The Beeches Residential Care Home Ltd

The Beeches

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 and 8 March 2018. At the previous inspection in September 2016, the service was rated 'Good.' At this inspection we found the provider was in breach of the regulations. The overall rating for this service is 'Requires Improvement.'

The Beeches is a residential care home that provides a service to older people and people living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Beeches is registered to provide a service for up to 40 people. On the days of our inspection there were 31 people living in the home.

The home had a registered manager who was present on the days of 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.

At our previous inspection we found that the management of medicines needed to be improved. At this inspection we found that the provider had not taken sufficient action to make improvements. The storage of medicines in the fridge was not monitored. The medication electronic tablet did not provide staff with information about how certain medicines needed to be administered safely.

We found where people had sustained a fall their risk assessment and care plan had not been reviewed in a timely manner to avoid a reoccurrence.

Hygiene standards within the home placed people at risk of cross infection. The environment was unsuitable for people living with dementia and this could add to their confusion.

The provider's governance was ineffective in identifying the shortfalls we found. The registered manager did not undertake regular training to ensure they had the skills promote good practices.

Staff's lack of understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards placed people at risk of their human rights being compromised. People's right to privacy and dignity was not always respected by staff. However, people confirmed staff were kind and friendly. People's involvement in their care planning ensured they received a service the way they liked.

People were cared for by staff who had received training and were supported in their role by the management team. People had access to a choice of meals and drinks and were supported by staff to eat

and drink sufficient amounts. People were assisted to obtain the necessary healthcare services needed to promote their physical and mental health. People were provided with the necessary aids and adaptation to promote their independence safely.

The involvement of other professionals in people's care assessment helped in ensuring their care and support needs were met. People could be confident their concerns would be listened to and acted on.

People told us they felt safe living in the home and staff were aware of their responsibility of safeguarding them from the risk of potential abuse. People were cared for by sufficient numbers of staff who had been recruited safely.

People were supported to maintain links with their local community. Staff were involved in meetings and they felt listened to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were required to ensure the safe management of medicines. Hygiene standards within the home placed people at the risk of cross infection. The assessed risks to people were not managed promptly to reduce the risk of further accidents. People were supported by sufficient numbers of staff who had been recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staffs' lack of understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards placed people at risk of their human rights being compromised.

The environment was unsuitable for people living with dementia and could add to their confusion. People had access to aids and adaptations to promote their independence safely.

People were cared for by staff who had received training and were supported in their role by the management team. People had access to a choice of meals and were supported by staff to eat and drink sufficient amounts. People were assisted to obtain the necessary health care support and treatment when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy and dignity was not always respected. However, people confirmed staff were kind and friendly. People's involvement in their care planning helped in ensuring they received a service the way they liked.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Systems were not in place to promote equality, diversity and

human rights. People's involvement in their assessment of their care which included other healthcare professionals assisted in identifying their physical and mental health needs. People were supported to pursue their social interests. People felt confident to share their concerns with the provider and these were listened to and acted on.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

The provider's governance was ineffective in identifying the shortfalls we found. The registered manager did not undertake routine training to ensure they had the skills to provide a safe, effective service or to identify when practices needed be improved. Meetings were carried out with people who lived in the home and they were supported to maintain links with other professionals and the public.

The Beeches

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 6 and 8 March 2018, and was unannounced. The inspection team comprised of two inspectors.

As part of our inspection we spoke with the local authority about information they held about the home. The local authority informed us that the provider was under a Large Scale Enquiry [LSE]. This was mainly due to concerns about insufficient staffing levels, poor hygiene standards and record keeping. Due to these concerns the local authority had taken action to suspend admissions to the home until improvements were made. Prior to our inspection visit the local authority confirmed the provider had taken some action to improve the quality of service provided to people. Hence, the admission suspension had been lifted.

We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home .

We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

At this inspection we spoke with five people who used the service, five relatives, four care staff members and a staff member who supported people to pursue their social interests. We also spoke with a domestic staff member, a healthcare professional, the registered manager and the provider. We looked at eight care records, medicines systems and records relating to quality audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection we found that the provider had not taken sufficient action and further improvements were required. This key question was rated 'Requires Improvement.'

At our previous inspection we found that medicines were not managed safely. At this inspection the provider told us they had recently introduced an electronic medicine system. However, we found that the registered manager was not entirely sure how to operate this system and had to ask a staff member to demonstrate this to us. The registered manager informed us they had found discrepancies with the system. For example, medicines in stock did not tally with the data held on the electronic tablet and during our checks we also identified this. This meant the provider was unable to maintain an accurate record of prescribed medicines in their custody. We found some medicines needed to be administered in a specific way. For example, one medicine should not be given with grapefruit juice. However, this information was not on the electronic tablet and the registered manager acknowledged this. The absence of this information could place people at risk of not receiving their medicines as specified by the pharmaceutical manufacturers. We observed that some medicines needed to be stored in a fridge. However, the fridge temperature had not been checked since January 2018, to ensure medicines were stored at the appropriate temperature range as identified on the medicine package. This meant the provider was unable to demonstrate that these medicines were safe for use.

The registered manager said that all staff who supported people to take their medicines had received training and the staff we spoke with confirmed this. Staff also confirmed that competency assessments were carried out to ensure their practices were safe and we saw evidence of these assessments. However, we found that medicine practices needed to be improved.

People were not protected from the risk of cross infection. Prior to our inspection visit the local authority had shared concerns about hygiene standards within the home. At our inspection we observed toilets were unclean with faeces present around the bowl. The registered manager said this was due to the cleaning staff not commencing work until 10am. In one room we saw a used continence pad on the furniture. The registered manager informed us this was an isolated incident. The registered manager acknowledged that during the period when cleaning staff were not on duty, it was the responsibility of the care staff to maintain hygiene standards. However, it was evident this had not been done. We found that certain areas within the home had an unpleasant odour. However, the registered manager had not recognised this. We asked the provider if they had experienced any recent infectious outbreaks. They confirmed there had been an outbreak of norovirus in January 2018, which affected both people who lived at the home and staff. Norovirus is contagious and good hygiene standards are important to reduce the spread. A staff member said, "I would live here but the hygiene standards would put me off." The local authority had shared concerns about stains on mattresses. The provider said all mattresses had been replaced and we observed that mattress were clean.

We looked at how the provider managed risk. We found two cases where people had sustained a fall, their

care plan and risk assessment had not been reviewed to reduce the risk of a recurrence. For example, one person had sustained a fall four days prior to our inspection visit and the emergency service had been called out. However, this person's risk assessment had not been reviewed. The registered manager informed us that risk assessments were reviewed on a monthly basis. However, they did not recognise the need to review the assessment after an incident to ensure the person's immediate safety. One person told us they had recently moved into the home, they told us they had sustained a fall. We observed there was a risk assessment in place for this person. However, it did not provide staff with information about how to reduce the risk of further falls. We shared this information with registered manager who confirmed they had not fully completed this risk assessment. This meant the person remained at further risk of falls. The registered manager confirmed these people had not sustained any further accidents. They informed us that if a person sustained two falls they would be referred to a physiotherapist. This was to assess whether the person required any aids or adaptations to assist with their mobility.

We spoke with a healthcare professional who raised concerns about staff's lack of understanding about skin care. They said staff were seen with long manicured nails and wearing jewellery and we also observed this. They said this could cause skin damage whilst staff assisted people with their mobility. They continued to say, "People have scratches and skin tears." We shared this information with the provider who said they had addressed this with the staff team. However, it was evident staff had not taken this on board or were unaware of the impact this could have on people.

We looked at how the provider managed accidents. The registered manager informed us that all accidents were recorded and we saw evidence of this. The registered manager was able to tell us what action they had taken to reduce the risk of further accidents. For example, where a person had sustained a fall, a sensor mat had been placed in their bedroom that alerted staff when they required support with their mobility. However, the registered manager did not have a clear system in place to monitor the number of accidents a person had sustained in any given time or to identify trends. This meant trends may not be recognised or control measures put in place in a timely manner to reduce the risk of this happening again.

Discussions with the registered manager identified they were aware of when to share information about abuse with the local authority for an investigation to be carried out. The registered manager said all safeguarding referrals were recorded and we saw evidence of this. However, the registered manager did not have a system in place to identify the nature of abuse and action taken to safeguard the individual from the risk of further harm.

People told us they felt safe living at the home. One person said, "I feel safe because there is always someone around." We spoke with a visitor who told us their relative had lived in the home for a year. They said, "I haven't had any concerns since [Person] has been here and I feel they are safe." Discussions with staff confirmed their awareness of different types of abuse and how to recognise these. Staff told us if they had any suspicion of abuse they would share this information with the registered manager. Staff were also aware of other agencies they could share their concerns with to safeguard people from the risk of further harm. All the staff we spoke with confirmed they had not witnessed any poor care practices or abuse at the home.

People told us there were sufficient staffing levels to meet their needs. For example, one person who lived at the home said, "When I buzz [activate the nurse call alarm] I don't have to wait long." A relative told us, "There always seems to be enough staff on duty." We observed that staff were nearby to assist people when needed. The registered manager confirmed they did not have any staff vacancies and was confident there were sufficient staff available to assist people. However, the registered manager was unable to tell us how staffing levels were determined. They told us the provider was responsible for deciding how many staff were

allocated per shift.

The provider told us about a dependency tool they used to find out how many staff were required to ensure people's needs were met. The provider said they had identified that most accidents had occurred during the afternoon. Hence, an extra staff member had been allocated to work during the afternoon to provide additional support and the staff we spoke with confirmed this.

People were cared for by staff who had been recruited safely. All the staff we spoke with confirmed that before they started to work at the home a Disclosure Barring Service [DBS] check was carried out. The DBS helps the provider to make safe recruitment decisions. We spoke with a staff member who had recently been recruited. They said, "I applied for the job, had an interview and DBS check. I had to wait for the all clear before I started." Staff also confirmed references were requested. These safety checks ensured the suitability of staff to work at the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection the provider was rated 'Good' in this key question. At this inspection we found that standards had not been maintained and this key question was rated 'Requires Improvement.'

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We asked the registered manager about any best interests' decisions they had in place. They told us about a person whose medicines were administered covertly. This is where medicines are hidden in food. The care plan showed the person's medicines were hidden in yoghurt. The registered manager said this had been agreed by the person's GP. However, a document shared with us did not identify the name of the GP who agreed this or any involvement of other healthcare professionals and we found the document had not been dated. The registered manager said the use of covert medicines was included in the person's Deprivation of Liberty Safeguards [DoLS] form. However, a copy of the DoLS was not made available to us. This demonstrated that appropriate procedures had not been followed to ensure this decision was in the person's best interest.

We found that some staff lacked understanding of the principles of MCA. However, the provider informed us that staff had received MCA training. Further discussions with the provider confirmed there were no systems in place to find out if staff had a clear understanding of MCA or whether the principles were put into practice. This placed people at risk of their human rights not being respected. However, the people we spoke with confirmed staff always asked for their consent before they assisted them.

The registered manager told us that a number of people who lived at the home lacked capacity to make a decision and had a lasting power of attorney in place. This meant the individual who had power of attorney had a legal right to make decision on behalf of the person. However, the registered manager did not have evidence of all the relatives who said they had this legal right. This meant some relatives may not have the legal right to make decisions on the person's behalf. The registered manager assured us they would take action to obtain the necessary evidence.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager informed us there were nine authorised DoLS in place due to the individual's lack of capacity to make a decision. The registered manager also confirmed they had submitted a further 16 DoLS applications to deprive people of their liberty. We asked the registered manager what systems they had in place to review DoLS to ensure they were still necessary and to alert them when they were near to expire.

They confirmed there were no systems in place to review or monitor DoLS. This meant people were at risk of having their liberty unnecessarily deprived. We found that some staff lacked understanding of DoLS. One staff member demonstrated a good understanding of DoLS but was not entirely sure who had one in place. This lack of knowledge placed people at risk of being unlawfully deprived of their liberty.

We saw that best interest discussions had taken place for people who had Do Not Attempt Cardiopulmonary Resuscitation orders in place. This meant if a person stopped breathing attempts would not be made to resuscitate them. This was in the case for people who had been assessed as lacking capacity to make certain decisions. We saw evidence of family involvement in these discussions as well as input from other professionals.

We looked at what aids and adaptations were in place to support people's independence and to ensure their safety. Prior to our inspection visit we had received concerns about hoists not being available to assist people with their mobility. At this inspection the provider told us they had recently purchased two hoists and staff confirmed this. Staff told us they had received training about how to use the hoist. We observed that raised toilet seats were in place to help people use the toilet independently. The registered manager said where necessary some people had been assessed for walking aids and people confirmed this and we saw these in use. Some bedrooms had been fitted with a sensor mat. This alerted staff when the individual required support with their mobility. Where people had a history of falling out of bed, a 'crash' mattress had been introduced. This reduced the risk of injury if the person fell out of bed.

The registered manager confirmed the undertaking of assessments to identify people's physical and mental health needs and we saw evidence of these assessments. However, there were no systems in place to promote equality and diversity and to avoid discrimination. However, both people and staff confirmed they had never been discriminated against. We spoke with the provider about technology in place to support people. They informed us of sensor mats in bedrooms that alerted staff when the person required support to move safely. They confirmed that no other technology was in use.

We looked at how the provider supported new staff in their role. All the staff we spoke with confirmed they were provided with an induction when they started to work at the home. Induction is a process of supporting new staff within their role. One staff member said, "During my induction I shadowed an experienced staff member until I felt confident to work alone." They said during their induction they had the opportunity to learn and understand people's care and support needs.

People were cared for by staff who were supported in their role. Staff confirmed they had access to one to one [supervision] sessions. One staff member said they found these sessions beneficial to express any concerns they may have. Another staff member told us, "Supervision gives me a confidence boost that I am doing my job properly."

The registered manager informed us that staff had access to regular training. The registered manager said they observed staff to ensure skills learned were put into practice. However, further discussions with the registered manager identified they had not kept abreast of training to ensure their skills were up to date. This meant they may not recognise when care practices were not suitable or safe. Although the staff we spoke with confirmed they had received training we found this had not been effective to support them to carry out their role. For example, medicines management needed to be improved. Staff had a lack of understanding of MCA, DoLS and the importance of preserving people's right to privacy and dignity.

People were complimentary about the choice and quality of meals provided. We saw that meals were well presented and people were given a choice. People told us they had a choice of meals and could have a

drink at any time. Relatives told us that the meals were good and people were supported to eat and drink adequate amounts. They told us and we observed that drinks and snacks were always available. We heard a person ask for a cup of coffee and this was provided to them straight away. We observed during mealtimes staff were available to provide support where needed. We saw a staff member assist a person with their meal in a kind and gentle manner whilst they encouraged them to eat.

Where staff had concerns about the amount a person ate or drank, a chart was put in place to monitor their diet. For example, one person told us about problems they had with swallowing certain foods, staff had acknowledged this and implemented a chart to monitor how much they ate and drank. Discussions with staff and the care records we looked at confirmed the person had been referred to a speech and language therapist for an assessment of their swallowing reflex.

We saw that people who required a special diet had received an assessment from a specialist and staff were following the advice given in relation to the texture of food to be given to the individual to reduce the risk of choking.

People were supported by staff to access relevant healthcare professionals when needed. For example, discussions with the registered manager confirmed people had access to a physiotherapist who provided people and staff with advice and support about how to mobilise safely. A relative informed us that their relative had pressure sores in the past and they had access to a district nurse who assisted with their treatment. One care record showed a person had lost weight and staff had shared their concerns with the GP who had prescribed supplements to increase the person's calorie intake. One person told us about the problems they had experienced with their swallowing and said they had seen a speech and language therapist who had diagnosed the problem. They continued to say, "I am pleased that I was able to keep my own GP." The registered manager informed us that some people had access to a community psychiatric nurse to support them with their mental health needs and the records we looked at evidenced their involvement. This showed that people were supported to maintain their physical and mental health.

Requires Improvement

Is the service caring?

Our findings

At our last inspection the provider was rated 'Good' in this key question. At this inspection we found that standards had not been maintained and this key question was rated 'Requires Improvement.'

People's right to privacy and dignity was not always maintained. For example, we observed that a toilet located on the ground floor did not have a privacy lock on the door. Later that day we observed a person using this toilet and the door had been left open. We heard the person ask for help, two care staff and a domestic staff walked passed. Staff failed to acknowledge this person's dignity had been compromised. We shared this information with the provider who took immediate action to have a lock fitted to the door. We observed another person required support with their continence needs. However, staff did not support this person in a timely manner to preserve their dignity. Whilst talking to another person in their bedroom. We found that not all staff knocked on the person's door before they entered. This compromised the person's privacy. We shared this information with the provider who assured us this would be addressed with staff. However, discussions with staff confirmed they were aware of the importance of preserving people's privacy and dignity. For example, one staff member said, "I also ensure the door is closed when I help people with their personal care." Another staff member said, "Sometimes people don't dress appropriately and I encourage them to change their clothes to help maintain their dignity."

People could not be assured that information about them was treated confidentially. We observed that confidential care records were not securely maintained and could be accessed by anyone entering the home. For example, we were able to freely access confidential records without the support from staff. We shared our concerns with the provider who assured us they would take action to address this.

People were cared for by staff who were kind. One person described the staff as, "Really kind and nice." Their relative said, "The staff are excellent, nothing is too much trouble for them." Another relative told us, "The staff are nice and always make us feel welcome." They continued to say, "I hear staff chat to people nicely and have a sing song with them. I have never seen anyone in distress." We spoke with a visitor who told us their relative was always well presented. They said staff supported their relative to attend the hairdresser on a weekly basis. A staff member said, "If I needed care I would be happy to live here and I have recommended the home." We observed one person appeared unwell and we immediately shared our concerns with staff. Staff were very kind and reassuring to the person.

People's involvement in planning their care ensured they received a service that met their needs. For example, one person told us about their involvement in planning their care. We found the information they shared with us was identified in their care plan. One person told us they had been involved in developing their relative's care plan and they were happy with the care provided to them. One care record stated, '[Person] takes pride in their appearance and likes to dress smartly.' We observed this person was dressed smartly as identified in their care record.

People were able to maintain contact with people important to them. People confirmed they were able to have visitors at any time. We spoke with a visitor who confirmed they were able to visit their relative at any

time. They continued to say, "The staff are like my extended family."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection the provider was rated 'Good' in this key question. At this inspection we found that standards had not been maintained and this key question was rated 'Requires Improvement.'

People were involved in planning their care and where appropriate their relatives were also involved to ensure staff were made aware of their specific needs. One person said, "Me and my relative were involved in my assessment." They told us they were happy with the service provided to them. The registered manager confirmed that an assessment was carried out before people moved into the home and the care records we looked at evidenced this. Where necessary other professionals were involved in the assessment such as a community psychiatric nurse and a social worker. This assessment identified the individual's care and support needs and whether equipment was required to promote their independence and safety. We saw that care plans provided relevant information about people's care and support needs. However, these plans did not include information about protected characteristics under the Equality Act. However, the people we spoke with and staff confirmed they were treated fairly and never felt discriminated against. On the second day of our inspection visit, the provider said care plans would be reviewed to include equality, diversity and human rights. This would ensure that regardless to people's disability, ethnicity, religion, sexuality and other protected characteristics they would be treated fairly.

The provider offered a service to people living with dementia. However, we found the environment was unsuitable for people living with this health condition. We observed that furnishings, curtains and flooring were patterned. The provider said "But the home is homely." Dementia can impact on a person's vision and patterned furnishings and flooring can appear distorted and add to the person's confusion and the registered manager acknowledged this. We saw that a photograph of the person was attached to their bedroom door. This assisted them in finding their bedroom. Discussions with visitors confirmed they had been encouraged to personalise their relative's bedroom, so it felt more homely and resembled their previous home. One relative said, "We've kept [Person's] bedroom like it was at home."

We heard a staff member ask people how they wanted to spend the day. For example, one person expressed they were feeling tired and wanted to go to bed for a while. We saw the person was assisted to their bedroom. People were supported by staff to access their local community. One person told us, "I can go down to Stoke and have my lunch if I like." Another person told us they had recently moved into the home and had not been out since due to the cold weather. However, they told us about indoor social activities that entailed a musical band and chair exercises. A different person said, "There seems to be a lot going on. I used to be in another place where there was nothing going on and my family said that's not good for you, so they brought me here."

The provider had appointed a staff member to support people to pursue their social interests. This staff member told us people were supported to access activities in the community. One person said, "They take us out now and again. They took us out to see the monkeys. That was good. It was a different experience." The staff member told us about arrangements for the forthcoming Easter activities. People were encouraged to make buntings to decorate the home. They told us about the link they had with a local

nursery, the children and their families had been invited to join in the Easter celebrations. The staff member said they had introduced an activity plan. However, they found this was not effective because people did not always want to engage in planned activities. Hence, people were asked daily what they would like to do. For example, the staff member told us about a person who had capacity to say what they wanted to do. They would ask at times to go out and they would be supported to pursue activities within their local community. The staff member informed us, "I sit with people and their family and ask what kind of things they enjoyed doing." The activities provided were geared around people's interests.

People told us about a hairdresser located in the home. The staff member responsible for supporting people to pursue their chosen activity said, "One person enjoys going to the barber shop." They said, "I know we've got our own hairdresser but I think it's nice for them to still be able to go to the barber."

We asked the registered manager what was specific about the service and stimulation they offered to people living with dementia. They said they used google to obtain ideas about suitable activities and this was confirmed by a staff member who had been appointed to assist people to pursue social activities. They said this entailed pet therapy, music and reminiscence. One person told us about their involvement in musical events within the home which they enjoyed. On the second day of our visit we observed people engaging in various activities. Smiles and laughter evidenced their enjoyment.

People could be assured their complaints would be listened to and acted on. People and their relatives told us they felt comfortable to raise any concerns they may have and they were confident their complaint would be dealt with appropriately. A relative said, "I would talk to the owner. They're very lovely. Concerns are dealt with. I've got no doubt about that." Another relative said the registered manager was always around and they believed their concerns would be sorted out quickly. The registered manager said they had not received any complaints since the last inspection visit. However, they said complaints would be recorded to show what action had been taken to resolve them.

At the time of our inspection visit the provider confirmed that no one was receiving end of life care. However, if and when people required end of life care, the relevant healthcare professionals would be involved to ensure they received a comfortable and pain free end of life.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the provider was rated 'Good' in this key question. At this inspection we found that standards had not been maintained and this key question was rated 'Requires Improvement.'

We found that the provider' governance was ineffective to promote quality. For example, systems in place were not robust to promote hygiene standards in all parts of the home and this placed people at risk of cross infection. Where people had sustained accidents protocols were not in place to ensure the prompt review of their risk assessment and care plan to reduce the risk of a reoccurrence. We found that although systems were in place to monitor the management of medicines, this had not identified that temperature monitoring of the fridge where medicines were stored had not been completed since January 2018. We found that the registered manager lacked understanding of the new electronic medication system which did not identify how specific medicines should be administered. There were no systems in place to ensure staff had a clear understanding about the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This placed people at risk of their human rights being compromised. There were no systems in place to ensure staff were aware of the need to preserve people's right to privacy and dignity. We observed that three staff members had failed to recognise that a person's dignity and privacy had been compromised. We also identified that confidential records relating to people who lived at the home were not securely stored and could be easily accessed by anyone entering the home. There were no monitoring systems in place to ensure the environment was suitable for people living with dementia to reduce their confusion. The provider's governance did not include the monitoring of equality and diversity to ensure people were not discriminated against. However, we did not find any evidence that people or staff members had been discriminated against.

We asked the registered manager what training they had received within the last 12 months to ensure they kept up to date with good practices. They confirmed they had received training about how to use the new electronic medication system. They said they had not received any other training within the last four years. This meant the registered manager could not demonstrate they had the skills to provide a safe and effective service. The governance was ineffective in monitoring the registered manager's training and development. Discussions with the provider and the registered manager confirmed they had not read the new 'key lines of enquiry.' This is a guide we use when inspecting care services. This meant the registered manager and the provider were unaware of the standard of care they were required to reach and maintain to ensure the service provided to people was safe and effective.

We found that the culture of the home needed to be improved to ensure people received safe care. For example, the registered provider informed us they had addressed the issue of staff wearing jewellery and the length of their finger nails. This placed people at risk of skin damage whilst they were assisted with their care. However, staff had not adhered to this and this raised concerns about staff attitudes.

This is a breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager what systems were place to enable people to have a say in the running of the home. We were informed that meetings were carried out with people and their relatives and we saw records were maintained of discussions held in these meetings. A relative said an invitation to meetings was often displayed on the notice board. Discussions were held about social activities and changes to the menus. The provider had not explored any other avenues to promote people's involvement in running the home. For example, people did not have a say who worked with them because they were not involved in staff interviews.

The registered manager said meetings were carried out with staff and the staff we spoke with confirmed this. A staff member said, "During these meetings we have a voice and we are listened to." They continued to say, "We asked for sheets to record people's daily activities and this was introduced." They said during a meeting it was discussed and agreed to divide the home into two units and this had helped to provide more consistent care. They continued to say, "The provider introduced headsets for staff. This enabled them to be aware of the whereabouts of staff and to communicate with them more privately."

People and staff were complimentary about the registered manager and provider, a staff member said, "The management support is fantastic, they actually show an interest in the staff."

The registered manager informed us that they maintained links with other professionals and the public. We observed on the days of the inspection other healthcare professionals were involved in people's care. Children from the local nursery came to visit and we observed that people enjoyed their company.

Further discussions with the registered manager confirmed their awareness of when to notify us of incidents that had occurred in the home which they are required to do by law. For example, a death of a person and any events that may compromise the service provided to people.

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 17 HSCA RA Regulations 2014 Good governance The provider's governance was ineffective to monitor and maintain hygiene standards to reduce the risk of cross infection. Systems were not in place to ensure the prompt review of people's risk assessment after an incident to avoid a reoccurrence. The governance did not review or monitor staff's understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards to ensure people's human rights were upheld. The governance did not review practices to ensure people's right to privacy and dignity was respected. The governance did not review or monitor the registered manager's training or development to ensure they had the skills to provide a safe and effective service.