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Beechcroft Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 30 August and 7 September 2017. This was the first comprehensive inspection since the provider first registered in January 2016.

A focused inspection took place on 24 May 2016 after whistleblowing concerns were raised about staffing, nutrition and personal care. We did not find any concerns during this focused inspection and the provider was rated Good in relation to safety.

The first day of our inspection was unannounced. We informed the home manager we would be returning to complete our visit on 7 September 2017.

Beechcroft Care Home provides nursing care, respite and accommodation for up to 30 older people, some living with dementia and some requiring palliative care. At the time of our visit there were 26 people living in the home. The home is located in a Victorian converted terraced property, arranged over two floors. The floors were accessible by a lift.

At the time of our inspection there was no registered manager in post. The home manager was in the process of applying to become the 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 in the Health and Social Care Act and associated Regulations about how the service is run.

People were not always protected from the risk of avoidable harm as staff were not always responsive to calls bells and there was not always learning from incidents when they occurred in the home. Some risk assessments were in the process of being reviewed and updated to reflect people's needs.

People told us the majority of staff were kind and caring, and respected their privacy and we saw examples of this.

Some people were not always given the opportunity to socialise with other people in the home and because of this felt isolated. There were activities that were held in the home but more needed to be done for those who wished to access the community and to meet people's individual needs and preferences.

People's feedback about the quality of the meals was varied and not everyone could read the menus on display as the writing was too small for some people to read.

People accessed healthcare services and we saw health practitioners visiting the home.

People were supported to give consent for their care and support and where appropriate capacity assessments were carried out and DoLs applications were submitted to the local authority to ensure decisions were made in people's best interests and protected their rights.

Some people told us there was not enough staff to meet their needs and some staff agreed with this. Staff recruitment checks were in place but verification of documents needed to be more robust to ensure that staff were suitable to work with people using the service.

Mandatory training was attended by staff who explained this was satisfactory. Regular supervision was not always carried out for some staff and the home manager acknowledged the need to address this.

People received their medicines when needed. There was a process for the safe management, storage and administration of medicines but there were some gaps in the medicines administration records.

People had access to information about how to make a complaint. The majority of people told us these would be resolved, with the exception of one person, who was unsure if their concerns would be listened to.

Audits were carried out; however they were not always effective as they failed to identify the issues we found. Records showed that people's feedback had been sought to find out their views about the quality of care the service provided.

We made two recommendations about the accessibility of information and the deployment of staff. We found three breaches of regulations relating to safe care and treatment, person centred care and good governance. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Aspects of the service were not always safe.

People told us their requests for care were not always responded to. Action was being taken to address safeguarding concerns that had been raised to ensure people were kept safe.

Some people told us there was not enough staff deployed to meet their needs and some staff agreed.

Staff recruitment checks were carried out but some background checks required verification.

People told us they received their medicines as required, but medicines were not always administered in a timely way to ensure that people received these as prescribed.

Is the service effective?

Requires Improvement ●

Aspects of the service were not always effective.

Supervision was not carried out for all staff on a consistent basis. Staff had received training to reflect the needs of the people they cared for.

People had mixed views about the meals provided. They were provided with sufficient food and drinks but menus needed to be provided in an easy read format.

People had access to health practitioners who frequently visited the service to support them with their health needs.

Is the service caring?

Good ●

The service was caring.

People told us the majority of staff were kind and caring and we observed examples of this.

People told us that people knocked on their doors before being given permission to enter their rooms and their privacy was respected.

Staff encouraged people to maintain relationships that were important to them.

Is the service responsive?

Aspects of service were not always responsive.

Some people were not always encouraged and supported to socialise with others as they wished. We observed activities in the home, but there was limited information to show how people were encouraged to engage in meaningful activities both inside and outside the home.

There was a system to manage complaints. Although most people told us that they felt able to raise any concerns, one person was not sure that they would be listened to.

Care records held information about how people wished to be supported with their care.

Requires Improvement ●

Is the service well-led?

Aspects of the service were not always well-led.

Systems were in place to check the quality and delivery of care in the home but these systems had failed to identify the issues we found.

An application had been received by the CQC to begin the registration process for the home manager.

The majority of people spoke of positive interactions with the management team but highlighted at times they were busy.

Requires Improvement ●

Beechcroft 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 30 August and 2 September 2017. The first day of the inspection was unannounced. We informed the home manager we would be returning for a second day. The inspection team consisted of one inspector, a specialist nurse advisor and an expert by experience on the first day and one inspector on the final day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the previous inspection report and notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

During the inspection we spoke with eight people using the service, the GP and a health and social care professional who was visiting on the first day of our inspection. We spent time observing the care people received and toured the building. We reviewed the records in relation to nine people's care including their medicines records, three staff recruitment files and information relating to the management of the service. Additionally we spoke with four health care assistants an agency nurse, the permanent nurse, the administrator, the home manager and the provider.

After the inspection we spoke with a representative of the local authority to gather further information and feedback about the service.

Is the service safe?

Our findings

People told us their care needs were not always met when they needed help and support. We asked people how they would contact staff if they needed support and they commented, "We have a call button to press, there is usually someone around anyway" and "I would press the call bell, or call out for a member of staff." However, other people said staff were not responsive to the call bells when they pressed these. One person said that they thought that some of the staff got upset with them because they took a long time to respond and added, "They say five minutes then they take a long time to come back to me, sometimes I press the bell and then they come and say 'one minute' then they take ages before they come back, it makes me feel upset sometimes I cry." A second person gave an example where they had to shout out every time they heard someone walking close by and said eventually another person heard them and came to help. They said, "When [the person who uses the service] came in [they] told me not to worry and [they] would get a carer." The person explained this was worrying because anything could happen and no one would be aware. Other people commented, "The call bell is on the wall, as long as you press it right in, it will ring through to the front desk If they aren't busy they will answer. Sometimes you get a good response and sometimes you don't" and "To be honest the bells don't go off often here however, some people have complained that the staff take their time before responding I haven't got a problem."

During our visit we checked the call bells and found when we pressed them that staff arrived promptly. However we saw that one person's call bell was out of reach, when we asked the staff why this was they stated they didn't know and put the call bell back within the person's reach. A second person was unable to use the call bell due to their physical health and to ensure that staff could respond to them a monitor was placed in their room and the second monitor in the quiet room, so staff could hear them when they needed support. However, on the first day of our inspection we found these were both unplugged. We asked a member of staff the reason for this and they told us they didn't know. We pointed this out to the management team who plugged these back in and found the monitor was not working; and explained they would they would report this to be actioned for immediate repair. This meant that people could not always call for staff attention when they needed support which increased the risk of people not receiving appropriate and safe care.

On the second day of the inspection we checked this person's monitor again and it was found to be working but the management team found a further fault with this person's call bell and explained the room number that was displayed on the call bell system showed a different room number. They explained they had actioned repairs to be carried out of the call bell system and informed staff of this. The staff we spoke with confirmed they had been notified of this.

The issues highlighted above constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. We observed that the morning medicines round was busy and an agency nurse was conducting this. The nurse explained it would be useful to have another member of staff to support them with the medicines, particularly as they did not know people's needs well. We noted

they did not finish the medicines round until lunchtime which meant that people may not have received their medicines as prescribed. On the second day of our inspection the permanent nurse also expressed their concerns about the length of time it took them to complete the medicines round on their own and stated that they needed another member of staff to assist and ensure people received their medicines in a timely manner.

Medicine administration records (MARs) were completed accurately in most cases, however we found there were gaps in the recording of the MARs for two people on two separate dates where there were no signatures to demonstrate that staff had administered their medicines. We discussed our findings with the home manager who said they would look into this. There were plans in place for people who were prescribed 'as required' medicines (PRN). However, there was not clear guidance for staff on the use of these medicines to ensure that they were appropriately managed to meet people's needs.

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

We observed that medicines were administered by the agency nurse in calm and unrushed manner, ensuring people received the support they required. One person told us the nurse supported them appropriately with their medicines and was polite and kind. A second person explained the nurse helped them to take their prescribed medicines when this was required. A third person said they had no concerns with their medicines and described how the nurse was always very patient with them.

Medicines were stored safely and securely, at appropriate temperatures including medicines which required refrigeration. Controlled drugs were stored in a separate cupboard and we found the stock count and recording of these to be accurate. At the time of the inspection we were told no one was receiving their medicines covertly.

The home manager explained that the Lewisham Integrated Medicines Optimisation Service (LIMOS) would be visiting the service. LIMOS is a service that provides support to people with long term health conditions to manage their medicines effectively and provide advice to ensure adherence with the safe administration of medicines.

Three out of eight people told us there was not always enough staff to support them which had an impact on them receiving care when this was needed. One person said they had to wait a long time for staff to provide personal care particularly when agency staff were on duty. They further commented, "Some of them didn't like coming in and feeding me, that's what I feel anyway. I always try to be nice and polite to everyone because I know it must be a very hard job." A second person told us they would like to go out more but sometimes there was not sufficient staff on duty. They said they spent a lot of time in their room and commented, "It's a shame really, I don't get a chance to go to the lounge, I did go down there before but they must be busy." A third person explained there was less staff on at the weekend and added, "One day I had to wait for what felt like 20 minutes to get a drink and I like to drink a lot." They further commented how they used to get taken into the lounge area to talk with other people but said that this didn't happen anymore. They commented, "I don't know, maybe it's because they don't have enough staff."

We checked the rota which showed there were five staff and one registered nurse working during the day time and one registered nurse and two staff working during the night. The weekend shifts showed the same shift patterns but with six staff working on the Saturday. The rota showed the home manager, deputy manager and administrator worked five days a week during the day. The deputy manager who was the clinical lead was on leave. The home manager said they sourced agency workers when the permanent staff

were on leave. They explained that they amended the rota based on occupancy levels to ensure that there was enough staff on duty. The majority of staff we spoke with told us there were sufficient staffing levels however some staff told us there were not. Our observations found that staffing levels during our visit appeared sufficient. We recommend that the provider reviews arrangements for the deployment of staff to ensure that people receive support in a timely way.

We noted the room numbers on doors were not displayed in order throughout the home which could cause confusion for people; this was due to the layout of the building. The provider told us about future plans for the refurbishment of the building which would take into account the room numbering on the doors.

People told us they felt safe living in the home. Their comments included, "They make sure I'm sitting on the chair right which is good for me because I didn't really know that I had to sit in the chair in a certain way, this is all to make me safe", "I'm confined to a wheel chair so it's important that I feel safe where I live and I do" and "I haven't been here long but I do feel relatively safe here."

Staff gave us examples of the types of abuse people may be at risk of and told us what action they would take if they had concerns. Staff also knew what to do to whistleblow if they identified any workplace concerns.

Since the last inspection we had been notified of three safeguarding concerns and the provider had kept records of these. The first safeguarding concern was raised by the London Ambulance Service (LAS) in November 2016 about staff responses in relation to a person's death. Following the incident the provider sent us details of the protocols that staff should follow in the event of an emergency and these were displayed in the home. The local authority made recommendations following the investigation but the home manager told us one of these had not been actioned. The home manager agreed to address this immediately.

The second safeguarding concern was raised by the LAS in July 2017 in relation the neglect of a person's healthcare needs. The safeguarding case was investigated by the local authority and was upheld and agreed actions put in place for the provider to implement. The third safeguarding concern was raised in August 2017 about a person being admitted into the home with a pressure sore. The person was seen by the GP and a referral sent to the hospital. The provider told us that the local authority had been informed of the concerns.

A representative of the local authority told us they would be monitoring the provider's actions to improve the quality of care at the service following these incidents to ensure that lessons were learned.

We noted when these safeguarding concerns were raised there was no registered manager in post. Additionally the provider's safeguarding and whistleblowing policies and procedures required updating. We pointed this out to the management team who acknowledged this and agreed to review these processes.

People had individualised risk assessments in place that informed staff about how to keep them safe whilst supporting them in regaining their confidence and re-learning daily life skills. Staff completed risk assessments in relation to people's personal care, nutrition, skin and mobility as well as any other risks associated with their health and wellbeing. For example, one person had been assessed for catheterisation and had a risk assessment in place which gave instructions for staff about how to manage the risks associated with this. However, three people's records required updating; we saw an audit checklist on these files which highlighted many areas of improvement that were required to bring the files up to date.

Appropriate measures were in place to prevent people from developing pressure ulcers. Records showed people were turned routinely and accompanying body maps were up to date and formed part of the agreed care plan. Staff we spoke were aware of the importance of completing turning charts and taking photographs of any wounds to identify any changes to the person's skin integrity, one staff commented, "We check for this and contact other services if needed." Notes evidenced there was contact with the tissue viability nurse (TVN) and on the second day of our inspection the TVN visited the service to check people's pressure area care. During the first day of our visit the home manager explained staff were booked on wound management training the following day. On the second day of our visit the staff reported the training had enabled them to learn more about supporting people with pressure area care.

There were systems in place to make sure that staff were only employed once the provider was satisfied they were suitable to work with people who used the service. Recruitment records held background checks about employees' suitability. The checks included evidence of the candidate's experience and criminal record checks. However, there was no evidence to demonstrate that copies of staff's identification, such as their passports had been verified to evidence their authenticity and that staff had the right to work in the United Kingdom. We pointed out our finding to the provider who agreed to action this.

A fire safety order was issued to the previous provider during November 2015 with a list of recommendations. Information showed they taken remedial action; the fire safety officer was yet to return to check this. We contacted the fire safety officer and they explained they would conduct a visit to follow up on the actions taken. There were records of regular servicing and testing of fire equipment on file and the home manager told us staff were booked to attend up to date fire safety training

The home was clean and free from odours. Staff explained they had access to personal protective equipment such as disposable gloves and aprons to prevent the spread of infections; however one member of staff told us the provider sometimes ran out of gloves and wipes but we saw these items being used during our visit. Staff told us and records confirmed they had completed infection control training.

Is the service effective?

Our findings

People were supported by staff who had access to the required mandatory training to enable them to meet people's needs effectively. We asked people if staff were able to meet their needs. One person told us, "Some staff give me tablets, some feed me so I can only assume that they are all trained." A second person told us they thought the staff were relatively well trained and could meet their needs, but said they were unsure about some of the night staff but was unable to give us an example of this. They further added, "I spend most of my time in my room on this bed therefore I always need someone to assist me, the staff are ok, some of them anyway. I suppose they are reasonably trained because of the things they say and do." A third person commented, "If I'm not fully sitting up in my bed when I'm fed I will choke. Some carers don't know this and I have to tell them, some carers are not good at positioning me."

Staff's views differed about how often they had received one to one supervision, some told us they had attended one to one meetings and some told us they had not. The records we checked showed that there were gaps in staff supervision. For example, the provider's procedure read that supervision was to take place four times per year, however records showed that for two members of staff their last supervision was recorded in January 2017. We pointed this out to the home manager who said they would address this.

During our visit we observed that staff demonstrated safe moving and handling techniques when transferring people. A member of staff told us, "I always transfer with two people and I am trained." Floor areas were generally uncluttered with space for manoeuvring people. Two members of staff supported people with hoist transfers to ensure this was completed safely. Staff confirmed they were up to date with their annual moving and handling training.

Staff told us they had access to essential training to carry out their duties and responsibilities and the records we viewed confirmed this. This included an induction before they commenced work. An agency member of staff working at the service told us, "I have been given a good induction and handover, and I am clear about my role." Staff files that we checked listed the training they had attended, such as dementia, person centred care, Deprivation of Liberty Safeguards, malnutrition and palliative care. Nurses had completed the provider's additional training which covered topics relating to the ageing process and a medicines workshop for senior staff facilitated by Lewisham council.

The majority of people we spoke with told us they enjoyed the food and had a variety of meals to choose from. Their comments included, "It's ok, not bad to tell the truth", "It's quite nice actually", "It's a bit plain and not much variety" and "I like to eat healthy and I find that there isn't enough fresh vegetables. There is always a lot of meat." One person told us the portion sizes were large so they didn't always manage to finish their food and a second person told us sometimes by the time someone come to help them eat their food had gone cold. We tasted the food during the first day of our inspection and found the quality, quantity and temperature of the food served was satisfactory.

We observed that staff were patient when helping people with their meals and addressed people by their first names. Some people needed full support with eating and drinking we saw staff interacting with people

whilst engaging them in light hearted conversation. A member of staff commented, "We will take as much time as needed with them."

There was a set menu for each week; this was displayed in the main communal areas and on the dining room table which showed the variety of meals on offer to people which included fresh fruit, vegetables, tea and coffee and fruit juice. However, when we asked two people what was on the menu they explained they did not know because the writing was too small on the menus and therefore could not read the food menu. We recommend the provider updates their information in accordance with the accessible information standards to ensure people are provided with information that meets their needs.

People had the option to choose to eat in the communal dining area or in their rooms. We observed that when the food was delivered to people's rooms the dishes were covered and staff supported them with their meals. Drinks were available throughout the day and were in easy reach of people in the communal areas and their rooms.

Care plans detailed the support people required from staff to ensure they were appropriately assisted with their meals. People's files noted their preferred choice of meals and particular requirements, such as a soft diet or puréed food. A staff member commented, "We have some residents who have difficulties swallowing or are in bed, we are aware of this, and will take them drink and food throughout the day." Care records showed that people were supported to manage conditions such as diabetes with the support of health care professionals. One person said, "I can't eat most cultural foods because of my diabetes but the food here is good, I like it."

People told us they were encouraged to make choices and were able to contribute to decisions about their care. One person explained the staff knew them well enough to make decisions about their care and said, "They all know me here, they know what I like." Most of the people who used the service were able to consent to their care and support. Some people's health needs meant that they did not have the mental capacity to make decisions about some aspects of their care. 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. Staff explained the importance of obtaining consent from people before helping them with their care and support needs and gave us examples of this. The records we checked showed evidence of best interests meetings taking place where people lacked capacity to make specific decisions about their care, such as use of bedrails.

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 are called the Deprivation of Liberty Safeguards (DoLS). There were gates with keypads at the top of the staircase in the service, we asked staff what these were for and we were told they were not used and found that these were unlocked during both days of our visit. We saw records to show that the provider had made 11 applications for DoLS authorisations to restrict a person's liberty in their best interests, some of which were in the process of being reviewed by the local authority.

People told us they were supported to access the appropriate healthcare professionals to meet their needs. One person told us they had seen the GP and other specialists had visited them in the home. A second person explained they had regular visits from the GP and dentist. A third person told us the optician visited them regularly and was happy their physical health needs were being addressed.

Records evidenced communication with external health and social care agencies to ensure people received the care, treatment and support they needed. We spoke with the GP who visited the service once a week. They told us that people's diabetes and end of life care needs were well managed and that people had access to an in-house optician. They added that all the people in the house had been given flu jabs. The spoke positively about the service provided and the holistic approach to working with people living with dementia.

Is the service caring?

Our findings

People told us the majority of the staff who supported them were kind and caring. Their comments included, "Staff do their best, I don't get to see much of the night staff because I'm asleep shortly after they arrive here. They will get you extra medication if you need it and they will come around and ask if you want them to turn the television and light off. All the staff here are good we can have a laugh and they are all so kind." A second person said, "Some of the carers are good but not all, some have no patience." A third person told us the staff were very caring particularly the staff who supported them and said, "They are like my family everyone is polite to me, they are all nice, otherwise I wouldn't let them into my home." A fourth said that there were a few members of staff who they got on with very well and would visit regularly but there were times when they did get lonely. They told us that staff were very busy and therefore understood if they could not be around all the time.

There was a peaceful atmosphere in the home despite our unannounced visit. We observed that people on bedrest were observed to be mostly comfortable, warm and their personal appearance attended to. We saw that staff communication with people was warm and friendly. Staff spoke about the reasons they enjoyed working in the home and explained, "I don't like to see people suffering so I have a passion for this" and "I love working here. We are a good team."

There was a quiet room for people to relax and sit peacefully. People told us at times they used the quiet lounge to enjoy time alone but mostly preferred to sit with their friends in the main lounge. People told us their relatives could visit the home whenever they chose and during our inspection we saw a relative spending time with their family member in the communal area who was welcomed by the staff on site. We saw that staff took time to sit beside people and speak with them in communal areas when time permitted. We observed the activity coordinator visit some people in their rooms and a person told us they were "very caring."

People told us their privacy and dignity was maintained and that staff knocked on the door before entering. Some people explained they preferred to leave their doors open during the night so the night staff could enter their rooms easily and check on them. One person said, "If the door is open they would call out to me and ask if it's okay to come in." A second person commented that staff always knocked on the door before entering and they were happy with the way they respected their dignity and privacy. There were occupied notices on people's doors advising staff, 'please knock before entering' and we saw staff adhered to this.

Appropriate systems were in place to support people who were at the end of their lives. We found for two people a discussion with their GP had taken place about their advanced care planning in accordance with their end of life wishes. The staff spoke about providing person-centred care for people at the end of their lives that was tailored to the needs and sensitivities of people and their relatives.

Is the service responsive?

Our findings

People were not always supported to participate in activities that met their needs and preferences. People told us about their interests and the things they used to do but said they were not given the opportunity to continue with these. One person explained they liked swimming but could not do this anymore due to their health and occasionally they played bingo or watched a film but said, "It would be good if we had some more (activities)." They told us they got bored sometimes and said "it's just life." Two people told us they were not always given the option of joining other people in the lounge. One person explained they liked talking to people but was unhappy because they were not given the option to participate in activities taking place and didn't really know why they were not taken downstairs any more. They further commented they couldn't remember the last time they were taken to an activity and said, "I don't know if I would be listened to if I said something about it." They explained that they used to like playing rugby and still enjoyed watching it on the television. They told us they read a lot and that the home provided a selection of books. The second person told us they used to get taken to the lounge to talk with other people, but this had not happened recently. Other people said they enjoyed talking, singing and reading and in the past had occasionally played the piano.

We asked staff about the type of activities that people participated in at the home and two of staff commented, "There is not much going for activities at the moment, they watch TV a lot" and "The activities could be better, people need to get out and get some fresh air, not just in the garden but on day trips."

Care records noted the pastimes and hobbies people enjoyed. There was evidence to show activities had been selected for people on the activity boards however there was a lack of information about people's involvement in these. For some people they had a daily living assessment of their daily routine and activities, however we found some of these records were not kept up to date for example, one person's last recording was April 2017. The activities log provided information about the activities that were available to people in the home such as arts and crafts, puzzles and birthday celebrations, but there was limited activities that people accessed outside of the home. We noted a record of a residents meeting to discuss possible day's trips and plan activities, however at the time of our inspection these had not taken place. Therefore we could not be assured that people were supported to engage in meaningful social and leisure activities that met their needs and preferences.

The above issues highlighted above are a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a bingo session, but not many people participated in this, and we noted the television was on in the background. We also observed a singalong activity that took place where the activities coordinator interacted frequently with people whom were complementary about the support they provided. One person showed us a croqueting napkin they were working on and during the first day of our inspection we met a volunteer from a local church who explained they visited the home to read books to a person.

The care records we checked held a pre-admission form and discharge summary sheet used to plan

people's care and determine how staff would meet their needs at the service. Care plans contained details of the requirements to keep people well and healthy such as the details of the medicines they received when moving into the home and the health practitioners involved with their support. During the inspection we spoke with a representative from the local authority who was visiting to review a person's needs and they spoke positively about the support the person received.

People had care plans that were written in the first person and evidenced person centred care and the staff we spoke with demonstrated a good knowledge of people's support needs. Those who had difficulty with communication and/or coordination were supported and we saw they were encouraged to be as independent as they could be and some who required full assistance and support were given help when this was needed. There were daily living assessments to show how to support the person with their medicines, eating and drinking.

Records showed people's individual bed time routine, and the times they preferred to go to bed, wake up and if they chose to have their doors left open. However, although people's records detailed their individual preferences, it was unclear to what extent people or their relatives had been involved in planning and reviewing their care. Two people told us they had a care plan, that their family were involved in their care and that their family frequently communicated with the provider. One person we spoke with told us they understood the information in their care plan and other information regarding their stay at the home, for example, the service user guide.

People spoke with us about their spiritual needs. One person told us about their Christian beliefs and told us, "They (staff) know I like listening to my church meetings on TV so they will come in and put it on the station I like to watch, I like watching the gospel channel." They also explained that the staff organised for them to be taken to church when they wanted and said they appreciated this. A second person said they had no cultural needs but explained there was a pastor who came in to visit them in the home. A third person told us the provider could do with more Christian based activities which they could get involved with.

People told us they knew who they could speak with if they had any complaints. Where one person raised a verbal complaint with the clinical lead they had not had any other concerns since and was pleased with the way the matter was handled and said, "To be honest, I really like the staff here they treat us well, I have no complaints about any of them." They further explained they had not raised a written complaint but was confident if they spoke with the clinical lead this would be resolved. A second told us they had raised a concern previously and were satisfied with the outcome but a third person explained that although they were confident about raising a complaint they did not think things would get done.

The complaints procedure was displayed in the home but it advised people to contact the CQC if they had a complaint. We explained to the management team that although CQC welcome information about care services, it is not within CQC's remit to investigate individual complaints. This was updated during the inspection. We saw there were complaint leaflets with contact details for the two placing authorities that advised people could escalate their complaints to the Local Government Ombudsman (LGO) if they were unsatisfied with the providers' response to their complaint. We looked at the complaints log and noted there had been one complaint since the last inspection, notes showed that action was taken and the complaint resolved.

Is the service well-led?

Our findings

Quality assurance systems were not always operated effectively as they had not picked up the issues we identified during the inspection. Although some of the areas we checked had been identified through the provider's audit processes, these did not pick up concerns relating to call bells checks and issues related to the lack of meaningful activities that met people's needs. For example, records showed that although one person's call bell required repair the audits identified that all the call bells were working effectively. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the time of our inspection the provider had not had a registered manager in post since May 2016. The home manager joined the organisation in April 2017 and told us they were in the process of applying for the position of registered manager of the home. CQC has received the manager's application to register since the inspection and are in the process of assessing this.

We asked people if the home was well managed. One person told us the lead nurse was good and seemed to know how to organise everyone and was aware a new home manager worked for the service. They further explained if they had to speak with the home manager they would and thought all the staff including the managers were okay and added, "Everything is good." A second person explained they didn't know who the manager was and didn't really get a chance to speak to the people in the office as they were always busy. A third person said sometimes they could not remember the manager's name but thought they were very kind. A fourth person said that in their experience the home was well managed and had no problems with any of the staff including the managers and when the managers had time they would come up to the floor to say hello.

People told us what the service did well and what they could do better. Their comments included: "I can't think of anything I would change about living in the home, everything is good it's my home", "They are very friendly, I love all of the staff", "I can't think of anything really but maybe the activities", "I am very dependent upon the staff therefore I am very grateful, they attend to my personal and medical needs. They sometimes seem to be restricted on equipment and resources like pads and stuff but they seem to get them from somewhere" and "I get on with everyone, I like the food and [activity coordinator name]."

Records from the staff meeting showed discussions with team members about infection control, distribution of medicines, the recording of accidents and incidents in relation to pressure sore care and people's personal care. One staff member told us that staff meetings needed to be held more frequently to discuss their ideas and suggestions about the overall delivery of the service; we noted meetings had been held in January, March and July 2017.

The provider asked people to complete a survey to enable them to express their views of the service. The most recent survey covered topics such as people's physical health, their well being and the environment and wellbeing were positive overall.

The staff we spoke with told us they felt well supported and were clear about their roles and duties. Relationships were good between the staff team and they spoke favourably about the lead nurse who was on leave at the time of our visit. A staff member explained the reason for this, "We have very loyal staff, I admire them. They communicate with each other very well." The majority of staff were complimentary about the new home manager but some staff said they needed more time to get to know them better and that communication needed to be more frequent. We observed that the home manager was visible during both days of our inspection and demonstrated she knew people well, even though she had worked at the service for a short period of time.

The home manager had recently attended a nursing and residential nurse forum facilitated by the local authority and spoke about the partnership meetings she would be attending in the future. The local authority had visited the home to check on the quality of care people received, they had made recommendations and the action plan showed the provider was in the process of working on implementing these.

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 How the regulation was not being met: Care and treatment of services users was not provided to achieve preferences and ensuring their needs are met. Regulation 9(3)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2) (a)(b)(c)

