sit out. The new manager informed us they were expecting new chairs to be delivered to the home.

The home had an activities co-ordinator who worked five days a week. During our inspection we saw they were carrying out individual activities with people. For example, we heard them reading the bible to one person and observed them selecting audio reading books so people could listen in their rooms. We saw one person looked calm and peaceful whilst listening to one of these stories. Where music was playing in peoples rooms we found this to appropriate and at pleasant volume.
At our previous inspection, people and staff had commented favourably about the activities coordinator. However as most people were nursed in their rooms this provided a challenge for the coordinator as there was not sufficient time for her to undertake individualised interests and activities with people.

Many people in the home were nursed in their rooms and were unable to be involved in group activities. We looked at people's care plans to see how they were supported with individual activities; one person who was nursed in bed had no plan to show that they received some social interaction each day.

There were no individual activities for people who lived with dementia. People living with dementia often benefit from one to one activities that are tailored to meet their individual needs. Life histories had not been completed for some people. This information was important as it supported staff in providing individualised care and holding meaningful conversations with people.
The provider acknowledged this and following our inspection took steps to provide further training to the activities coordinator so that care plans could be updated with individual activity plans for people. Life histories would also be completed for everyone who lived at the home.

We looked at three people's care records. Some of the care plans and assessments held within contained detailed information however some lacked important information.For example one person receiving end of life care did not have a plan in place to support their pain management or psychological needs. Other people with PEG tubes in place did not have information to record management of the tube, and the site,

which is necessary to ensure they are safely maintained. One person did not have a mouth care plan about when, and how frequently to provide mouth care. This is important to prevent a person's mouth and lips from becoming dry and sore when they cannot drink or eat due to their medical condition.

We found that some care plans had not been reviewed as regularly. One person who had been admitted to the home initially for a short stay had not had their care plan updated following their full time admission to the home. Their care plan also had conflicting information as to whether they should be nursed in bed or sat out in a chair. Guidance from a healthcare professional had not been updated in the care plan. This meant staff would not have up to date information on how to support this person with their health and well-being.

Some people told us they had not been involved in formulating and reviewing their care plans. They told us, "I don't remember seeing it, or any review." Another told us, "My care plan, no I am not involved and have not seen it."

However one relative told us, "Yes I have been involved in [persons] care plan review." Another said, "I have been involved in the past and they let me know of any changes."

The manager acknowledged that care plans needed to be improved and told us, "Care plans are improving but they are not quite where they should be." Following our inspection the area manager informed us all nursing staff were to receive support and training around the correct completion of care plans from the resident experience team. A meeting had been held with the nurses to discuss the concerns we identified the week after our inspection and a future date organised for a study day.

We spent a period of time observing in the dining room to see what the lunchtime experience for people was like and if staff responded to people's needs. Only two people ate in the lounge, everyone else ate in their bedrooms. We observed one staff member and they described the meal to the person and asked if it was hot enough and if they liked what they were being given. One person was reluctant to eat the main choice offered and we saw a member of staff give alternative choices. At the end of their meal the person indicated that they were finished by raising their hand and the member of staff responded to their gesture and stopped feeding them. We then saw the person was given a drink and their hands and face were washed.

Staff told us there were staff handover meetings between each shift when they would be informed of any changes in people's health so they could respond appropriately. During our inspection visit we saw the nurses were responsive to the care staff when they asked questions and requested the nurse to assess people. We also heard them give advice and support to staff about correctly meeting people's needs.

Information about how people could raise complaints was displayed on a noticeboard in the entrance hall of the home. We asked people if they knew how to make a complaint, one person told us, "I'm not sure what I would do, I suppose I should know, perhaps speak to a senior member of staff." Another person told us, ""I would just go to the office."

Relatives we spoke to told us, "I will go and speak to the manager but the managers change a lot." Another told us they felt confident to approach the managers to discuss any concerns but they also commented that the change of managers had been a problem as there had been a lack of consistency on who to speak to.

We saw there was a 'tablet computer' in the reception area which was available for anyone who visited the home to use. This could be used to request an appointment to speak to the manager and also to raise concerns and complaints. There was a sign above the computer indicating where it was and why it was there. The new manager told us they reviewed information entered onto the computer regularly and

addressed any issues raised. People were provided with a service user guide that contained information about how they could make a compliant.

Learning from complaints had been shared with staff in staff meetings, for example ensuring people could reach their call bells. The manager told us all formal complaints received were recorded on to a 'tablet computer' so they were able to identify any emerging trends and take appropriate action. One we saw said there were not enough staff available to spend time with their relation and that staff were "rushed". This was being addressed by the manager.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection visit we found the provider was in breach of the regulations in relation to good governance of the home. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would improve.

At the time of our last inspection in November 2015 the area manager responsible for the home had been on a leave of absence. The home had not had consistent senior managerial oversight and quality audits had not been consistently carried out to monitor and improve the service. There had been a temporary manager in post who had no clinical background and there was no deputy manager in post.

We served the provider with a warning notice and asked them to provide an action plan outlining the improvements they intended to make. At this inspection we found the provider had made some improvements.

There was a new manager and area manager in post and they had been at the home for one month prior to our inspection visit. They were in the process of registering with us. They had a clinical background which meant they had a better understanding of the complex needs of people who lived at the home. The provider also employed a new deputy manager to the home. The new manager and area manager had already identified some of the shortfalls we identified at the time of this inspection and were putting plans in place to address these.

The area manager who had been covering the home on a temporary basis was now employed permanently which meant the home had consistent senior managerial oversight. The provider had also recruited permanent nursing staff to the home and the use of agency nurses had reduced to one a week. As a result there had been lots of staff changes since our last inspection and the new team were settling into their new roles.

We found that there had been an improvement in how the provider monitored the quality of the service. The manager was responsible for carrying out spot checks and "walkabouts" in the home to look at quality of care, safety and cleanliness. The new manager told us when they first came to the home they had carried out one 'spot check' in the early hours of the morning so they could monitor the quality of the service being provided by the night staff.

There was a timetable indicating audits that needed to be carried out by the manager on a weekly and monthly basis and these included medications, falls analysis, and skin damage. Random checks of care plans were conducted and staff were spoken with to see if they had any concerns. We asked the registered manager what happened at weekends and they told us these checks were still conducted by the staff on duty. We saw evidence these checks were carried out, however some audits had not highlighted some of the issues we identified such as medication stock levels.

We spoke with the area manager the day after our inspection visit to express our concerns over our findings and they were open and transparent about the challenges the home faced. They told us, "I am of course disappointed that the outcome was not as positive as it could have been, however, I am very confident that the manager and the team will be able to move forward and our commitment is to the health and wellbeing of our residents."

They immediately responded to our concerns by reviewing all the dependency needs of people who lived in the home to ensure staffing reflected the needs of people. Staff rotas were reviewed and additional care staff were placed on to shifts to offer further support to people. The provider took steps to reduce admissions to the home to one a week and the area manager informed us any pre-admission assessments would be reviewed by the senior managers to ensure the home could meet the needs of people moving into the home.

We asked people if they felt the home was well led. One told us, "It's well maintained, you see painters and decorators all the time and the manager comes in a lot." Relatives we spoke with were aware there was a new manager, one told us, "I know there is a new manager here now, I hope they stay so we can have some consistency in the home. " Another relative commented about the deputy manager, "[Person] is good, they are knowledgeable."

At our previous inspection staff told us they had felt vulnerable with the constant change of managers and lack of information from the provider about changes in the home. We asked them if there had been any improvements made and they told us, "Right now I think we are in a good place. We have a good manager and deputy manager." And, "[Person] is lovely and she is approachable and friendly. If needs be she digs in." Other staff told us they found the new manager approachable and supportive.

The new manager was motivated to make improvements within the home. They told us they felt well supported by the area manager and the provider to carry out their role. In addition they received support from an experienced registered manager from one of the providers other homes who was present during our inspection visit. They told us they were committed to improving the service and said, "I want to know if there are any problems and to I want to improve communication with people and staff."

We received mixed responses from relatives when we asked whether communication was good and if they felt informed. One relative said, "The previous manager who just left was lovely, she understood and related to what you were saying." Another said, "Communication can be a bit hit and miss. I did see an advert recently for a relatives meeting but I didn't go."

The new manager told us they were keen to improve communication and share information with residents and relatives and had organised a meeting the month before our inspection visit. No-one had attended, however the manager told us they were planning to reorganise this at a different time of the day to try and encourage more attendance. We saw the poster advertising the meeting and the manager had informed people they could approach them directly to discuss any issues if they could not attend. They told us, "I will hold these meetings every month, we need to give a voice to people."

We asked how they listened to the experience of people who were unable to attend the meetings as they were mostly in their rooms. The manager told us as part of their quality of life audit system a senior member of staff would visit people to discuss if they had any concerns or issues. The information would be entered on to the 'tablet computer' and each week a minimum of seven people were spoken with to see if they had any concerns. Healthcare professionals were also being encouraged to provide feedback on the service.

Negative responses given by people showed as 'red' on the system and this gave a visual cue for the manager to address the issues. If these were not addressed, the area manager would follow this up directly with the manager to establish why actions had not been taken.

Whilst we acknowledge some improvements have been made by the provider since our last inspection, the home was operating at increased levels of occupancy and it was clear the staff struggled to support the needs of people living in the home.

The area manager responded immediately to the concerns we identified and outlined the actions they intended to take to address the issues we highlighted. We found the new manager and area manager open and transparent and acknowledged that improvements were required.

The new manager told us they felt supported by the provider and other managers from the providers nearby homes. They went on to say they were keen to make improvements in the home and wanted to encourage communication with both staff, people living at the home and relatives.
They told us, "My priorities are the residents and the care they receive and also to support the staff."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2) (f) Sufficient equipment that is necessary to meet people's needs was not available at all times. 12(2) (g) Proper and safe management of medicines. Medicine stocks were not maintained and there were insufficient supplies to meet people's requirements.

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 There were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's care and treatment needs.