Flightcare Limited

Beechcroft

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

Overall summary

Beechcroft provides support for people with both nursing and personal care needs. It is a 43 bedded home with 37 single and three shared bedrooms. There were communal toilets and communal bathrooms with specialised bathing facilities for people to use on each floor. At the time of our visit, there were 42 people who lived at the home.

The registered manager of the home at the time of our inspection was on annual leave and did not participate in the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run'. Due to the manager's absence, the deputy manager of the home took responsibility for our visit.

During this inspection, we found breaches of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of

Summary of findings

Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

We looked at eight care plans and found they did not cover all of people's needs and risks. Some risk assessments and care plans failed to provide adequate or clear information to enable staff to ensure they delivered safe and appropriate care. Some care plans had not been updated appropriately when people's needs had changed and some risk management actions were not followed. For example, two people's risk management plans for pressure area care specified that they were to be re-position every two hours but repositioning charts failed to evidence that this was being appropriately undertaken. We also found however that some of the nutritional guidance for staff to follow in relation to people's care was not consistently monitored or adhered to in order to ensure people's nutritional needs and risks were managed.

Where people's care plans indicated they had mental health conditions which may have impacted on their ability to consent to decisions about their care, their capacity had not been assessed in accordance with the Mental Capacity Act 2005 unless the person was subject to a Deprivation of Liberty Safeguard. Consent forms in people's files had often been signed by relatives and there was little evidence the person themselves had participated in or agreed with consent given.

Where a mental capacity assessment had been undertaken as part of DOLs, the assessment process was very good. We spoke to the deputy manager about this, who told us they had just started a new mental capacity assessment process.

People had a choice at mealtimes and were given a suitable range of nutritious food and drink. People we spoke with were happy with the food and choices on offer. We saw that the home catered for special diets such soft diets or diabetic needs and alternatives to any of the mealtime options were always provided. People identified at risk of malnutrition received dietary supplements to promote their nutritional intake and were involved with professional dietary services where this was appropriate.

We observed a medication round and saw that the way in which medication was administered was unsafe. Staff did not follow the provider's medication policy in the administration of medication which placed people at risk. Some medicines were stored un-securely in communal areas and people's bedrooms which placed them at risk of unauthorised use. Staff we spoke with, during our visit, who were responsible for administering medication, did not demonstrate they were knowledgeable about safe administration practices or were competent to do so. Medication training for some staff was over two years old and the majority had not had their competency checked since they commenced in employment.

A health professional we spoke with during our visit said they thought staff at the home cared for people well. We observed staff supporting people at the home and saw that they were warm, patient and caring in all interactions with people. Staff supported people sensitively with gentle prompting and encouragement and people were relaxed and comfortable in the company of staff. From our observations it was clear that staff knew people well and genuinely cared for them. People looked well cared for and both people who lived at the home and their relatives were positive about the staff at the home and the care they received.

Staff when recruited had suitable employment and criminal convictions checks to ensure they were suitable to work with vulnerable people but some staff had not had their personal identify or right to work in the UK checked. The provider told us they had recently put systems in place to resolve this. Recruitment risk assessments had not always been completed prior to recruitment and required improvement.

The number of staff on duty was sufficient to meet people's needs. We observed staff to be kind and respectful and the activities co-ordinator offered a range of activities to occupy and interest people.

Staff we spoke with said they felt confident and supported in their job roles. Records showed staff had received an annual appraisal and regular supervision. Training records showed the majority of staff had completed adequate training although there were some gaps in the training of some staff members with regards to safeguarding, mental capacity and medication. We found when speaking to staff that these training gaps impacted on the staff's knowledge in these areas.

Summary of findings

The home was clean and well maintained with good infection control standards. The home had achieved a five star rating (very good) from Environmental Health in relation to its catering facilities and standards.

The culture of the home was positive and inclusive and visitors were made welcome by all the staff team. Good teamwork was evident throughout the home in meeting people's needs and all staff we spoke with told us they had a good relationship and confidence in the management team. This demonstrated that the manager and provider had fostered good staff leadership and morale.

There were audits in place to check the quality of the service where audits had identified improvements were required these had been undertaken. Some of the audits in place however were ineffective. For example, care plan audits had not identified the lack of clear and coherent care planning information in people's files; accident and incident audits were limited and did not provide sufficient information to enable the staff team to learn from and prevent similar accidents or incidents re-occurring and the lack of staff and management adherence to company policies had not been picked up and addressed. This indicated that the service's management and leadership required improvement.

People were able to express their feedback through a satisfaction questionnaire which was sent out each year to gain people's views on the quality of the service. The surveys returned so far indicated people who lived at the home and their relatives were very satisfied with their care.

At the end of our visit, we provided discussed some of the issues we had found with the deputy manager and provider. We found that they were receptive and open to our feedback and demonstrated a positive commitment to continuous improvement.

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 and required improvement.

The provider had a safeguarding policy in place and staff we spoke knew how to identify and respond to potential abuse.

People's individual risks in the planning and delivery of care had not always been fully assessed and appropriate risk management actions had not always been carried out.

Staff personal identity and right to work in the UK checks had not been undertaken when recruiting staff but the provider had just put systems in place to do this.

Medication was not safely administered or managed at the home. This placed people at risk.

Is the service effective?

Requires improvement

The service was not always effective.

Where people had mental health needs that could potentially impact on their capacity, the principles of the Mental Capacity Act 2005 had always been followed to ensure people's consent was legally obtained and their human rights respected.

Staff had received regular supervision and appraisal. There were some gaps in the training of staff but the most staff had completed adequate training.

People were given enough to eat and drink and a choice of suitable nutritious foods to meet their dietary needs.

Is the service caring?

Good

The service was caring.

Everyone we spoke with, spoke highly of the staff at the home and the care they received.

Staff were observed to be kind and respectful when people required support. Interactions between people and staff were pleasant and people appeared relaxed and comfortable with staff.

People's independence was promoted and people were able to make choices in how they lived their lives.

Staff we spoke with were familiar with people's needs and spoke warmly about the people they cared for.

Is the service responsive?

Requires improvement

The service was not always responsive

Summary of findings

People's needs were individually assessed and care planned but the quality of the information was poor and sometimes confusing.

Person centred information was limited. Some care plans and risk assessments were generic.

A range of social activities was provided and visits from the local church were arranged to support people's religious needs.

There was a complaints procedure in place displayed in communal areas. People and relatives we spoke with knew how to make a complaint and said they would have no concerns in doing so.

Is the service well-led?

Requires improvement

The management and leadership of the service required improvement.

There were some quality assurance systems in place to monitor the quality of the service but they did not effectively identify all of the risks to people's health, safety and welfare.

Policies and procedures at the home had not always been followed by the staff team. This placed people at risk.

The manager held regular staff meetings and people's satisfaction with the service was sought through regular resident meetings. A satisfaction questionnaire had recently been sent out to people who lived at the home. People's feedback was positive.

Staff told us they felt supported and confident in the management of the home. We found that staff had a positive work ethic and staff morale was good. The culture of the home was open and transparent which demonstrated an element of good leadership.

Beechcroft

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 1 and 2 July 2015. The first day of inspection was unannounced. The inspection was carried out by an Adult Social Care (ASC), a Specialist Advisor in Mental Health and End of Life Care and an Expert by Experience. An Expert by Experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also spoke with the Local Authority after our visit and they had no concerns about the home.

At this inspection we spoke with five people who lived at the home, five relatives, the provider, the deputy manager, the care quality manager, nine staff and a healthcare professional. We looked at a variety of records including eight care records, four staff records, a range of policies and procedures, medication administration records and a range of audits.

We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms. We observed staff practice throughout both of our visits.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they felt safe at the home and had no worries or concerns.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with two staff members who demonstrated an understanding of types of abuse and the action to take should any potential abuse be suspected. They both said they had received safeguarding training from the provider. Training records indicated that ten members of staff had either not had any safeguarding training or it had not been updated. This meant there was a risk these staff members may not know how to recognise and respond to signs of abuse.

Some of people's needs and risks in the delivery of care where in place for example, moving and handling, skin integrity, nutrition and their level of dependency. These risk assessments in the main where satisfactory. We found however that other risks had not been adequately identified or managed. Some risk assessments were not always individualised and risk management actions were sometimes generic. For example, bed rail risk assessments, outlined the general risks associated with the use of bed rails but did not assess or manage the specific risks relevant to each person.

We also found that risk management actions were not always followed in accordance with the person's care plan. For example two people's risk assessments for the prevention of pressure sores stated they were at high risk. Their care plans specified they were to be repositioned every two hours. We asked the Deputy Manager for evidence of this. We were provided with repositioning charts. Repositioning charts record the positional changes people are supported to make by staff in order to maintain skin integrity. The charts were incomplete and did not evidence that people were repositioned in accordance with their plan of care. The Deputy Manager acknowledged people's repositioning charts did not demonstrate that people had received the care they required.

One person was under the care of a dietician. The dietician had advised that changes to the person's fluid intake were required to mitigate the risk of malnutrition. When we looked at the person's food and drink charts, we found that on some days they had received double the amount of fluids recommended by the dietician. We spoke the deputy manager about this. The deputy manager was unaware of the change. They acknowledged that there was no system in place to check that the amount of fluids the person received was in accordance dietary advice. Staff we spoke with were unaware of how much fluid the person was to receive. The person's care plan had not been updated despite having been regularly reviewed. This meant the home had not taken suitable action to mitigate the risks of further weight loss.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that identified risks in relation to people's care were adequately managed.

The premises were well maintained and clean. There was evidence to show regular health safety tests were carried out on the premises and the equipment in use at the home. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected and serviced by external contractors who were competent to do so. This ensured the premises and its equipment remained safe and suitable for its intended purpose.

Both the kitchen and the laundry were well managed. The kitchen was awarded a five star food hygiene rating from Environmental Health in April 2015. This meant food hygiene standards were rated as "very good". Improvements in the operation of the laundry had been made in response to the provider's last infection control audit and there were adequate supplies of personal and protective equipment such as hand gels, gloves and aprons for both staff and visitors to use.

There were individual emergency evacuation plans in place in all of care files we looked at. There was also a 'grab' file in place for staff to use in the event of an emergency situation. The grab file included a profile of each person who lived at the home; their photograph, a description of their individual risks and their medication needs. This ensured emergency services and any alternative carer givers in the event of an emergency had clear information on people's needs and care.

Accidents and incidents were recorded on accident and incident forms. We reviewed one person's accident and incident information and saw that appropriate action had been taken to access suitable support for the person.

Requires improvement

Is the service safe?

The manager analysed people's dependency needs on a weekly basis and used this information to plan staffing levels. We reviewed a sample of staff rotas for June 2015. The number of staff on duty matched what the manager's dependency analysis had advised was safe and sufficient. We saw that people's needs were responded to promptly by staff, calls bells were answered quickly and there was a constant staff presence in communal areas to ensure people had access to support.

We looked at the personnel records for four members of staff. We saw that staff members had completed an application form, had references sought and a criminal record check undertaken but checks on the staff member's personal identity and proof of their right to work in the UK had not been done. We spoke to the deputy manager about this, who told us this had recently been addressed and these checks had commenced in June 2015 for new staff. We saw evidence of this. Where staff had criminal convictions prior to employment, a risk assessment had been undertaken but these had not been completed prior to employment. Risk assessments were limited and did not adequately mitigate potential risks.

We looked at the arrangements for the safe keeping and administration of medicines at the home. On the first day of our inspection, the medicine trolley was left locked but unsecured to the wall in the communal lounge till 11a.m. We found prescribed laxative medications left on the window ledge and a several boxes of prescribed eye drops, Ibuprofen gel and Lidocaine ointment stored in an open box on top of the medication trolley. This meant medication was not always stored securely, leaving the medicines accessible to unauthorised staff, visitors and people who lived at the home.

Two sets of the prescribed eye drop medication should have been stored in the fridge. On the first day of our inspection, this medication was left out of the fridge for approximately two hours. It was very hot weather and the temperature in the communal lounge was 25 centigrade. This meant it may not have been safe to use.

We found a variety of prescribed creams in people's bedrooms. We asked the deputy manager if any of the people who lived at the home self –administered their medication or creams. The deputy manager told us that no-one self- administered. We reviewed the home's medication policies and saw that people's capacity and capability to self-administer their medication was to be assessed prior to authorisation for medication to be stored in their own bedrooms. No risk assessment in respect of the prescribed creams had been undertaken.

A nurse we spoke with told us that it was usual practice to leave medication with people in their bedrooms for them to take independently if they had capacity, as staff did not want to "Treat them like children". This meant that staff did not witness the taking of this medication, did not know if the right person had actually consumed the medication or the actual time the medication was consumed. This placed people at risk of harm.

On day of our inspection, we observed a nurse administer morning medication. The nurse was polite and kind to people during the administration of medication and checked people's blood pressure prior to administration where this was required. The nurse however signed the person's medication administration record (MAR) as having observed its consumption prior to its administration, left the room on administering the medication and failed to witness if the person actually took it. This meant a false entry was made in the person's MAR as the nurse had not administered or observed the consumption of the person's medication prior to signing the record.

People's medicine administration records (MAR) indicated people were due their medication at 8am. We saw that medications administered at approximately 10am, were signed for as having been given at 8am. This meant there was a risk that people could be give over their recommended dose of medication by the time the next medication round was due.

We checked the arrangements for the administration of controlled drugs. Controlled drugs require two staff members to check, administer and observe their consumption. Two nurses were in the process of administering this medication when we checked. We saw that one nurse had signed the controlled drugs book as having administered the drug before it had been given.

We asked to see evidence that staff administering medicines were suitably trained and competent to do so. Training records indicated that the majority of staff had not received up to date training in safe medication

Requires improvement

Is the service safe?

administration and had not had their competency checked since they commenced in employment. For some staff members, this meant their competency had not been checked for over four years.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable systems in place to ensure the proper and safe management of all medicines in the home.

We saw that there were pain management assessments in place to enable staff to monitor people's pain in order to administer adequate pain relief. People's medication was within expiry date and there was sufficient stock. A check of the balance of people's medication left in the medication trolley matched what had been administered. This demonstrated that people had been received their medication.

Requires improvement

Is the service effective?

Our findings

People we spoke with said staff knew them well, that the care was good and they were very satisfied. One person told us that "Pretty well everything is taken care of" by the staff". Relatives we spoke with were also very positive about the staff at the home.

We spoke with the deputy manager and two care staff about the people they cared for. We observed staff supporting people throughout the day and from our observations it was clear staff had good relations with the people they cared for. Staff we spoke with demonstrated sufficient knowledge of the support people required.

Staff training records demonstrated staff members were offered training in a wide range of health and social care topics such as moving and handling, safeguarding, health and safety, food hygiene, Mental Capacity/Deprivation of Liberty Safeguards (DoLS), dementia, dignity and first aid. We saw that the training checklist indicated the majority of staff had completed most of the training to enable them to care for people effectively. Gaps were evident however in the training of some staff members in safeguarding, mental capacity, dementia and medication. When asked, we found that some staff member's knowledge regarding mental capacity was poor and staff administering medication did not demonstrate they had sufficient knowledge to do so. The training of staff members in these areas required improvement.

Nursing staff told us that they received updates in tissue care, catheter care and end of life care. When asked however, they said they did not receive any refresher training in relation to some of the physical health conditions we identified in people's care plans for example, stroke, heart failure and epilepsy. This meant there was a risk their knowledge could be out of date.

We saw evidence in staff files that staff received appropriate appraisal and supervision in their job role. Regular staff meetings also took place to inform staff of any changes in the home or updates in care for example infection control and end of life care. We spoke to two staff at the home about the support they received. They both said they felt supported in their job role. One staff member told us "You can talk to the manager about anything. They are the boss from heaven". Another said the staff were "Well looked after"; "Knew what you are doing" and that they had "Every faith" in the management.

We viewed the care plans of eight people who lived at the home with dementia type conditions and/or complex needs. The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Where people had dementia type conditions or short term memory loss, we saw some elements of good practice in the planning and delivery of care. For example, some care files contained detailed mental capacity assessments for specific decisions relating to their care for example where a deprivation of the person's liberty was to be undertaken. These assessments were comprehensive and gave clear information as to the reasons why a deprivation of liberty was required and evidenced best interest discussions.

Other care files lacked any adequate information about the person's capacity to make their own decisions and held little evidence of any best interest meetings or decisions about aspects of the person's care where consent was required. Where consent had been given, consent had been sought and obtained in the majority from the person's relatives. The Mental Capacity Acts 2005 states that relatives cannot be asked to signed consent forms when a person lacks capacity unless they have authority to do so under a Lasting Power of Attorney or a Court Appointed Deputy.

For example, one person's care file indicated that they had difficulty communicating but had some degree of understanding in relation to day to day decisions. The person's care plan stated their capacity as intermittent. There was no evidence of how the person's ability to communicate had been assessed and there was no evidence a mental capacity assessment had been undertaken to determine their capacity as intermittent. Records showed that discussions and decisions about the

Is the service effective?

person's care had been undertaken with the person's relatives and showed no evidence that the person had been encouraged or enabled to be involved in these decisions.

One person's care file had an advanced directive form in place in the event of a deterioration of their health which included a 'do not resuscitate' order (DNAR). Both documents stated that the person lacked capacity but there was no adequate mental capacity assessment in place or evidence that the person had been enabled to participate in these discussions. Records simply stated that discussions had been held with the person's family. Two people's end of life discussions been held with their family rather than the person themselves. There was no evidence that the person had been enabled to participate or that they lacked the capacity to do so as no capacity assessment had been undertaken.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We spoke to the deputy manager about why some of the care files we looked at contained good information about mental capacity and DoLS whilst others were poor. The deputy manager told us that they had recently introduced a new method of assessing a person's capacity to ensure this was done in accordance with the Mental Capacity Act 2005. They said they were still in the process of assessing people whose capacity was in question, using this method.

We spoke with five staff about their knowledge of mental capacity and deprivation of liberty safeguards and found it to be limited. One staff member clearly understood what it meant, whereas others understood what a lack of capacity meant but had little understanding of the Mental Capacity Act and DOLs legislation in practice. One staff member told us "I am not dealing with mental capacity. We have DOLs in place for people who don't have capacity now".

We found that the premises did not provide a dementia friendly environment and there was no evidence that the provider had considered how to support people with dementia conditions to remain as independent as possible. For example, through the use of contrasting colours in the home's decoration or other environmental cues which would help people's orientation for example pictures. Signage throughout the building was limited and the home was decorated throughout in magnolia, with bathrooms primarily white.

Where people had communication difficulties, a pictorial system was available within the home. A pictorial system is a set of pictures that are designed to convey a certain meaning or feeling for example, "I am hungry". They enable people with verbal communication difficulties to communicate their needs, wishes or feelings to staff. This demonstrated that staff at the home had considered other ways to enable people to convey their feelings or wishes in the delivery of care.

People told us the food at the home was good. Their comments included "You couldn't do better. Plenty of choice"; "Good choice of food" and "I'm very Happy with it". Relatives we spoke with told us that the home provided a "Good Sunday lunch when a family event occurs" and that they were "Happy" with the food.

On the day of our visit, the home held a barbecue lunch in the garden for people who lived at the home and their relatives. The expert by experience and specialist advisor tasted the barbecue food and observed the lunchtime period. Both said that the food was of good quality, of generous portion size and served pleasantly and promptly by staff.

We saw that the lunch menu was displayed on various notice boards throughout the home. We saw that the chef came round and spoke to each person individually about what the meal choices were and asked what they would prefer to eat for their meals that day. The home operated a five week rolling menu, the chef told us people who didn't like the menu could select an alternative off a set menu or ask for something different. We saw that the five week rolling menu was varied and offered a balanced diet.

People's nutritional needs were assessed and regularly reviewed. People's food preferences, special dietary requirements and cultural or religious needs were taken into account with people's individual needs clearly identified and known by catering staff. Dietary supplements were readily available for people at risk of malnutrition and drinks and snacks were provided regularly throughout the day. Staff assisted people who required support to eat in a sensitive and dignified manner, using encouragement and gentle prompting.

Requires improvement

Is the service effective?

Appropriate referrals to dietary services had been made for people who were at risk of malnutrition. Some people at the home had their nutritional needs met intravenously via either a peg tube or enteral feeding tube (parenteral nutrition) on dietary advice. Peg or enteral feeding tubes are sometimes used to ensure that people who are in poor physical health or who have difficulty swallowing food receive nutritionally complete meals through their stomach.

People's records showed that they had prompt access to medical and other support services in the event of ill-health or ongoing healthcare needs. This was confirmed by people who lived at the home and their relatives.

Good

Is the service caring?

Our findings

Everyone we spoke with spoke highly of staff at the home. One person told us "I was given a very clear personal choice about the care that I needed". Another told us the care was "Very good". One relative told us they were "Extremely satisfied with the care provided particularly as Mum has deteriorated". Another said "I am very satisfied with the care. I have a good knowledge of staff and feel that they know her very well".

Throughout the day, we saw staff supporting people at their own pace, talking to people with familiarity and tending to people's needs in a prompt, warm manner. From our observations it was obvious that people felt comfortable in the company of staff. Staff maintained people's dignity at all times and people looked well dressed and well cared for.

We saw that there were periods throughout that the day when staff took the time to sit with people and have a general chat. The mood was homely, relaxed and appropriate music played softly in the background at various points throughout the day. People and staff were seen to chat either in passing or in a direct face to face conversation about everyday things that most people would talk about when they knew people well. This promoted people's emotional well-being. From our observations it was clear that staff genuinely cared about the people they looked after.

We saw that care plans included a dependency assessment which contained information in relation to what people could do independently and what they needed help with in relation to their mobility and personal care. People were provided with mobility aids to enable them to be independently mobile and we saw that people who were mobile where able to move freely around the building.

Staff we spoke with understood how to promote people's independence and gave clear examples of how they treated people with dignity and respect in the delivery of personal care. One staff member told us "If they are able to do something, even if it takes a long time, we encourage them to do it".

A healthcare professional we spoke with, said staff were always welcoming when they visited the home and that it was "A nice nursing home to come into".

There was a service user guide in place for people who lived at the home to refer to. This gave people information about the home, the staff team and its facilities. It included a list of advocacy services for people who lived at the home could contact should they require any additional support. This showed that people had access to adequate information about the home and external support services.

We saw that staff at the home had recently completed and achieved re-accreditation in the Gold Standard Framework for end of life care and were awarded Beacon Status for good practice. There was evidence that person centred planning with regards to end of life care had taken place in people's files with people's preferences noted. The home's staff regularly received updates on end of life care and had appropriate medicines in place to alleviate people's pain and discomfort. We saw that people's relatives had sent in thank-you cards in respect of people's end of life care. One thank you card stated "Thank-you for all your wonderful care and attention".

Requires improvement

Is the service responsive?

Our findings

We found that in the majority staff were knowledgeable people's individual needs and the day to day care they required but that these were not well documented.

Each person's care file contained an assessment and care plan. The planning of care considered a range of people needs for example people's dexterity, mobility, eating and drinking, continence, personal care requirements, emotional health and skin care. We found however that some care files had lots of out of date or duplicated information that made it difficult to get a clear picture of people's most up to date needs and care. This placed people at risk of receiving inappropriate or unsafe care.

Some care files contained information about people's health related illnesses but others lacked information about what these conditions were and the care people required to manage any potential symptoms or physical decline. Some information in relation to physical health was also out of date. For example, one person's assessment indicated they had a number of physical health conditions that impacted on their day to day well-being. None of the health conditions however were explained or care planned and there was confusing information in the person's file about the medication they were to take in order to manage their symptoms.

One person was bed bound but there was no information relating to what had caused the person's decline. The person's care plan simply said they were bed bound for "safety reasons".

Some care plans were generic and not personalised to the individual. For example, sections of one person's care plan were a photocopy of another's with the person's name changed. The care plan did not identify the person's individual needs and offered general rather than specific advice about how to support them.

We saw that there was a 'This is Me' document in each file which captured the personal life history of each person. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia. People's care plans however lacked sufficient information about how the person's dementia or lack of capacity impacted on their day to day life at the home, the decisions they were able to make and the support they required.

Care plans and risk assessments were reviewed regularly but some reviews lacked any meaningful information and simply stated that the care plan remained "unchanged".

We saw that there was a range of activities on offer at the home. Activities such as movie matinee, games, bingo and outside entertainment were offered. On the day of visit, a poetry session took place in the communal lounge and a barbecue lunch was provided which some of the people who lived at the home participated in, with relatives or friends. Representatives from a local church also visited people at the home.

The majority of people and relatives we spoke with had no complaints or concerns about the care they received. Both people and relatives said if they had any concerns they would raise them with either staff or the manager of the home. A relative told us "I know the management well and if there's a problem, I go straight to matron".

The provider had a complaints policy in place and this was displayed on the resident's noticeboard. There had only been one recent complaint which had been dealt with by the provider.

Requires improvement

Is the service well-led?

Our findings

Most of the people who lived at the home and their relatives told us they knew the manager and said they were a visible presence within the home.

During our visit we found the culture of the home to be positive and inclusive. Staff were friendly, welcoming and hospitable to visitors. They were observed to have good relations with each other and were caring and warm in all their interactions with people at the home. We found that staff had a positive work ethic and were confident in the management of the home. This demonstrated good staff leadership. Improvements were required however in how the provider and manager monitored the quality and safety of the service.

We saw that the provider undertook a range of regular audits to monitor the quality and safety of the service provided at the home. This included an audit of care plans, health and safety, environmental audits, hand hygiene audits, equipment audits, accident and incident audits and medication audits. We saw where actions for improvement had been identified, these had been undertaken and the issues resolved. Some of the audits undertaken by the provider were however ineffective.

We found a number of inconsistences in people's care records about their needs and risks. Some people's care files contained duplicated or out of date information and some files were disorganised. This made care files difficult to read and understand. This meant that the provider's care plan audits failed to be effective in ensuring the information about people's needs was adequate, easy to understand and up to date.

Accidents and incident audits were too brief to enable the analysis of trends for example, location and time of accident/incidents, type of accident/incident and staff on duty.This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

Policies and procedures in some instances were out of date or not adhered to by staff and the management team. For example, the provider's medication policy clearly stated the procedure for staff to follow to ensure the safe administration of medication. From our observations and conversations with staff during our visit, it was clear staff were not adhering to this policy. By not doing so, they placed people at risk of harm.

We reviewed the provider's accident policy and saw that the policy stated that the provider's local registration authority must be notified in the event of serious accident or injury. The policy did not provide any details of who this regulatory authority was and made no specific reference to notifying the Care Quality Commission. This is a requirement of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We reviewed a sample of accident and incident records completed during April and May 2015 and found that three accidents were of a serious nature and had required a hospital visit. These incidents had not been appropriately reported to The Commission. This was a breach of Regulation 18 of the Care Quality Commission's Regulated Activities) Registration conditions. We have written to the provider regarding this.

The provider's policy on the recruitment of ex-offenders failed to specify how potential risks would be assessed and the provider had failed to spot that personal identity checks and evidence of the staff member's right to work in the UK were not being undertaken in accordance with the policy. This indicated there was no effective management system in place to check that the recruitment of staff was properly undertaken.

The provider's complaint policy failed to provide contact details for whom people should address their complaints to at the home and although contact details for the Local Authority were provided, they were out of date.

These examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to have effective systems and processes in place to assess and monitor the quality and safety of the service provided.

The manager sent out an annual questionnaire seeking feedback from people who lived at the home and their relatives about the quality of the service provided. The last questionnaire was sent out in January 2015. We reviewed the feedback results which had been analysed into the percentage of people who responded negatively or

Requires improvement

Is the service well-led?

positively to the questions asked. Some results were difficult to understand as the percentages recorded did not add up to 100% so it was unclear if some people declined to provide any feedback in those areas.

The results showed that the home had scored highly in a number of areas including the courtesy, attitude and approach of staff at the home; privacy and respect and staff assistance with personal care.

Weekly reports to the senior management team and staff meetings regularly took place where issues of concern, resident care and staffing issues were discussed and resolved.

At the end of visit, we discussed some of the areas for improvement identified during our inspection with the management team and the provider. We found the management team and provider open and receptive to our feedback. They took on board that some improvements were required and demonstrated a positive attitude to continuous improvement.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no suitable arrangements in place to ensure that the service obtained the consent of, and acted in accordance with the consent of people who lived at the home. Regulation 11(1),(2),(3) and (4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The assessment and care planning of people's individual needs and risks did not ensure that safe and appropriate care was provided as people's needs and risks had not been fully identified or mitigated against in the delivery of care. Regulation 12(1),(2)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users as the management and administration of medicines to people who lived at the home was unsafe. Regulation 12(1),(2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor their service against Health and Social Care Act Regulations or to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service. Regulation 17(1),(2)(b).
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to notify the Commission of injuries to service users which required treatment by a healthcare professional. Regulation 18(2) (b)(ii) of the Care Quality Commission (Registration) Regulations 2009.