Beech House (Partington) Limited

Beech House Nursing Home (Partington)

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

Overall summary

We inspected Beech House Nursing Home on 01 and 03 December 2015. The first day of the inspection was unannounced.

Beech House Nursing Home provides nursing and residential care for up to 28 older people. At the time of our inspection there were 26 people living in the home. People are supported in two buildings. The house provides accommodation for people requiring nursing care. The bungalow next door provides residential care. The house has a communal lounge area and large conservatory used as a dining room. The bungalow has a small dining area and separate small lounge area. The kitchen where meals are made is in the main house and

Summary of findings

there is a smaller kitchen for snacks and drinks in the bungalow. The laundry room is situated in the bungalow. The house has two floors; the upper floor is accessed by stairs and a lift.

The service had a registered manager. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection took place on 27 October 2014. At that time we rated the service as good overall, with a good rating for safe, caring, responsive and well-led.

The service was judged to require improvement in terms of its effectiveness and this was mainly due to a lack of training and awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We received an action plan from the registered manager and most actions had been put in place, including processes to ensure people who were being deprived of their liberty were done so lawfully. However, during the inspection we found that assessments for people who might lack mental capacity were not comprehensive and staff lacked knowledge and understanding of the MCA and DoLS. This was a finding from the last inspection and constituted a breach of the regulation relating to the need for consent.

On two occasions during the inspection we observed members of staff assisting a person to stand and also to change position in a chair by placing their hands under the person's underarm area, referred to as a 'drag lift'. This type of manoeuvre can cause pain to the person being assisted to move and can also cause injury to the person or carer undertaking the manoeuvre. We informed the registered manager about our concerns and made a safeguarding referral to the Local Authority.

People, their relatives and staff told us that there were not always enough staff to support all the people as they needed, especially at busy times. Our observations during the inspection supported this. The home was short of nurses and used agency nurses regularly although the registered manager tried to ensure that the same agency nurses were used in order to provide consistency for the people and care staff team.

We found that people's risk assessments and care plans were not always comprehensive or consistent and changes in people's needs or condition were not always updated in their care plans. Daily records written by care workers did not reference people's care plans. During the inspection the home was in the process of switching to electronic care records. The registered manager said that as each person's records were transferred to the electronic system they would be reviewed and updated and that there was a plan for this to be completed within four weeks of the inspection.

People, their relatives and staff told us that that people were not provided with meaningful activities. Our observations and records at the home supported this. The registered manager was in the process of recruiting an activities coordinator.

The home did not have an effective system of audit in place to monitor the safety of the service and audits for most aspects had not been carried out since June 2015. It was not always possible to tell from records how audit actions had been followed up or if they had been resolved, although the registered manager could provide this information when asked.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

We found a box of controlled drugs in the controlled drugs cupboard that had been prescribed for a person who no longer lived at the home. The medicine was not recorded in the controlled drugs book. Not all 'as required' medications had instructions for staff, some MARs contained ambiguous directions for use, not all creams and lotions dated upon opening and we found one topical medicine that had no prescription label attached. All other aspects of medicines management and administration were done properly.

Feedback about the food provided by the home was mostly positive. Kitchen staff could describe how to prepare foods for people with special dietary needs and knew people's personal food likes and dislikes. However, we found that food and fluids records for people losing weight or with other nutritional issues were not kept properly.

Summary of findings

The home environment was not dementia-friendly, in that adjustments had not been made to help people living with the condition to navigate around the home. We recommended that the home investigates and implements good practice in modern dementia care to improve people's quality of life.

People had access to a range of healthcare professionals, including GPs, district nurses, opticians and podiatrists; the service supported people to meet their holistic healthcare needs. We identified one person who had not been referred to mental health services for assessment when they needed to be and found other examples of poor documentation with regards to communication between external healthcare professionals and the home.

Most parts of the home were clean, tidy and odour-free. We raised some concerns with the registered manager about the bath in the house not being cleaned after use, the storage of continence bottles on a bathroom windowsill, an overflowing and unsecured outdoor clinical waste bin and the siting of a laundry cupboard next to a bedpan washer, all of which could increase the risk that infections might spread. Actions raised by a recent NHS Trust Infection Control Audit were in the process of being implemented.

The complaints policy was clearly visible in both buildings and there was a system for reporting, recording and responding to complaints, although it was not always clear from documentation how complaints had been resolved.

People told us that they felt safe at the service. Staff had received safeguarding training and safeguarding issues were recorded, investigated and reported properly, although it was not always possible to tell from the home's records how issues had been resolved by the service.

People and their relatives told us that the staff were caring and promoted dignity and privacy. Interactions we observed between people and staff were mainly positive and people could exercise a choice over their daily routines. We did observe interactions where people's dignity was not respected by care workers.

We received mixed opinions on whether people and their relatives, where relevant, were involved in the planning of their care to ensure their needs and wishes were considered.

Staff were recruited safely; all the correct checks and documentation were in place. We saw records of staff who had been disciplined by the registered manager. The home's disciplinary policy had been followed and investigations and outcomes were recorded properly.

Staff had received a comprehensive programme of training and received supervision, although not as frequently as stated in the home's supervision and appraisal policy. Staff did not have annual appraisals or personal development plans.

People, their relatives and other healthcare professionals received an annual survey and feedback was used to improve the service. Relatives and residents' meetings were also held after publication of Care Quality Commission reports. The registered manager had offered to host these meetings more often and had a booking system whereby relatives could come and see her at their convenience.

Staff had received fire safety training, fire equipment was serviced and tested regularly and drills were carried out and documented. Utilities and other equipment at the home, including the lift and hoists, were tested regularly and a system was in place to make sure this happened when it should. Not all the people had personal emergency evacuation plans (PEEPs) in place; we saw the registered manager completing these during the inspection for the people in the home who did not already have a PEEP.

People were referred to independent advocates when they needed them and we saw examples of when staff at the home had advocated on behalf of people using the service. An end of life policy was in place and most people and their relatives, if appropriate, had been asked about end of life wishes.

People, their relatives and staff described the registered manager in positive terms; most felt she was approachable and receptive to feedback.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

We observed care workers using moving and handling techniques which could cause injury to both the person being assisted and themselves.

We identified issues with medicines management at the home in relation to controlled drugs, topical medicines and 'as required' medicines.

People, their relatives and staff told us that there were not enough staff to meet all of the care needs of the people using the service.

Safeguarding procedures were in place and staff could describe the different types of potential abuse and said they would report any concerns.

Recruitment procedures were robust; all necessary checks had been made on new staff before they started work at the home.

Is the service effective?

Requires improvement

The service was not always effective.

Authorisations to deprive people of their liberty were in place but assessments of people's mental capacity to consent to their care and treatment were not done. Staff had limited understanding of the Mental Capacity Act 2005.

People had regular access to healthcare professionals however we identified some issues with referrals and poor communication.

We found that food and fluid records were not kept properly.

People were happy with the meal quality and choice that was provided by the home. The kitchen staff were knowledgeable about people's nutritional needs and likes and dislikes.

We saw that staff were adequately trained to care and support people who used the service. Staff we spoke with confirmed this.

Is the service caring?

Requires improvement

The service was not always caring.

Most interactions between care workers and people we observed were positive and supportive, but some were not.

People and their relatives were unhappy about the laundry service provided by the home.

We received mixed feedback on whether people and their relatives were involved in people's care planning, although staff could demonstrate that they knew people as individuals.

Summary of findings

People and their relatives told us that staff were caring. People could exercise a choice over what time they got up and went to bed.

People had access to advocacy services and were referred to advocates when they needed them.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's risk assessments and care plans were not consistent or updated when changes in their needs or condition had occurred.

People, their relatives and staff told us that there were not enough meaningful activities on offer for the people to participate in.

We recommended the service does more to improve the environment for the people living with dementia at the home.

Is the service well-led?

Requires improvement

The service was not always well-led.

Proper audits and checks on the quality and suitability of the service were not in place to ensure people were kept safe.

People, their relatives and other healthcare professionals were asked to give feedback on the quality of the service.

Most people, their relatives and staff gave positive feedback about the registered manager.

Beech House Nursing Home (Partington)

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.

The inspection took place on 01 and 03 December 2015. The first day was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had helped find a residential home for an older relative and had been a regular visitor when they lived there.

Before the inspection we reviewed the information we held about the service. This included asking the Local Authority and Healthwatch Trafford for information. The Local Authority did not raise any concerns. Healthwatch Trafford said that they had received concerns from the relative of a person who had used the service in relation to a lack of activities and clothing going missing.

We also reviewed information from the local NHS Trust's infection control lead; an infection control inspection had been carried out in October 2015. The infection control lead had drawn up an action plan for the service after issues had been identified.

On the day of the inspection we spoke with eight people who used the service, six people's relatives, the registered manager, four members of care staff, the administrator, two cooks and a housekeeper.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building including bedrooms, bathrooms, the kitchen, the laundry room, clinic rooms and in communal areas. We also spent time looking at records, which included five people's care records, three staff recruitment files, training records and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person when asked if they felt safe said, "I don't feel bullied or anything, the people are quite nice", another person asked the same question said, "I feel very safe in here." A third person told us, "I'm safe here, not bullied", and a fourth said, "It's OK, I'm safe and well looked after."

During the inspection we observed people being assisted to transfer by care workers using hoists on a number of occasions. Manoeuvres were carried out safely with the consent of the person and reassurance was provided by the care workers. However, on two occasions during the inspection, a member of the inspection team observed care workers assisting a person to move using inappropriate moving and handling techniques. The technique observed could have caused pain or discomfort to the person being assisted and resulted in damage to care workers' backs. The registered manager was informed after each occasion and the second time the inspector spoke with the care workers after the manoeuvre about the incorrect method they had used. The registered manager said she would speak with all care workers at the home and provide further moving and handling training.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection the house was providing nursing accommodation for 20 people and the adjacent bungalow was providing residential accommodation for 6 people. When we arrived at 7am on the first day of our inspection there was one care worker in the bungalow and a nurse and a care worker in the house. We looked at the rota and saw that during the day there were two care workers in the bungalow and a nurse and four care workers in the house. In addition there was a cook in the main house and a housekeeper who prepared cold drinks, managed the laundry and did the cleaning in both buildings.

We asked people and their relatives if they thought there were enough staff and opinions were mixed with the most positive feedback about staffing levels coming from people living in the bungalow. One person said, "I suppose they could do with an extra person as they're too busy, but it doesn't affect me", another person said, "I think there's enough staff if there are two on and they're the set staff", and a third person said, "There's not enough staff, especially at weekends. I might have to wait a while if I call the bell at night." Another person said, "I think there's enough staff. If I call them they're quick to come, at night times and at weekends as well." Relatives we spoke with said, "We think there's enough staff. [My relative] doesn't have to wait long [when they press the call bell]", and, "Recently there seem to be a lot of staff leaving and the new ones seem to be agency staff."

We asked staff if they thought that staffing levels were appropriate. One care worker said they didn't think there were enough staff, particularly at night in the house. They said that if both staff were assisting one person it meant there were no other staff available to support the other people in the house if they needed it. Another care worker said, "I would recommend an extra staff member", and a third commented that there was only enough time to support people with their personal care, and not to do activities with them. Two other care workers also thought there were not enough staff as a high proportion of people using the service needed two members of staff to assist them with their personal care.

We spent two days observing the care people at the home received. This included observing care using the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We noted that whilst people's voiced care needs were met and the call bells we heard were answered in a reasonably timely way, staff were always busy with tasks and did not have time to spend interacting with people or ask them what support they required. For example, we spent 30 minutes observing nine people in the house lounge area. During the entire observation two members of staff walked through the room to the dining area but there was no interaction with any of the people at all. We also noted that unless people asked for assistance to use the toilet or it became apparent to staff that a person needed to use the toilet, people were not asked by staff if they wished to go. This accounted for the majority of the people in the house, most of whom had problems with communication and required full support with all of their care needs. We also saw that the interactions people nursed in bed had with staff were limited to support with personal care and eating and drinking.

Requires improvement

Is the service safe?

By speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the home, it was clear that whilst people's basic care needs were largely being met, there were not enough staff to support all of the people as they needed. In addition, staff did not have time to provide engagement and stimulus to the people living at the home.

We spoke with the registered manager about staffing levels during the inspection. The home used a dependency tool which scored each person monthly according to the level of support they needed with the activities of daily living and calculated the number of staff hours needed to provide the required level of support for all the people. According to the October 2015 dependency calculation, staffing in the bungalow was appropriate, and we saw this was reflected in the views of people living there. The October 2015 dependency calculation for the house showed that the home was 23.5 hours short in terms of care worker hours to meet the needs of the people living there. This was reflected by our observations of the interactions between care workers and people living in the home and how busy the care workers were seen to be during our inspection.

The registered manager said that finding and retaining permanent nursing staff had been a problem at Beech House Nursing Home in 2015 and that there had also been disciplinary issues. At the time of inspection there were no permanent nurses working day shifts, although the registered manager had an arrangement with an agency whereby the same two agency nurses were working at the home on days for the next few weeks to provide some consistency for the people and the other staff. The registered manager stated that the lack of permanent nursing staff meant that she had to prioritise the jobs that would ordinarily be delegated to them and do as much as she could herself and that tasks such as care plan reviews and general audits may not have been done. This meant that the lack of permanent day nurses was having a detrimental effect on the overall management of the home.

The lack of sufficient staff was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for some of the medicines with others supplied in boxes or bottles.

We observed two medicine rounds in the house where nursing care was provided. People were given their medicines in a caring way and those who required more time or encouragement and support received it. The nurse made sure the medicine trolley was locked when they went to give medicines to each person, ensuring items were kept securely. This demonstrated people were receiving their medicines safely and in a person-centred way.

We asked people and their relatives about people's medicines. One person told us, "My medicines are all looked after, they make sure I get them on time, they're very good", and a relative said, "They're OK with making sure the medicines are taken, but they have to be reminded sometimes to apply the cream (to the person's legs)."

We looked at medication administration records (MARs) for three people in the house and one person in the bungalow. Each person's MAR contained a photograph of them and there were details of any allergies and a copy of their medicine prescription. MARs for each person's tablets and liquid medicines were up to date with no gaps in recording. Boxes of tablets and bottles of liquid medicines in the drug trolley were dated upon opening. Staff recorded when people had refused medicines. There was a system in place so that people could have homely medicines when they needed them; homely medicines include over the counter medicines such as paracetamol, laxatives and cough syrup. We noted that the home's medicine policy stated that homely medicines were not in use; we brought this to the attention of the registered manager who said she was in the process of reviewing the home's policies and procedures to make sure they were up to date. There was a system in place for the destruction of medicines and we saw that records were kept.

We checked the storage and management of controlled drugs; controlled drugs are prescription medicines controlled under Misuse of Drugs legislation and include medication such as morphine. We checked the stock of three controlled drugs and found that it tallied with what was documented in the controlled drugs book. Two staff members had checked in new supplies and recorded the administration of any controlled drugs. During our checks we found one full box of a controlled drug prescribed for a person no longer at the home that was not recorded in the controlled drugs book, so it was not possible to see when the drug was received by the home or by which members of care staff. This was contrary to the home's medicines

policy and meant that controlled drugs were not always managed safely. We brought this to the attention of the manager who began an investigation with the pharmacy into who had received the drug at the home and when, so that further training could be provided. The drug was also logged in the controlled drugs book and then destroyed.

We noted that some people were prescribed medicines to be taken 'as required'; this meant they were prescribed to be taken when the person needed them. When people receive support to take their medicines staff need guidance to explain the circumstances when the medicine should be given, so a medicine protocol is developed for each 'as required' medicine a person takes. A protocol is therefore a list of written instructions that states what the medicine is for, the correct dose and how often it can be taken. Protocols are especially important when people have problems communicating or live with conditions like dementia. If protocols are used correctly they ensure that a person gets medicine when they need it and they also prevent people from receiving too much of a medicine or having it too frequently. Some medicine protocols were in place at Beech House Nursing Home but they were not present for every person that needed them. For example, not all people had medicine protocols for 'as required' pain medication. The requirement for medicines protocols was not in the home's medicine policy, however the manager was in the process of updating the policy to include the use of protocols for all 'as required' medicines and was going to check MARs for each person to add them where they were needed.

We found one MAR had instructions for eye drops which were to put 'one drop at night into the affected eye' but did not specify which eye it was. In another person's care file we found a letter from a hospital consultant stating that nurses at the home had been applying two different eye drops into both of the person's eyes when it should only have been one of them. This meant that people were not always getting their medicines as prescribed and were at risk of harm. We checked the MAR for this person and it had been updated since receipt of the consultant's letter and signed by two members of staff.

We saw that people's medicated creams were stored in their bedrooms and applied by the care assistants. Application records and body maps to explain why, how often and where creams and lotions should be applied were kept in people's rooms and signed by the care staff.

Creams and lotions that were in use did not all have the date they were opened written on them; this is important as some medicines expire a certain time after they are opened. In one person's room we found a prescribed cream that had no prescription label attached to it. This meant that people may have been receiving creams or lotions that were out of date or may not have been prescribed for them and could therefore cause them harm.

We looked at the medicines audits that were completed weekly at the home. They were detailed and involved checking MARs, counting stock, checking CDs and checking that the dates medicines were opened were written on packaging; action plans at the end of audits included any issues that had been identified and these had been signed as followed up. Some of the issues we identified with medicines management should have been picked up by this audit but most of them were not included as areas to examine.

We recommend that the registered manager reviews and improves medicines management practice and audit at the home in line with current national guidelines and standards.

All the people we spoke with said they were satisfied with the level of cleanliness at the home. One person we spoke with said, "The rooms are nice, they keep everything nice and clean", and a relative commented, "The place is very clean." People and their relatives had recently completed the annual survey which included questions about the cleanliness of the home; all of the feedback was positive. We noted that each person who required assistance to transfer or change position with either a hoist sling or slide sheet had their own and so did not have to share with others which minimised the chances of cross-infection.

As part of the inspection we looked at how clean the home was. We noted that the lounge and dining areas and people's bedrooms were clean, tidy and odour-free. The kitchen and laundry room were also clean. We did, however, see some issues which might increase the risk of infections spreading. Continence bottles were stored on a bathroom windowsill and the communal bath in the house was not being cleaned after each use. We noted that clean linens were being stored in a cupboard next to a bedpan washer in the house and an outside clinical waste storage was overflowing for half of the first day of our inspection. This meant that it could not be locked as it should have been. We also noted that the room containing the bedpan

Is the service safe?

washer and linen cupboard was adjoining the main bathroom in the house and people using the bathroom entered by walking through the area containing the bedpan washer and cleaned bedpans and urine bottles.

We reviewed the findings of the local NHS Trust's infection control audit in October 2015. At that time it was identified that there was no suitable area for the disinfection of cleaning equipment such as mops and buckets. At our inspection the home was planning to install a sluice into the bungalow for this purpose but it had yet to be actioned. This meant that not all measures were being taken at the home to reduce the risk of infections spreading.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse to the registered manager. Care workers could explain the forms of abuse that the people using the service could be vulnerable to. All care workers we spoke with said that they would report any concerns to the registered manager. Referral details for safeguarding concerns were clearly displayed in the house foyer. This meant that staff understood their responsibilities in terms of safeguarding and people were kept safe.

As part of the inspection we checked the accidents and incidents that had been logged at the home since the last inspection. Details of accidents or incidents were recorded and kept in people's care files and notifications had been sent to the Local Authority and to the Care Quality Commission as appropriate. This meant that accidents and incidents were recorded and reported by the home.

We saw that some people living at Beech House Nursing Home had Personal Emergency Evacuation Plans (PEEPs) in their care plans, but not everybody. PEEPs provide instructions on how to evacuate a person from the building in an emergency. The PEEPs we saw listed the person's name, age, any mobility issues and room number; they also outlined the level of support each person would need to leave the building in the event that evacuation was necessary. We raised concerns about the lack of PEEPs for all people with the registered manager on the first day of the inspection. By the second day of the inspection she had spoken with other care home managers to find out good practice and was in the process of revising the content of the PEEPs and making sure all the people had them. This meant that the registered manager took steps to ensure people could be safely evacuated in the event of an emergency.

We looked at the records for gas and electrical safety and manual handling equipment checks. All the necessary inspections and checks were up to date. A detailed emergency plan was in place in the event of a systems failure or other emergency situation and there was a continuity plan for the house and for the bungalow. The home had records of internal checks on aspects such as water temperatures, the lift, emergency lighting and hoists.

We found that effective systems were in place to protect people from harm or injury in the event of a fire. The fire alarm, smoke alarms and emergency lighting had been inspected in 2015 and there was a schedule of regular fire drills, during which the maintenance person spoke with staff about fire safety and the safe evacuation of people. There was a sled for use when evacuating people from the first floor of the house and the registered manager said staff had been trained to use it.

We looked at the recruitment procedures in place to ensure only staff suitable to work in the caring profession were employed. When we checked the records for three members of staff we saw that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups.

The personnel files we looked at all contained a copy of the original application form and two written references were obtained before the staff member started work. There was also a record of the interview on file and we could see that any gaps in employment had been explored. Employees had provided the required photographic identification which had been copied and stored on file. Records showed that the registration of the nurses was checked annually with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse. This meant that the recruitment procedures used by the home were robust and all the required checks to make sure staff were suitable to be employed had been made.

Requires improvement

Is the service effective?

Our findings

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some of the people living at the home who lacked mental capacity had complex health care needs which meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that capacity assessments for DoLS had been done and applications for DoLS had been made by the service to the Local Authority for the people who needed them.

When we looked in the care files of people identified as lacking mental capacity we found that capacity assessments for all other aspects of care had not been done. Some people's care files contained a basic mental capacity assessment completed as part of the admission process but this had never been updated since they moved into the home and was not comprehensive.

People's care files contained a consent form which covered aspects such as consent to share information, consent to have photographs taken and for the home to administer people's medicines. One file we saw lacked this document although a note had been added to say the person's family had not returned it; there was no information on the file to say why this person might lack capacity to sign the form so that their family needed to do it for them. One of the same person's relatives had also signed a 'deterioration care plan' which detailed their end of life wishes. We spoke to a care worker about this person and they said that the person lacked capacity to make decisions due to a diagnosis of dementia; however, when we asked the registered manager she said the person had no formal dementia diagnosis and capacity had not been established either way. This meant that people's capacity to consent to their care had not been assessed and care plans did not tell staff which decisions a person could make, which decisions they needed support to make and which decisions must be made for them in their best interests.

At the last inspection in October 2014 we found that the registered manager was the only member of staff that had attended MCA and DoLS training and that other members of staff could only demonstrate a basic understanding of the legislation. During this inspection, the registered manager told us that some MCA/DoLS training had been carried out but that none of the current care staff working at the home had received the training. As part of this inspection we asked staff about their knowledge of MCA and DoLS. Whilst some staff could explain what DoLS involved, most of the staff did not understand MCA and the requirement for capacity assessments to establish people's ability to consent to care.

The lack of capacity assessments for people identified as lacking mental capacity and the lack of understanding shown by staff in relation to the Mental Capacity Act constituted a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the food that was served at the home and the feedback was largely positive. One person told us, "The food's lovely, I get plenty and I get a choice", a second person said, "The meals have got a lot better, particularly the portion size, recently", and a third person added, "The food is good. I get to choose." Other people we asked about the food told us, "The food's ok, not brilliant. I suppose there's a choice", and, "Some of the food's alright". Relatives we spoke with also told us about the food. One relative said, "The food's good", another said, "[My relative] doesn't always like the food, but the meals in general are OK", and a third relative told us, "The food is very nice."

Dining tables were set with place mats, cutlery and napkins, and people could also choose to eat in their chairs in the lounge areas or in their own rooms. The main meal of the day was at lunchtime; people were asked in the morning if they would like the meal on offer and could

request an alternative if they did not. One of our inspection team ate the lunchtime meal with people using the service. They observed that the quality of the food was acceptable, that there were three types of vegetables on offer and the portions were adequate. We saw that most meals were homemade using ingredients of good quality. People using the service were seen to be enjoying their food and the meal time period was not rushed; they were offered disposable aprons to protect their clothing.

During the inspection we spoke with two cooks and looked round the kitchen. Both cooks were aware of the people using the service who had specific eating or nutritional needs, such as diabetes and swallowing difficulties, and knew how to prepare foods for them. The cook spoke with the dietician when they visited and was kept informed about new people at the home and any changes to existing people's needs. We saw that a survey of people's food likes and dislikes had been undertaken two months prior to the inspection. To find out the preferences of those people living with dementia who could not respond to the survey the cook had spoken with relatives and care staff. The information obtained was used to modify the food choices on offer.

Some people's care plans required that their food and fluid intake had to be recorded due to concerns about weight change or medical conditions such as diabetes. The recording of food and fluid intake is useful for care staff and dieticians to understand why people may be losing or gaining weight. For this reason it is very important that that the types and quantities of foods and fluids people consume are recorded and that fluid totals are calculated for each day.

We looked at fluid charts for seven people in the house for the two weeks prior to the inspection. Fluids had been totalled for one day for one person out of the seven people for the preceding two weeks. We checked the fluid charts of a person in the bungalow. Fluid amounts had not been completed for the day prior to the first day of our inspection. This meant that fluid charts were not completed correctly so people not receiving sufficient fluids could not be identified.

We looked at food charts for nine people for the two weeks prior to the inspection. None of the charts contained quantities for any of the foods people had consumed. This meant that food charts were not being completed correctly and could not be used to identify reasons for weight loss or gain. Food charts could also not be used to indicate times when the blood sugar levels of diabetics might be too high or too low due as the amount of foods they had consumed were not recorded.

We recommend that the home reviews the current system of food and fluid recording for people with identified nutrition or hydration issues in line with relevant good practice.

We saw from the care files that the people using the service had access to a range of healthcare professionals. People had seen GPs, opticians, podiatrists, a dietician, and people receiving residential care had seen district nurses. We spoke with people about their access to other health care professionals. One person said, "They'll call a doctor for me if I need one", and a second person said, "They keep a good eye on me, so if I need a doctor they'll call one out." Relatives we spoke with about other healthcare professionals told us, "If [my relative] has to go to the hospital they sort it all out for [them], arrange [their] transport etc., They sort out the doctors, chiropodists, hearing aids. They're very good", another relative said, "The carers who know [my relative] are on the ball about when [they] need a doctor and they'd call him out straight away", and a third relative said, "If they need to the home rings for the doctor and they keep me well informed."

During the inspection we observed two occasions when people using the service told care workers they didn't feel well. Both times the nurse on duty was informed and they took observations, such as blood pressure and pulse rate, which were then recorded. The person was reassured and spoken to with empathy until they felt better. This showed that care workers responded appropriately when people said they felt unwell and that individuals' health was being monitored.

We read people's care files and daily records to see if referrals were made when people had new or worsening symptoms. The daily records in September and October 2015 of a person without a diagnosed mental health condition showed that they had experienced significant neurological symptoms at least three times; they had also presented some behaviours that might challenge others. Although ABC charts had been started for this person, there had been no referral made to the community mental health team for a formal assessment. ABC stands for Antecedent Behaviour Consequence and is a way of monitoring people's behaviours to identify any potential triggers. ABC

charts help staff to understand challenging behaviour and manage situations better by considering the impact of aspects such as dementia and what was happening around the person when the behaviours occurred. This meant that changes in people's condition did not always result in the appropriate referrals to other healthcare professionals so the care they received might not be appropriate for their needs.

We also had concerns about communication surrounding healthcare professional's visits, the decisions they made and how these were recorded. For example, in the medicine folder we saw that one person who was diabetic had their blood sugar level checked three times a week 'as directed by the dietician on 1/10/15'. When we checked the person's care file we could find no record of the dietician's visit and could therefore not establish where the instruction for checking the person's blood sugar levels had come from. This indicated that not all visits by healthcare professionals were recorded which could result in details or instructions relating to people's care being missed, thereby putting them at risk.

Staff told us they had received training. Records showed that most care staff had attended mandatory courses on safeguarding, fire safety, food hygiene, manual handling, medicines administration, nutrition and infection control. The registered manager, who is also a registered nurse, and two other nurses had also attended catheter training. Those that had yet to complete all courses had had their training needs flagged to the service's area manager. This meant that the home ensured that care workers received the training they required to care for the people using the service.

We looked at the records of care workers' inductions and spoke with staff about the start of their employment at the home. The home had yet to implement the Care Certificate which started in April 2015; the Care Certificate is a set of standards against which the competency of staff new to health and social care can be assessed. It is not a legal requirement but if homes choose not to use it they must be able to demonstrate how their own induction meets the needs of both people and staff. The registered manager had completed training on the Care Certificate previously and had arranged for the training of all staff in 2015, but this had been cancelled by the training provider. Between the first and second day of this inspection, the registered manager and a senior care worker attended further training on the Care Certificate with a view to implementing it for all new employees.

We spoke with one member of staff about their induction at the start of their employment at the home and they said it was very good. The induction had involved instructors and training videos and included all the mandatory training aspects, such as moving and handling, fire safety and infection control. The induction also required shadowing of senior care workers and new staff had to be assessed and signed off as competent before they could work independently. This showed us that the home provided training to ensure that new staff could meet the needs of the people using the service.

Requires improvement

Is the service caring?

Our findings

We asked the people using the service if the staff were caring. One person told us, "The staff are alright, they're very good to me. They listen to me, treat me respectfully, know what I like and don't like", a second person said, "They're all very nice but some of the younger ones get a bit impatient sometimes", and a third person told us, "Some of them are alright." We also spoke with people's relatives, they told us, "The staff always give [my relative] respect", "They do know [my relative] and know what [they] like and don't like", "The majority of staff are very nice", "It's the best place for [my relative] to be", and, "The staff are very kind, helpful, approachable, very good. But they don't have time to chat (with the people)."

During the inspection most of the interactions we observed between care workers and the people living at the home were warm and friendly. The atmosphere appeared relaxed; staff were responsive to people's needs and patient when they gave support. We did, however, observe occasions when people's privacy and dignity were not promoted. For example, during the lunch meal we observed two care workers who were supporting people to eat at different ends of the dining area, having a loud conversation across the room with each other instead of speaking with the people they were assisting. We overheard two members of staff discussing a financial matter between themselves while they were assisting a person with their personal care and we witnessed two care workers discussing whether a person was unwell as they stood right in front of the person, as if the person was not there. In addition, due to problems with space and storage at the home, the carers had a work station located in the corner of the lounge of the house. At this location we overheard several conversations between care workers about the people who lived at Beech House Nursing Home when people were sitting within earshot in the room. This showed that care workers did not always respect the privacy and dignity of the people they supported and the environment did not lend itself to this.

We wanted to find out how people had been involved in planning their care so we looked at five people's care files and spoke to people and their relatives about their care planning. All care files contained a personal history at the front which gave details about people's families, past employment and preferences. We looked at people's care plans and could not see how information in the personal histories had been used to personalise people's care. This meant that the service had not used information on people's personal history to individualise their care.

The home had a system where each person had a named care coordinator or keyworker. We asked people and their relatives how care coordinators had involved them in their care plans or if they had seen and signed their care plans. One relative told us, "We don't know who [my relative's] main carer is, it used to be [name] but they left and we don't know if a new one has been assigned." We checked this person's file and a new care coordinator had not been assigned since the last care worker left. Another relative said, "I've had no input into [my relative's] care plan", and a third family member described how their relative had been moved to a different room within the home without any consultation with the family on their relative's behalf. Another relative we spoke with said, "They've discussed [my relative's] care plan with me and [two other relatives]. We've no concerns."

The feedback about care planning on a questionnaire carried out in November 2015 at the home was also mixed. One person replied that they didn't know their care coordinator, were not involved in their care planning and had not read their care plan, whereas another person answered that they and their family were involved in their care planning and they'd read their care plan too. A third person responded to the questionnaire saying that they hadn't been involved in the care plan and didn't know their care coordinator but that they had read their care plan. In one care plan of a person who had capacity to make their own decisions it was not clear that the care aims were in line with the person's wishes. The person was a diabetic and one of the care aims was 'to control [the person's] weight and reduce BMI'. BMI, or body mass index, is calculated using a person's height and weight and is a good indicator of whether someone is a healthy weight. We could see no evidence that the person had been involved in creating the care plan and actively wanted to try and lose weight. This meant that people's involvement in their care planning, and that of their families with the person's permission, was not consistent and people were not always consulted on aspects of their care that could affect them.

Feedback from people and their relatives about the laundry service at the home was almost entirely negative. One relative told us, "They do laundry for [my relative] but

Is the service caring?

things have gone missing." Another person told us about a special item of theirs that had gone to be laundered and had not come back. Other people and their relatives had fed back about the laundry service provided using the recent questionnaire. One relative wrote on a person's questionnaire, "All [my relative's] clothes have been labelled and missing things have been an issue since day one." Another relative had submitted a formal complaint, stating that they had provided a wardrobe of clothes for their family member and upon returning to visit had found that only the coat was in the person's room; no other clothing could be located. We also noted that laundry concerns were discussed at the last residents' and relatives' meeting held in March 2015, so this was a long-standing issue. We raised concerns about the laundry with the registered manager; she told us she was aware of the issues and had recently employed an additional member of staff to work 18 hours a week in the laundry. However, this person had only worked for a few days and had then left the week before this inspection. The registered manager stated that she was in the process of recruiting again for the position. This showed that the registered manager had tried to act upon feedback that had been provided by people and their relatives to improve the issues with the laundry system.

We saw that people looked well cared for. They were dressed in clean clothes and their hair had been brushed or combed. We asked people if they were happy with the support they received with their personal hygiene. One person told us, "I need help with a shower, I get one every other day. I wait until the staff suggest it. I would like a bath, but have a shower instead as it's dangerous to have a bath." A relative we spoke with said, "[My relative] has a shower once a week, as per schedule. [My relative] would like it more often but I don't think they have time." During the inspection we overheard staff discussing which people would be assisted to have a bath or shower that day; this was according to staff availability rather than people's expressed wishes or needs. This meant that people did not always receive assistance with their personal care at their preferred time or in their preferred manner.

We saw that people's bedrooms had been personalised with their own furnishings, ornaments and pictures; they were also clean and tidy. This showed us that people were encouraged to individualise their rooms and that care workers respected people's belongings.

We asked care workers to describe people's personal histories and likes and dislikes to find out how well they knew them. We found that all care workers could tell us details about the people they supported, including who their family members were, what jobs people had done and what foods people enjoyed. This showed us that care workers knew the people they supported well as individuals.

People we spoke with and their relatives told us that visitors could come to the home at any time and were always made to feel welcome by the staff. A sign for visitors was displayed in the house reception area; it stated that visitors were welcome between 9am and 9pm, and that visiting outside these hours could be arranged with the registered manager. One person told us, "The staff make my visitors quite welcome"; another person said, "[My relative] comes to visit and [they're] made quite welcome, they let her know how I am." Feedback on a recent questionnaire read, "We always find the staff welcoming and they let us know how [my relative] is doing."

On the first day of our inspection we arrived at 7am and there were only three people up and dressed at that time in the house. We observed that people were supported to rise by staff in an unhurried manner and were served breakfast individually when they arrived in the lounge or dining area. Care workers told us that people were asked if and when they wanted to get up; one staff member told us "People can choose when they want to get up. We deliver care according to what they want."

People living at the home were provided with information on advocacy services and some people at the home currently had an advocate. The registered manager provided examples of when staff at the home had acted as advocates for people in the time between their need for advocacy being identified and an advocate being assigned. People and their relatives that we spoke with told us about issues that the registered manager was helping to resolve; these included sorting out finances and arranging new spectacles.

We asked about the end of life care that was provided by the home. End of life care relates to people who are approaching death; it should ensure that people are as comfortable as possible and can make choices about their care. No person at the home was receiving end of life care at the time of our inspection so we read the home's policy and people's care files instead. In some care files we saw a

Requires improvement

Is the service caring?

document called 'preferred priorities for care' which set down a person's end of life wishes and preferences. In one care file we also saw a 'deterioration care plan' which covered much the same areas. We discussed end of life care with the registered manager; she said that the transfer of people's records to an electronic system would provide an opportunity for each person's details to be checked and updated, and that this would include people's end of life wishes. We read the home's end of life policy; it included aspects such as eating, companionship, pain control, support for relatives and friends and procedures for after a person dies. This told us that the service was prepared to meet the needs of people using the service who were at the end of their lives.

Requires improvement

Is the service responsive?

Our findings

We looked in detail at the care files of five people who used the service. We found that care files were not consistent; they contained information that was duplicated and were always not up to date. Some people had risk assessments for aspects such as falls, nutrition and pressure areas which were updated monthly, but not all people were risk assessed according to their needs. For example, one person who needed a hoist to transfer did not have a moving and handling risk assessment; another person who received controlled drugs for pain relief did not have a pain assessment or any pain charts. This meant that people's needs were not adequately assessed to ensure care plans could be put in place to meet those needs, so the care people received might not be appropriate.

We found that care plans were not always in place to mitigate for risks that had been identified and some care plans were duplicated. For example, one person had care plans for 'dementia' and 'maintaining safety due to dementia'; another person had a 'pressure area' care plan and a 'risk of skin breakdown due to being nursed in bed' care plan. Information on each of these care plans was largely the same and could easily be combined into one plan. In addition we found that interventions listed as required on people's care plans were either not done or not documented. For example, one person's breathing care plan required the checking and recording of their blood oxygen saturation every four hours; we found records for two weeks' of six hourly checks dated June 2015 and no other records. Another person's pressure area care plan required that they be assisted to change position every two hours. We checked the position charts that were kept by care workers; records for helping people change position were kept by the day care workers but not by the night care workers. This meant that people were not receiving care according to their care plans.

Care plans that we saw were not consistently evaluated; they were also not always updated when changes had occurred in people's needs or when audits and reviews identified that care plans needed to be revised. For example, in the daily records we noted that one person had experienced a fall in October 2015. One of the night staff had documented in the daily records that the person's care file did not contain a care plan for either falls or mobility and that this was a requirement. At the time of our inspection these care plans had yet to be added to the person's care file. In the care file of another person who had been living at the home for over nine months, we noted that care plans for treatment and care of skin problems, personal hygiene, dementia and medicines administration had never been evaluated. In addition, the registered manager had added actions identified by her care plan audits to some care files. Two files we saw had actions with no recorded progress, even though the issues were identified in June 2015 and timescales were listed as 'ASAP' (as soon as possible). This meant that care plans were not always evaluated or updated and may not reflect the current needs of the person, so the care people received might not be appropriate.

We read two people's daily records for the two months prior to our inspection to see if their care was delivered according to their care plans. We found that people's daily records did not correlate with their care plans; for example, daily records for people who had care plans for breathing problems, diabetes or pressure area care rarely, if ever, mentioned these conditions. Most entries we saw focused on whether people were 'settled', had taken their medicines, slept well or had eaten meals. This meant that people may not be receiving care according to their care plans.

The issues with risk assessments and care plans were a breach of Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about the issues with risk assessments and care plans we had identified in people's care files. She told us that the home was in the process of transferring over to an electronic records system and that each person's information would be added individually thereby providing an opportunity for plans to be evaluated, reviewed and updated. We were shown an example of the care plan documentation that would be generated for each person using the new electronic system; the example we saw incorporated the person's life history and as a result was individualised and person-centred. During the inspection we saw care staff being trained to use the new computer system and the registered manager said there was plan to have the system fully operational within four weeks of the inspection.

All the people, their relatives and the staff we spoke with about the activities that were on offer at Beech House

Requires improvement

Is the service responsive?

Nursing Home told us that people did not have enough to do to keep them stimulated. One person told us, "The only thing missing is activities. Anything would be good but there's nothing", another person said, "It's boring sitting in this chair all day (in the person's room). I prefer to stay in my room though, it's miserable in the lounge", and a third person told us, "There's nothing to do all day, nothing provided, no one to talk to." Relatives we spoke with agreed. One relative said, "The only thing is there's no entertainment or activities. [My relative] just sits in [their] chair", another relative said, "[My relative] is not motivated to do anything, nothing to do or keep [their] brain active." The results of the recent questionnaire completed by the people living at the home were consistent with our findings, in that people said that daily activities were not available.

One member of care staff we spoke with about the activities on offer at the home said, "I think there should be an activities coordinator." Another care worker agreed with this sentiment. Two other members of care staff described how they had to prioritise people's personal care and that there was no time left for them to provide activities. One care worker when asked about activities stated that the most frequent activity was listening to music.

We checked the activities records for the three months prior to our inspection for four people living in the house. We noted that a visit to hospital was deemed to be an activity, as was receiving visitors and seeing the hairdresser. One person's activity record listed two activities for September 2015 and nothing between then and the time of our inspection; a second person's activity plan listed two activities in October 2015 and nothing between then and the time of our inspection; a third person's plan had one record for September 2015 and nothing between then and the time of our inspection; and a fourth person's activity plan listed two activities in October and nothing between then and the time of our inspection. This meant that activities were either not being provided or were not recorded properly.

Both the kitchen in the house and the kitchen in the bungalow had 'staff only' signs on them which suggested that people living at the home were not allowed to get involved in cooking or in preparing drinks or snacks; however, the recent questionnaire did ask people if they would like to be involved in helping to keep the home clean. Involving people who live in care homes in domestic tasks such as baking or cleaning can be very satisfying for the people who wish to take part and may help them maintain independence. We saw that a list of the week's planned activities were displayed on the wall of both buildings. The activity for the first day of our inspection was beauty therapy. In the afternoon we observed one member of care staff painting the fingernails of several ladies in the house, however, this was done without any conversation or other interaction with the person. We saw that the male residents were not engaged in an alternative activity as this was going on. During the two days of inspection we also saw no involvement of people who preferred to stay in their rooms or who were nursed in bed in any activities or interactions other than those related to care interventions, apart from one lady who had her fingernails painted. Other activities listed for the week included a music afternoon and reminiscence. Saturday was described as a 'free day' on the activity plan and Sunday was 'church on request', which meant that non-religious people or those not wishing to leave the premises would receive no activities at weekends.

Our observations and people's records showed that daily activities and stimulation was not available to everybody living at the home. This was echoed by the people we spoke with, their relatives and care workers. We spoke with the registered manager about the lack of activities provided to the people living in the home; she said she was aware of the issue and was about to offer an 18 hour a week contract to a staff member to provide activities on three days per week, with a view to increasing to five days per week. This care worker's current role would be back-filled so that these were additional hours and would not affect the personal care people received.

The lack of meaningful activities at the time of our inspection was breach of Regulation 9 (a), (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some word signage was used at the home to indicate which rooms were toilets or bathrooms and which rooms were to be accessed by staff only. There was no picture signage and most people's bedroom doors had a number only; it was therefore not easy for people to navigate around the home. There are ways to design environments for people living with dementia in nursing and residential care homes, for example, by the use of plain carpets and curtains to reduce visual disturbance as well as certain wall

Requires improvement

Is the service responsive?

and floor colours, pictorial signage and door photographs to help people to navigate. We discussed dementia-friendly environments with the registered manager. She said she was in the process of arranging for photographs to go on people's bedroom doors (with their permission), planning to purchase coloured crockery, thought to help people with sight loss and dementia to eat, and was obtaining picture signage and pictorial menus to assist people living with dementia.

At the time of our inspection Beech House Nursing Home was not a dementia-friendly environment. We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

We found there was a system of reporting and responding to complaints and concerns in place at the home. Information on how to make a complaint was located next to the visitors signing in book and there was a framed cartoon on the wall in the reception area that stated 'A complaint is not negative. See it as a gift that will help me change things.' We asked people and their relatives if they had ever made a complaint. One person told us, "I've never had to complain, I know the lady in charge." Another person said, "I've never had to complain, if I did, I'd go to the staff," and one relative said, "They're quite responsive, especially [the registered manager]. She doesn't mind the feedback."

We checked the complaints file and noted that relatives that had made a complaint either verbally or by email had been asked to make a formal written complaint. We saw that written complaints were investigated promptly and in depth by the registered manager and documentation was kept which showed the date each complaint was deemed to be resolved. However, it was not always clear from the documentation how the complaints had been resolved and what measures (if any) had been put in place to ensure the issue did not reoccur. For example, one complaint involved missing laundry, and another, a person whose fingernails were not clean. We raised this with the registered manager who told us that the documentation would be amended so that it would be clear how the complaint was to be dealt with, how it had actually been resolved and what mechanisms the home would put in place to ensure the issue did not happen again.

Requires improvement

Is the service well-led?

Our findings

We asked people and their relatives about the management at Beech House Nursing Home. One person told us, "The manager's very nice, she's a very good organiser. I've no complaints", another person said, "[The registered manager's] quite approachable, she's nice. [The registered manager] gets on well with staff, they make a good team", and a third person said, "I don't think she's (the manager) very approachable. She might say hello but she always gives the impression of being busy, busy, busy." One relative we spoke with told us, "[The registered manager] has played a very big part in sorting things out and getting things organised (for my relative)."

We also spoke with staff about the management at the home. One care worker said, "The manager is always ready to respond and welcomes feedback", another care worker said, "She's (the registered manager) the best manager I've ever worked with", and a third care worker described the registered manager as strict but approachable.

We looked at the audit systems that were in place to ensure the quality and safety of the service was maintained and improved. We saw records of a pressure ulcer audit in May 2015. The registered manager said that pressure ulcer audits were not ongoing at the time of our inspection as there were no people at the home with pressure ulcers currently and there had not been any for some weeks. We saw documented audits for health and safety for February 2015 and May 2015; aspects assessed included building checks, clinical waste and staff training. No health and safety audits had been completed since May 2015.

Audits for infection control and hand hygiene were recorded for January 2015, April 2015 and June 2015 with none since then. Actions recorded as needing to be completed 'ASAP' (as soon as possible) on the January 2015 audit were also recorded on the two subsequent audits; in fact, apart from the dates on the top, each document looked exactly the same. We also noted that there was no acknowledgment on subsequent audits that actions were outstanding from previous audits or any comment as to why they had not been addressed. The outstanding actions on the infection control and hand hygiene audits were installation of a handwashing sink on the first floor of the house and creating a sluice area for the disinfection of cleaning equipment. We asked the registered manager why the outstanding actions had not been addressed. She said that a suitable site for a handwashing basin had not been identified and the sluice area was in the process of being fitted.

There had been laundry and housekeeping audits in February 2015 and May 2015, and a care audit in June 2015, but none of each audit since. We asked the registered manager why there had been no audits of any kind since June 2015; she said that within a short period around that time three permanent day nurses had left the home, so that she had taken on all of their responsibilities in addition to her own as home manager.

The registered manager also confirmed that there were no formal audits of safeguarding incidents, falls, and accidents and injuries. The registered manager told us that as she led on the documentation and investigation of safeguarding and other incidents, including their reporting to the Local Authority and to the Care Quality Commission when required, that she maintained an overview of what was happening at the home. As a result of our raising the issue the registered manager said that she would revise the documentation used so that safeguarding incidents, falls, and accidents and injuries could be tracked and audited.

At the time of our inspection the service did not have effective systems in place to monitor and assess the safety and suitability of care provision. This was a breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held for care workers with the registered manager on a monthly basis. We saw that meetings were minuted and care workers we spoke with confirmed they attended them.

We checked the notifications that we had received from the home for Deprivation of Liberty Safeguards application approvals, deaths, safeguarding incidents and serious injuries, all of which the service is legally required to report to CQC. They correlated with the records we saw at the home. This meant that the registered manager was reporting to CQC in line with legal requirements.

We wanted to find out how the service involved the people and their relatives with the running of the home and if their feedback was ever sought. The annual questionnaire had recently been sent out to people and their relatives in

Requires improvement

Is the service well-led?

November 2015 and we saw that 21 people's relatives had received the questionnaire either by post of email, depending on their preference. Two questionnaires had been sent to healthcare professionals who regularly visited the home.

The relatives' questionnaire was one page and asked for feedback on aspects such as whether they were made to feel welcome, the cleanliness of the home (inside and out), relative's knowledge of the complaints policy and if they knew who the manager was. The questionnaire for the people using the service was comprehensive, with separate pages for cleanliness, care, laundry, privacy and dignity, food and activities. As discussed elsewhere in this report, we saw examples of the registered manager acting upon feedback received in the questionnaires. This meant that the registered manager used the feedback received in the questionnaires to try and improve the service.

The registered manager also held meetings with the people at the home and their relatives in order to find out what they thought about the service. The last meeting was held in March 2015 and was also attended by the area manager for the service. One relative we spoke with during this inspection said of the meeting, "We had a meeting with [the registered manager], the area manager and other families soon after [my relative] came here and on the whole it was very reassuring. Families were generally grateful and appreciative. There are minutes of the meeting." We saw in the minutes that the frequency of these meetings was discussed and it was agreed by the people and their relatives that meetings should be held to discuss the outcome of each CQC inspection. As this was likely to be annually at most, the registered manager had also created a system whereby people and their relatives could book appointments with her to discuss any issues, this included one evening a week for relatives that worked during the day. This meant that the registered manager listened to people and their families and had put a system in place whereby people and their relatives could discuss issues or provide feedback at times that suited them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Moving and handling techniques that could harm the person and the care worker were observed on two occasions.** Regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient staff to meet the needs of the people. The lack of permanent nursing staff was affecting the overall management of the home.** Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Mental capacity assessments were not consistent or comprehensive and staff knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was poor.** Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care assessments and plans were not consistent or comprehensive and were not always updated when changes had occurred.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 9 (3) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not have access to meaningful activities. Regulation 9 (3) (a), (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to assess, monitor and improve the safety and suitability of the service in order to mitigate the risks to people so they are protected against the risk of unsafe or inappropriate care, treatment and support. Regulation 17 (2) (a) and (b)