Ringdane Limited

The Beaufort Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 24 August 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. 17 people lived at the home at the time of our inspection, however four were in hospital.

We inspected the home in November 2015 and found there were 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. 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.

We carried out a follow up inspection at the home in May 2016 and found some improvements had been made but further improvements were still required. The provider had recruited a new manager, deputy manager and a new regional manager.

At that inspection we 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 the proper and safe management of medicines. We also found sufficient equipment necessary to meet people's needs, was not available at all times. The provider sent us an action plan outlining how they would make improvements.

We completed a further unannounced inspection on 24 August 2016. This inspection was in response to concerns we received about how people's care was managed. There had been a recent incident in the home which had resulted in investigations from a number of organisations including local commissioning, the clinical commissioning group and police.

At this inspection, we found there had been inconsistent management and clinical leadership in the home since our last inspection in May 2016. This was because the manager and deputy manager at the time of our last inspection had recently left the service. There had also been a change in the regional manager and managing director.

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.
A new manager was in post however they had only started at the service two weeks before our visit and there had been another temporary manager supporting the home. The provider was looking to recruit a new deputy manager.

The provider and manager were responsible for completing a range of checks to ensure the quality of the service was maintained. These checks had not been completed consistently to identify when improvements were required and they were not robust. This also meant that any improvements made had not been sustained.

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. Individual staff members were committed to providing a good standard of care but we saw delays in attending to the needs of people, and call bells were not always in reach for people to request support.

Staff were kind and caring when they provided 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. Some relatives felt their family members did not receive the personal care required to promote their dignity and people did not consistently receive baths and showers when they wanted and needed them.

Due to the recent concerns the provider had increased the number of staff who worked at the home. However this meant the home was reliant on agency staff as several experienced care staff had left their employment at the home and people were not always provided with care by staff who knew them well.

After the May 2016 inspection we asked the provider to take action to improve the management of medicines in the home. We found the provider had not made the necessary improvements as some people did not always receive their medicines as prescribed and stock levels were not maintained.

Analysis of incidents and accidents were not always carried out to minimise the likelihood of them happening again.

Permanent staff had received training required to undertake their work but staff told us they would like further training in some areas, which the management team were arranging.

Staff told us they did not feel valued and that the provider had not kept them informed about changes within the service. Staff had started to receive sufficient support and supervision (one to one meetings) to help them work effectively but this had not been maintained due to the change in management.

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).

The provider employed an activities co-ordinator, but some people told us they would like to be involved in more activities and spend time outside of their room and the home.

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 or when they had been seen by a healthcare professional. People and their relatives were not consistently involved in planning the care provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The overall rating for this service is 'Inadequate' and the service will therefore be placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not receive consistent care from staff who knew them well and people did not always receive care and treatment that met their individual needs and ensured their safety and welfare. People did not always receive their medicines as prescribed. Staff mostly understood what action to take if they had any concerns people were not safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Permanent staff had received some training to deliver effective care however some staff felt the training they received could be improved. The provider was addressing this. 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; however drinks were not always within people's reach. People were referred to a range of healthcare professionals however there was a delay in some referrals being made.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not consistently receive personal care that met their individual needs and preferences. 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 providing care. People's privacy and dignity was not always respected

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support was not always provided in a way people preferred. People and their relatives were not consistently involved in planning and reviewing care provided. People and

relatives were not consistently given opportunities to share their views about the care and support received.
The provider employed an activities coordinator however some people wanted more activities, and opportunities to go outside of the home.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager or deputy manager in post and there had been a lack of managerial oversight since the last inspection.
People and staff felt a lack of consistency in management had affected the quality of care provided. The provider had not kept people or staff informed
about recent events and changes in the home. The provider and management had systems in place to monitor the quality and safety of service provided but audits were not carried out effectively in order to sustain improvements and drive improvement for the benefit of people who lived at the home.

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 24 August 2016 and was unannounced. The inspection was carried out by three inspectors, 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 and had been present at our last inspection in May 2016.

We reviewed the information we held about the service. This included the information from the inspections held in November 2015 and May 2016. We also looked at more recent 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 concerns about the quality of care being provided and were working with the home in relation to these. We also spoke to the local authority safeguarding team and police following a specific incident that occurred at the home in August 2016.

During our visit we spoke with five people who lived at the home, three relatives, three care staff, three nurses and two ancillary staff. We also spoke with the new manager, two of the provider's regional managers, and one of the provider's trainers.

We saw how staff interacted with people, and the support they provided in the lounges and dining area. We reviewed the care plans of three people. We also looked at other records such as medication records, supplementary records, complaints records and quality assurance records including meeting notes.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2016 we found the provider was in breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's care and treatment needs. We asked the provider to send us as action plan outlining how they would improve.

At this inspection we found that, despite the provider having recently increased the number of staff on duty, staff were not always available at the times people needed them.

People and relatives told us they did not feel there were enough staff to meet their needs. One person told us, "I have to wait a long time for them [care worker] to come when I need help." Another person told us, "No, there are not enough staff. I am forever waiting." We observed one person in the lounge who needed assistance from staff to return to their bedroom. The person told us, and a staff member confirmed, the person had been waiting for over an hour.

Relatives we spoke with commented, "Staffing is a problem. It is difficult to find a staff member which means [person] has to wait and wait, all the time. When [person] came here I was told by staff," 'It's not very good here they can't keep their staff'. I tried to keep an open mind."
Another relative we spoke with told us, "The staff take too long to deal with buzzers…once we buzzed [call bell] for over an hour."

Staff were not always available for people in the communal areas of the home. For most of our inspection visit, the activities coordinator was in the lounge, however we observed from 10.45am – 11.30 am there were no staff present. One person dropped their newspaper on three occasions and called for assistance to pick it up, they did not have a call bell to request staff and a relative assisted the person.

On the day of our inspection three out of the four care staff on duty were agency workers. This meant they did not work at the home on a permanent basis. The provider had recently changed the agency they used to supply them with care and nursing staff. This was because they were not happy with the quality of agency staff supplied. Staff from the agency now being used, had not had time to get to know people's needs or the routine of the home. One person told us, "Some staff know how to help me other's don't."

Permanent staff told us they were under pressure to support people and also guide and monitor the agency staff who had not previously worked at the home. They explained to us that there were only four care staff who were permanently employed by the provider, the rest were agency staff. They said the agency staff did not know people's needs, the layout of the building and how the home was managed.

The provider used a 'staffing tool' which identified the number of staff required to meet the needs of people based on their dependency levels. However, people's dependency levels were not always accurately assessed; this meant the tool had inaccurate information entered which affected the results of staff numbers required to meet people's needs. For example, one person was assessed as having 'medium' dependency.

However, by looking in their records we saw information which demonstrated their nutritional, behavioural and mental health needs were much higher, and should have been assessed as 'high' dependency according the provider's assessment tool.

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

We spoke to the management team who informed us they were actively recruiting new staff to the home. They acknowledged it was a challenge for people and staff during this process, and the use of agency staff would reduce once new staff were recruited. They told us peoples' dependency levels would be reassessed to ensure the staffing tool had accurate information entered.

At our last inspection in May 2016 we found the provider was in breach of Regulation 12 HSCA RA Regulations 2014. Safe care and treatment. This was because we found that medicine stocks were not maintained and there were insufficient supplies to meet people's requirements. In addition, equipment that was necessary to meet people's needs was not available at all times. We asked the provider to send us as action plan outlining how they would improve.

At this inspection we found some people still did not consistently receive their medicines to maintain their health and well-being.

We looked at 11 medicine administration records (MAR charts) and found that five people had not received their medicines because they were out of stock. For example, one person required their medicine to help with stomach reflux and their medicine was out of stock for four days; another person who needed medicine to help them with nausea did not receive it for three days.

One person needed medicine to maintain safe blood levels. Their medicine record showed they only received half of their prescription in the morning and the remainder in the evening. This was because staff could not find all of the medicine in stock until later in the day. There was no indication from the person's records that medical advice was sought before doing this. This meant the person may have been at risk because they did not receive their full medicine dose to maintain their correct blood levels.

We looked at how pain relief was managed for people and if they received their medicines as prescribed. One person required strong pain medicine and should have received their medicine patch once every seven days to ensure their pain levels were manageable and they were kept comfortable. We saw on one occasion they were a day late receiving their medicine. This meant the person was at risk of experiencing pain or discomfort due to the delay.

Some people had medicines prescribed on an 'as required' basis (PRN), for example, pain relief medicines. However, medicine plans to inform staff of when, and why, people might need these, were not consistently in place. 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 continuity in the administration of these medicines, to ensure people remain pain free.

Some people were prescribed special creams to manage skin conditions and prevent sore skin, but we could not determine whether staff were applying the creams. 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 two days this was not carried out.

These issues were also identified at our last inspection in May 2016.

We shared our findings immediately with the nursing staff and the new manager who acknowledged that the ordering and maintenance of sufficient supplies of people's medicines had been disorganised. They told us they were addressing this. One member of the nursing staff we spoke with told us, "There is no communication book and things don't get handed over, that's how things get missed."

The provider's 'resident experience' team manager told us a full medication audit would be conducted on the day after our inspection visit and the provider's pharmacy technician would attend to review systems and processes. We received a copy of the audit carried out following our visit with an action plan stating what improvements would be made and who would be responsible.

We asked people if they received their medicines on time and they told us, "I just ask and I get a tablet." Another person told us, "I had a tablet for my pain but it didn't suit me so they [Staff] called the doctor straight away."

There was a procedure to identify and manage risks associated with people's care. These included the use of bed rails, moving people, sore skin, nutrition, medications and the risk of choking. Risk assessments were in place; however some of these did not contain enough detail.
For example one person's medication dependency was recorded as medium however they had been refusing their medicines which may have impacted on their health and wellbeing. The risk assessment had not been updated to reflect this. This meant staff who were unfamiliar with the person would not have accurate information to keep the person safe and ensure they received the correct support to take their medicines.

People's risk assessments were not always followed, therefore at times people did not receive the care or support they needed which put them at increased risk. For example, we spoke with an agency care worker who told us they had assisted a person to eat their lunch when they were lying flat in bed. This person had been assessed as being at high risk of choking by the speech and language therapist and their care plan and risk assessments stated they needed to be sat upright to eat their meal safely to avoid them choking on their food. They also required thickener (thickener is used in drinks in varying amounts when people are at risk of choking on fluids) added to their drinks. However the agency worker we spoke with told us they had only added one spoon of thickener and not the required two spoons.

We raised this immediately with the nurse in charge and asked them to ensure all agency staff were informed of people's need in relation to their risk of choking. They confirmed this had been done and we also discussed this with the manager who had been informed by the nurse that the staff had been spoken to.

We asked two agency staff if they read people's care plans to find out what their care needs were and they told us did not have time. They told us they relied on being told about any concerns or risks associated with people's care in the staff shift 'handover' meeting. We looked at the staff 'handover' records for the three days before our visit and found they did not contain detailed information about risks associated with people's care and support. We looked at the report for that morning and we could not read the handwriting to understand what the report said.

This was a continued breach of Regulation 12 HSCA RA Regulations 2014. Safe care and treatment.

We saw an agency member of staff leave soiled continence pads on the top of the dirty laundry in a person's bedroom. This presented a high risk of contamination and spread of infection. The permanent staff member took immediate action when they identified the issue and reported the poor practice to the manager.

One relative we spoke with told us their family member did not have a call bell in their room. We looked and confirmed this was the case. We raised this with the manager who told us they would look into this immediately. Call bells were available for some people, but were not in people's reach in four of the rooms we visited. We asked people how they would call for assistance because they did not have their call bell. They told us, "I would have to shout very loud because I haven't got my button." And, "Call out or wait. They would come at some point." This meant people could not request support from staff when they required it.

Staff told us they understood their responsibilities to report any concerns about safeguarding people. However one staff member we spoke with when presented with a safeguarding scenario was unclear about the action to take in reporting incidents of this type. Another staff member told us, "I would report it straightaway."

Requires Improvement

Is the service effective?

Our findings

People told us some staff did not have the necessary skills and training to support them effectively. One told us, "The new ones [agency] most of the time don't have a clue." One relative we spoke with told us, "Staff try their best but they are so, so busy. If agency staff are on they don't know about [person's] needs."

Some staff had not received training to support them in meeting the complex and specific needs of the people who lived in the home. For example, one member of staff told us they wished they understood how to work more effectively with people who lived with dementia. They said they did not know how to comfort people during times people became anxious. They also said they worked a lot with people who required end of life care but had not received training to support them with this. They also told us they had been put into a leadership position but had not been given the training they felt they needed to work the role effectively. They told us, "I shouldn't be leading a shift. I do and will do my best but I don't feel confident if I haven't had that kind of training. Today has been a little bit too much."

One of the nurses told us they had received an induction pack when they first started working at the home however as there had been a change in management they had been unable to receive adequate support and they felt their induction was not complete. Agency staff were not given a thorough induction to the home as permanent staff told us that they did not have sufficient time to support them.

The provider told us at our last visit all new staff working within their homes would be enrolled on the Care Certificate. The Care Certificate standards support care workers to have the relevant knowledge and skills to provide compassionate, safe and high quality care to people.

The provider's regional managers told us they were actively working to source appropriate training and support for all staff who worked in the home. They told us that training was planned to provide staff with further skills and knowledge. The provider had registered all permanent staff on an online training programme which they considered to be mandatory and since our last inspection a number of staff had completed this. The training covered areas such as health and safety, safeguarding, infection control and the Mental Capacity Act. Nurse training in areas such as catheterisation had been planned, and all staff had training scheduled for moving people safely, treating people with dignity, dementia care, and end of life care.

Staff told us they had received supervision (one to one meetings with their line manager), however due to the change in management at the home these had not been taking place regularly since our last inspection. The management team had already identified this, and scheduled meetings dates with all staff were in place.

People mostly received food and drink to maintain their health and well-being. However we could not be assured that people who could not communicate their needs and who relied on staff to monitor their drink and food intake were receiving the food and fluids they required. This was because some monitoring charts were either not completed, or inaccurately completed. Prior to our visit we had received information that

monitoring charts were not accurately maintained and we found that improvements had not been made in relation to this.

One member of staff told us, "Agency staff do not complete food and fluid charts which causes problems." We looked at one person's chart and the agency worker had recorded the person had roast beef for lunch but this meal was not on the menu. This person had been unwell in the morning and we could not be certain they were well enough to eat their lunch; however the agency worker told us they had supported the person to eat their meal. We raised the inconsistencies with the management team who told us they would address these immediately with the agency worker.

Following the concerns identified (at the last inspection, or as a result of an investigation into a specific incident at the home) the provider had written to all staff, including agency workers, to remind them of their responsibility to ensure records were accurately maintained. Staff were now recording when a person had been offered fluids but declined. However one person's chart did not contain information about how much fluid the person should be drinking. Staff would need this information to make sure the person was having enough fluids to maintain their health and well-being.

On the day of our visit we saw people had drinks available however four people in bed were unable to reach them without assistance from staff. One relative we spoke with told us they had visited previously and observed their family member could not reach their drink and they had raised this with the nurses. They also told us they had purchased cold milk, a glass and a cool bag from the local garage because repeated requests to staff to provide their family member with cold milk had been ignored. The person told us, "Cold milk is my favourite drinks. I had it every day before I came here."

At our inspection in May 2016 we had been informed by a member of staff that they were concerned full drinks were being thrown away and people were not having enough to drink. We asked the staff member at this inspection if this was still happening and they told us, "There has been a big improvement since then, I don't see many drinks being thrown away now." We observed people throughout the day being supported to have their drinks and they were served regularly to people.

At our last inspection some people were unhappy about the variety of some of the food provided and the temperature it was served at. We also saw long delays in people receiving their food. At this inspection we found improvements had been made. People told us, "The food is good but you don't get a choice." Another told us, "I enjoy the meals." A member of staff we spoke with about the food told us, "It is beautiful and they will do anything they ask for. It is presented nicely as well...Yesterday someone said they would like an omelette and they made her one."

We saw lunch was served at the time people expected and staff supported people to eat and drink at a pace that was appropriate for them. One of the nurses supported a person with their lunch and we saw they were attentive and supportive.

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 however one person's records showed conflicting information regarding their capacity and their ability to make simple decisions and understand what was being said. This meant staff who were not familiar with this person would not have clear information about how best to support the person to make their own decisions. We discussed this with the manager who told us they would discuss this immediately with the nurses.

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. We saw one that had not yet been submitted and the manager told us this would be sent immediately.

Staff followed the principles of the Act when they provided 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 asked people if staff gained their consent before providing care and they told us, "I think they ask me most of the time but they are busy so you need to be ready when they are." Another commented, "Yes they do and say 'shall we help you now'."

Most 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 we saw in one person's records that a GP was to be contacted due to a change in their health on 22 August. We could not see in the records this had been done and spoke to the new manager about this. They told us they could not confirm this had been done and would contact the person's doctor. This lack of communication meant there may have been a delay in the person receiving the appropriate care and treatment for their condition.

During our inspection visit the nurse in charge requested another person's GP visit them as they were concerned about a change in their health condition. After the GP visit, the person was admitted to hospital.

One person had several wounds and we saw the specialist wound care nurse (tissue viability nurse) had been requested to assess the person's wounds and their recommendations in the care plan were being followed. The person's wounds were improving and they were repositioned every two hours as recommended by the health professional.

Some people had a DNAR (do not resuscitate) in place. One person's care plan stated they had a DNAR but the actual document was not available. This meant the person could be resuscitated against their wishes. We discussed this with the new manager who told us they would address this with nurses to ensure the end of life care plans were reviewed and we were informed following the inspection that all the DNARS were being checked by the nurses and the person's GP would be contacted if the information was not up to date.

Requires Improvement

Is the service caring?

Our findings

At our inspection in May 2016 people did not always receive baths or showers when they wanted them. During this inspection visit people told us they still were not always supported to have a bath or shower because staff were busy. One person said, "I think I've only had one bath since I came here. I would like one more often." Another person said, "I like to have a shower but I usually get a wash in bed." This person had been at the home for four months.

Relatives we spoke with expressed concerns that people did not consistently receive good quality personal care. One told us, "[Person] wants a shower and staff keep saying they are coming to do it, they had to ask three times." Another told us their relation had wanted a shower but had to wait for a full day, this was after experiencing a stomach upset, they told us, "I told them [staff]. This is a care home. CARE. [Person] has [medical condition] and has come here to get special care, love and support and that's what we expect."

Staff told us people did not receive the baths or showers they wanted. One member of staff told us, "Baths and showers are non-existent and it is like somebody's birthday if they get their hair washed." And another said. "Showers and baths could be given a lot more regularly."

Staff told us they did not have the time to respect people's dignity by ensuring they were clean at all times. Some people with complex needs required extra staff vigilance to ensure their hands were clean, however staff told us this did not always happen. A visiting healthcare professional also told us they had seen a person with faeces under their nails.

Staff members told us, "They [people] can go two to three weeks without having a hair wash and they have had scabies twice." One staff member commented to us, "We don't get time to do many baths or shower's. But the new manager is very hot on this so I think it will change."

Although people's care records showed their preference for how they liked to have their care they did not always receive it. For example one person's records indicated they should be asked if they wanted to have a shower or a bath, however we only saw washes and bed baths recorded for twelve days. Another person's records stated their preference was to have a shower, however for three days it was recorded they had received a wash.

We asked agency staff if they had supported a named person to have personal care on the morning of our visit and they told us they had only changed the person's nightwear. We informed a member of the permanent staff who organised for the person to have a wash.

When we asked people if they were able to make daily choices on how they received their care we received mixed responses including, "I can choose when to get up and go to bed." And, "You can't choose when to have a shower you have to wait till staff can help you."

This was a breach of breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Person-centred care.

Staff were discreet when people needed assistance and were seen knocking on bedroom doors and identifying themselves before entering the room. People's dignity was mostly respected, staff closed doors whilst providing personal care. However we saw one person's room still contained soiled pads which did not show respect for the person's dignity or privacy.

We discussed these concerns with the new manager who told us this was unacceptable and would be addressed immediately. Following our inspection the registered nurses were tasked with ensuring that people received their personal care according to their own individual choices and that this was documented in their records.

People and relatives told us individual staff members were kind and caring. Comments made were, "I am happy living here, they are nice people. Staff are kind to me." And, "Staff are very pleasant and kind. There is no nastiness with any of them." Relatives we spoke commented, "Staff seem caring, kind and attentive." One relative told us, "The staff here are really nice."

During our inspection we saw staff treating people with kindness. One person was having difficulty eating their lunchtime meal which was causing them to become upset. A nurse asked if they could sit by the person and assist them. The nurse was observed gently touching the person's arm and heard to say, "[Person] don't worry, we all struggle a little at time. We can take our time, there's no rush and I can help you." The person thanked the nurse and was seen eating their meal with assistance. The nurse and person chatted and reminisced about their past lives. The activity coordinator became aware that a person in the lounge was upset about the death of their mother. They went to speak with the person and spent time listening to them and looked at old photographs. The person began to smile and engaged in conversation.

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 did not contain information about the person's wishes and preferences. This meant staff would not be aware of how this person wished to be supported as they approached the end of their life.

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, "As a family we come here most days."

Requires Improvement

Is the service responsive?

Our findings

At our inspection in May 2016 we found most people who lived at The Beaufort Care Home remained in bed because of poor physical health. At this inspection visit we still found most people remained in their rooms in bed, however one relative we spoke with told us, "I did notice that [person] didn't get out of bed. I thought this was normal so I didn't question it. But the last three to four weeks [person] has been got up and is sitting in the lounge. I have noticed the difference, [person] seems much happier now they get out of bed."

At this inspection we saw staff assisted people to sit in the lounge during the day and the management team told us five people had recently had assessments for specialist seating to support them so they could sit out of bed. The provider had informed us following our last inspection that people would be asked if they wished to sit out of bed and this would be recorded in their records.

We looked at people's care plans and saw one person had stated at a review meeting on 10 August 2016, that they wished to have time out of their room for a bit of company, however they had restricted mobility and the care plan did not reflect how this was going to be achieved. The person's daily records did not show the person had spent time out of their room. During our visit we observed this person stayed in their room.

We looked at three people's care plans. Care plans and assessments contained some information that supported staff to meet people's needs however we found that where healthcare professionals had recommended treatment and support this was not consistently reflected throughout the care plan. For example, we saw one person had been assessed by the dietician as they had been losing weight. Although their weight had stabilised the care plan did not fully document the recommendations suggested by the dietician for staff to follow.

Another person who had also lost weight had been seen by the appropriate healthcare professionals and prescribed food supplements which they had been refusing. They were on a special diet to maintain their health and well-being. Information relating to both of these issues had not been identified in the nutrition section of their care plan, or the section relating to them being at risk of skin breakdown. This person had limited mobility and was at risk of sore skin; poor nutritional intake may impact on a person's skin integrity and lead to skin breakdown. This information is important to guide staff on the support the person required. Although the permanent staff we spoke with had an understanding of the issues for this person, the high levels of agency staff in the home meant there was no consistency in the staff supporting them. Agency staff would need up to date information in the care plan to ensure they were aware of all of the person's issues and their care needs.

People could not recall being involved in care reviews. One relative commented, "I don't ever remember being asked to contribute to a care plan." Another told us a meeting to discuss their family member's care had been arranged but cancelled by the home and they were not informed why. The meeting had not been re arranged.

The new manager was open with us at the beginning of our inspection visit and told us that care plans

needed improving and they had already identified this. They told us one of their priorities was to work with the nurses to improve the care plans and make sure people and their families, where appropriate, were involved. The provider's 'resident experience team' regional manager told us they would also support staff within the home to make improvements to the care plans.

Staff told us they did not have time to read care plans. A nurse said, "There is no time to read care plans. The shift is so busy." Another nurse told us before the provider had increased the number of staff on duty they had been the only nurse on duty and they did not have time to carry out care plan reviews. They told us this would now improve following the increase in staff. A care worker told us, "There simply isn't enough time to do all our jobs let alone read care plans." An agency care worker told us they had not been asked to read care plans and took guidance about people's need from other staff on duty.

We saw in people's care plans there was a section called 'My Choices'. One person stated they preferred to sleep on their back with two pillows and they liked to watch the news channel. We saw the person's wishes had been followed and they had two pillows and the television was on at the news channel.

The provider employed an activities coordinator who had completed people's life histories. These gave staff important information about the person. On the day of our visit they spent most of their time in the lounge and we asked if activities were ever with individuals in their rooms. They told us it was not usual for them to be in the lounge all day and commented, "I like to go round the rooms as well." They went on to say, "There are quite a few, three or four people who don't speak at all. I have got audio recordings of stories from the library. I will do that over a couple of days. Other days I will sit and read to them." They told us that occasionally a young man with a guitar visited the home and would go to individual rooms and sing to people. During the afternoon we saw the activities coordinator spending time with one person who enjoyed the individual one to one time and took them for a walk around the garden. We did not see activities taking place with people in their rooms during our visit.

We asked people if they knew how to make a complaint, one told us, "I've never complained but no one has told me how to." Another commented, "I would tell one of the regulars [staff]." One person told us information about how to make a complaint was available in the lounge, and we saw there was a poster on the wall and a folder with complaint information on the lounge table. There was also a tablet computer in the main foyer where visitors or healthcare professionals could leave comments or make a request to see the manager.

However prior to our inspection visit we had been contacted by a concerned relative who told us they had wanted to make a complaint and speak to the deputy manager and they had not been satisfied with the response given. We could not see that this complaint had been recorded.

The manager and provider's regional manager told us they were not able to confirm with any assurance that the records accurately reflected all the concerns and complaints received at the home prior to them joining the service. They told us that from this point onwards they would ensure all formal and informal complaints received were properly recorded so they were able to identify any emerging trends and take appropriate action.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in November 2015 we found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Governance. We served a warning notice and the provider sent us an action plan outlining how they would improve. At our last inspection in May 2016 we found there had been improvements and the provider was compliant with this regulation. At that time the provider had recruited a new manager and deputy manager, and a new regional manager had taken on responsibility for the home.

When we returned to the home we found there was inconsistent leadership and managerial oversight which had resulted in improvements not being sustained with poor outcomes for people who lived at the home. We found previous issues of concern continued, staff were not always available at the times people needed them and shortfalls with the management of people's medicines continued. Staff did not feel supported in their role or trained to undertake their roles and there were poor systems for communication between the staff team.

Since our last inspection in May 2016, all the new management team had left their employment at the service. A temporary manager from one of the provider's other homes had been in post until the most recent manager started working on the 1st August 2016. The home did not have a deputy manager at the time of our inspection and the provider was actively recruiting for this post. Another regional manager had only just been appointed and the provider had also moved a new managing director in from one of the providers' other geographical areas overseeing the service.

On the day of our visit the new manager was present with a supporting regional manager who had never been to the home before. The regional manager of the 'resident experience team' also attended with one of their team.

Staff told us the constant management changes had impacted on the quality of care people received and staff morale was poor. Comments made were, "It's so difficult, I feel I am chasing my tail, I don't feel like I achieve anything, it all changes. Now we have yet another new manager because the other left." Another told us, "Everybody wants things done differently so every manager has brought their own way of doing things. We have had so much change nobody knows what they are wanted to do. We need stability…We have had six managers since I started…We keep getting different managers and that affects morale more than anything."

There had been a recent incident in the home which was being investigated by a number of organisations including local commissioning and the clinical commissioning group and police. The provider had not explained to staff why external organisations were visiting the home and staff told us they felt worried and concerned. Two staff members, who were in the home on the day of the incident, described the lack of management support as extremely stressful and upsetting. One told us, "You worry don't you. When I am here I put 150% into everything. To know the police were here and there could be anything going wrong with people you look after, it is horrible. It is not nice not to know."

The provider acknowledged they had not communicated with people who lived at the home and relatives regarding recent events at the home or the changes in management. The new manager told us this was being addressed and a meeting was organised on the 7 September where the provider's managing director would be attending to speak with people. Introductory letters were being sent out to introduce the new manager and we were informed a joint letter from the provider and commissioning team had been sent out to reassure people and their relatives following police and social workers recently attending the home.

Staff did not feel the provider was caring towards them and they told us this had caused some care staff to leave their employment at the home as they did not feel valued. One member of staff told us why staff were unhappy, they said, "Because of the management, the way they treat the staff. The managers said 'we can get anybody off the street to do this care job', that is why two carers have just left."

We asked staff if they would report concerns anonymously (whistle blow), they did not feel the manager or provider took their concerns seriously. One member of staff told us they would report concerns but would think how best to do this, they told us "I would whistle blow but one has to be careful of whistleblowing so I would have to think about it and how I would do it, but definitely."

The provider had systems and processes in place to monitor the quality of care the service provided, however we saw these were not being followed to assure the provider that quality was being maintained and improvements sustained. For example, the analysis of incidents which occurred in the home had not been completed. This meant potential trends or patterns in incidents were not being identified and action taken to minimise risk.

The provider's regional manager's quality audit in 5 July 2016 showed that the previous manager had not received the training to use the auditing systems and they had not been completing analysis of incidents. The 7 August 2016 provider audit identified that staff had a 'poor understanding' of the requirements to complete the audits and further training was required. They also showed the weekly medication audits and care plan audits were not fully completed.

All of the managers present at the inspection acknowledged that although systems and processes were in place to monitor and audit the quality of care provided they could not be assured these had been carried out effectively or accurately. The new manager told us, "The auditing carried out didn't highlight the issues and concerns."

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Governance.

The new management team acknowledged staff had not received adequate support, and that they and the people who lived there had gone through a difficult and challenging time. The constant change of managers and the high use of agency staff had left the service unsettled and they told us they were committed to making improvements. They told us that the auditing systems would now be closely monitored to make sure that they were completed correctly and any areas for improvement would be addressed. The new manager was experienced from another of the provider's homes and had undertaken training in the use of the audit systems.

Following our inspection a full staff meeting was organised to update the staff and to focus on team building to improve staff morale, this was also to include the regular agency staff. After the general meeting individual supervisions meetings with staff were to be held to offer support.

The new manager told us, "We have to embed quality and sustainability; we also need the right staff." We asked how they were going to achieve this and they told us, "I want to see and give direction to my staff. We need open transparency. It will take time to make all improvements and this has to be continuous."

Staff we spoke to felt the new manager was approachable and they were confident improvements would be made. They told us, "[Manager] is brilliant and I think will do her best." And, "[Manager] makes you feel appreciated. It hasn't been there and I think that is why staff left." "It is definitely getting better by the day."

The provider told us they had stopped admitting people to the home to allow time for improvements to take place. The local commissioning team had also placed a stop on admissions and were monitoring the service closely. In addition they were meeting with the provider on a regular basis.

The provider and managers had submitted statutory notifications to us so that we were able to monitor the service people received.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1)The care and treatment of service users was not consistently appropriate and meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) (2) (a) (b) (c) Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not established. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1)There were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's care and treatment needs.