Four Seasons Beechcare Limited

Beechcare Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Beechcare Nursing Home provides accommodation for up to 40 people who needed nursing and personal care. All communal areas and bedrooms are on the ground floor. There is a garden to the rear and sides of the building. At the time of our visit, there were 40 people who lived in the home, although two people were in hospital when we visited. People had a variety of complex needs including physical health needs, mobility difficulties and a few people had early on set dementia.

There was a registered manager at the home. 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.

The home decoration looked tired in areas but there was an ongoing plan of works at the home. The home cleaning schedules showed the home was cleaned thoroughly. However we did see that infection control measures had been compromised in some parts of the home. Where we noticed any odour new flooring was already on order. We have made a recommendation about this.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. This included nursing and care staff who were not hurried or rushed and when people requested care or support, this was delivered quickly. However there had been isolated days when the home has not been fully covered. The provider operated safe recruitment procedures. We have made a recommendation about this.

The provider had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. People gave us positive feedback about the home. People felt safe and well supported.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's individual risks and were able to tell us about the arrangements in place to
manage these safely.

Medicines were ordered, stored and administered safely. Clear and accurate medicines records were maintained.
Staff knew each person well and had a good knowledge of the needs of people who lived at the home. Training records showed that staff had completed training in a range of areas that reflected their job role. Staff told us that they had received supervision and appraisals were on-going.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found the home to be meeting the requirements of Deprivation of Liberty Safeguards.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. People had choices of food at each meal time. People were offered more food if they wanted it and people that did not want to eat what had been cooked were offered alternatives. People with specialist diets had been catered for. The chef had a good understanding of how to make sure even puréed and soft diet could look appetising.

People and/or their family were involved in their care planning, and staff supported people with health care appointments and visits from health care professionals. Care plans were amended immediately to show any changes, and care plans were routinely reviewed every month to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice; however trips in to the community were currently limited.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager and deputy manager were very approachable and understanding.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken.

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.

There were insufficient monitoring of infection control that could lead to peoples safety being compromised

Staff were knowledgeable in recognising signs of potential abuse. Risks to people's wellbeing were understood and addressed in their care plans, or with representatives, where appropriate.

There were effective recruitment procedures and practices in place and being followed.

Medicines were safely stored and administered to people.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs, and these were updated through attendance at training courses. Staff received supervision from their manager to ensure they had the support to meet people's needs.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food that met their individual needs.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and or their families were included in making decisions about their care. The staff in the service were knowledgeable about the support people required and how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The home had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There was a robust staffing structure in the home. Both management and staff understood their roles and responsibilities.

There were effective systems in place to monitor and improve the quality of the service provided.

Beechcare Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 4 April 2016 and was unannounced. The inspection was carried out by three inspectors including a bank inspector and one expert by experience. An expert by experience is a person who has personal experience of in this case using or caring for someone whose uses this type of older person nursing care service.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

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We spoke with 10 people, six relatives, ten staff including the registered manager, deputy manager who was a qualified nurse and clinical lead, a senior manager visiting the home, a nurse, care staff, activity coordinator, and the chef and his assistant. We also spoke with one visiting GP.

We spoke with people and we observed people's care and support in communal areas throughout our visit to help us understand the experiences people had. We looked at the provider's records. These included six people's records, which included care plans, health care notes, nursing interventions, risk assessments and daily records. We looked at five staff files, a sample of audits, feedback surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside spaces available to people.

At our last inspection on 11 November 2014 we found the provider was meeting the essential standards

which had been a follow up inspection regarding previous non-compliance.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. One person said "I do feel safe, both physically and mentally. They've got my records here" others told us "Its ok, I feel safe" and "There was a time when I didn't feel safe at all, but I do now. The change of management has been good".

The home did not have an infection control lead/champion which is good practice for this type of service. We could not see that this had been audited and staff were not sure who to report any issues to. We did see that infection control was occasionally discussed during the daily staff meeting. Staff we spoke with had received infection control training unless they were very new to the home. Infection control around the building was seen to be compromised. The bedrooms had en-suite shower room with toilet. We saw that some toilet seats were worn and could not be cleaned satisfactorily, however the same day all such toilet seats were replaced. On top of some of the open toilet seats, we saw washing up bowls which were used to hold the water for assisting people with a wash. As these are placed on the person's bed table when in use, we checked how these are cleaned. We were told by care staff that these were just wiped over, no chemicals were used to make sure they were clean and infection free before or after use. A work surface in the dining area was also seen to be missing its side strips and there was some damage at one end making it difficult to clean effectively. The communal areas of the home looked clean and tidy. Most areas of the home were free from odours. However, there were several rooms where stale urine could be detected. The rooms had been cleaned and the house keeper confirmed that the carpets have been cleaned but the smell was detectable. They said that new carpets had been ordered for those rooms, which the registered manager confirmed.

We recommend that infection control good practice is followed and an in depth audit is undertaken to identify areas of risk regarding infection control.
The provider had taken reasonable steps to protect people from abuse.

There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues. Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, and knew what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. Staff told us they were confident that registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of the local authority safeguarding team and CQC. Staff had access to their up to date safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. This showed that the registered manager had systems and processes in place that ensured the protection of people from abuse.

People were protected from avoidable harm. Staff had a good understanding of people's individual care

and nursing needs. Records provided staff with detailed information about people's care and support needs. Through talking with staff, we found they knew people well, and told us about the people they cared for. The nursing staff told us about people needing there specific care, such as wound dressings and care staff describe the care and support they provided to meet peoples individual needs. As well as having a good understanding of people's needs, staff had identified risks relating to people's care needs. People were supported in accordance with their risk management plans. Staff demonstrated that they knew the support needs of the people at the home, and we observed support being delivered as planned.

Each person's care plan contained individual risk assessments in which risks to their safety were identified such as falls, mobility, diet, bed rails and skin integrity. Guidance about any action staff needed to take to make sure people were protected from harm was included in the risk assessments. This enabled staff to understand what was needed to help people to remain safe. People who were able confirmed that the risk assessments had been discussed with them, one person told us staff remind me to use my frame so I don't fall.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one person who had had a number of falls. There was a clear plan in place which staff were aware of and used. Where people's needs changed, staff had updated risk assessments and changed how they supported people to make sure they were protected from harm. For example, where people were identified as at risk of developing pressure ulcers, specialist equipment such as pressure relieving mattress had been obtained.

Nurses and care staff maintained an up to date record of each person's health needs and referrals. This meant any changes in health and care needs could be recognised and addressed. Records of each referral to health professionals were maintained, and used to build up a pattern which allowed for earlier intervention by staff. For example, staff sought advice from SALT (Speak and Language Therapy) team about a person who was find it difficult to swallow and often coughed when eating. We spoke with two members of staff who told us that people with swallowing difficulties are seen by SALT and that they are often put on special diets such as a soft diet or puréed meals. Staff checked peoples care plans regularly, to ensure that the support provided to a person follows their care plan. The staff members were able to describe the needs of people at the home in detail, and we found evidence in the people's support plans to confirm this. This meant that people at the home could be confident of receiving care and support from staff who knew their needs.

The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. For example, during the day there were always two nurses plus care staff and other auxiliary staff such a chef and kitchen assistance. The rotas showed there were sufficient staff on shift if they were all on duty. We observed that there were sufficient staff on duty to meet people's needs when we visited. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their bank staff team to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster is based on the needs of people, staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly. We saw the tool they used for this and we saw the rota cross reference with these staff hours. However, there had been staffing issues the previous weekend, when they were unable to find care staff to work at short notice when others had gone off sick. People told us that they had had to wait for assistance, with one saying "You have to wait such a long time. Night is not too bad. It took me an hour to get my breakfast." Another said "I go to the loo at 4.05 pm, if later staff are doing tea and before they are dealing with other people and I need help to get off the loo." The registered manager explained the situation at the

weekend and said this was not normal, they had exhausted all avenues to find cover. They said they were now looking at how the bank staff can be increased still further.
We recommend that the registered manager explores other ways that the rota can be covered when they are not able to replace staff with the own bank staff.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken to ensure all staff including nurses was undertaken. Enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Nurses were checked against NMC (Nursing and Midwifery Council) registration to ensure they had the required nursing qualification and were able to practice. This being repeated yearly following employment to demonstrate they checked the nurses registration remained current and up to date. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

People were protected from the risks associated with the management of medicines. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed registered nurses administering people's medicines during the home's lunchtime medicine round. The registered nurse checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely. The registered nurse discreetly observed people taking their medicines to ensure that they had in fact taken them before the MAR chart was signed.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. Fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was kept locked away in both the medicine trolley and the cupboard in the medicine room. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered nurses conducted a very regular audit of the medicine used. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

The home had a grab bag in the entrance of the home. This records the assistance that people would need to be evacuated form the property. The bag also included the names of all the people living in the home. Personal Emergency Evacuation Plan (PEEP) was put in place during our visit. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment had been reviewed. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place and those present, people and staff were recorded as attending the drills. Staff had completed fire training, and there were several staff that had trained as a fire warden. A fire warden would take charge of the evacuation if the home did have a fire.

The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff knew how to deal with all foreseeable emergencies.

The design of the home enhanced the levels of care that staff provided because it was purpose built. Corridors were spacious good when a person needed equipment to mobilise. The lighting was good which can be crucial for helping a person with sight difficulties or dementia to make sense of their environment. Some of the areas are the home and the en-suit faculties had décor that looked both dated and tired. The registered manager said that funding had been agreed and parts of the home were due redecoration soon.

Good

Is the service effective?

Our findings

People also told us that the staff are very attentive. One person said, "Yes, I just ring the bell if I need anything and wait for someone to come, how long I wait depends on what is going on, I know the staff come as soon as they can". Another said "I can't fault any of the organisation, staff are nice but it's not home".

People we spoke to said that generally the food was good, for example people told us "The food is ok. I'm particular, there's always a choice and you can always have an omelette." Others said "To be honest food is not great, they try to make it nice but there is only so much minced meat you can have" and "The staff certainly ask me what I "like to eat – whether I get it or not is another matter". Relatives told us "Very happy with food, I have dined with Mum. Chef is Ben, so good. Pureed food presented well, looks tempting, he is very accommodating. He bakes cakes for afternoon tea, makes soup every day. There are bowls of fruit around the place."

We saw carers working well together with kitchen staff. People were served their food and provided with the support they required. We spoke with the head chef after everyone had eaten. They showed us that they had been provided with the information they needed to cater for people's individual needs. They told us how they differentiated the meals prepared to take into account people's preferences. For example, one person who preferred not to use cutlery was provided with finger foods, another with a vegetarian diet and others with soft or puréed meals. Meals for people with medical conditions such as Crohn's disease and diabetes were also prepared such that they reflected the dietary advice from health care professionals. The head chef had a record of all those that requires a special diet. Menus were cross referenced with allergens. The chef had details of people allergies. Some of the care staff had completed training relevant to caring for people with particular dietary needs. This included training to support people who had difficulty swallowing and for people who could not take food or drink orally. The head chef explained that unless it was otherwise indicated food was fortified for people who were at risk of weight loss. This meant that people's health needs in relation to nutrition were understood and catered for.

We observed the lunchtime meal in the dining room. Tables were laid out with table cloths, napkins, cutlery, sauces and condiments. A choice of hot and cold drinks were offered and made available. People were offered a choice of food at the table from that which was on the menu for the day. Alternative choices and special diets were catered for. We saw food dished up onto plates from the kitchen server and brought to people at the table in a timely manner. People that needed help to eat were supported by staff to do so. This included people that chose to eat their meals in their private rooms. We saw two people being helped to eat by their relatives. We spoke to these people. They told us that the quality of food had been good and that their relative's food preferences were taken into account and provided for. One of the relatives told us that they had been able to contribute to the records kept which were used to monitor their relative's dietary intake. They said that records had been maintained when there had been concerns about weight loss. They said that as their relatives weight had been stable for some time that such detailed records were no longer required. This was in line with the persons care plan. We saw another instance where fluid charts had been maintained for people at risk of dehydration. We spoke with nursing staff about this and they told us that this person's care and health status was reviewed by their GP every two weeks.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and they are offered snacks and at other times"; "People can get food and drink during the night if they want it, like tea and toast". Staff said that people who were awake early in the morning were offered drinks and snacks.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they encouraged people to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

New staff had been supported to complete an induction program. Staff started the induction when they first started working in the home. Inductions had been completed within set time scales. The induction covered what was expected of staff in relation to their roles, day to day practice and key policies and procedures. These for example included health and safety, safeguarding, the use of bed rails and quality management systems. The induction for registered nurses included competency assessments in relation to the management and administration of medication and observations of key areas of practice, for example wound care and dressings. Fifteen staff have currently completed the care certificate. The Care Certificate is a set of standards that social care and health workers must stick to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. A senior manager told us that the Care Certificate had in the last month been added to core training program for all staff. They told us that mentors had been appointed to help deliver this training. This meant that the service had taken action to ensure staff have the required values, behaviours, competences and skills to provide high quality, compassionate care.

A range of additional training had also been organised in 2015 and 2016. This training was relevant to the individual needs and conditions of people living in the home. For example training in relation to diabetes, stroke, Crohn's disease and Parkinson's disease. This meant that people had received care from staff who have gained the knowledge and skills they need to carry out their roles and responsibilities effectively.

We were told by a senior manager that company policy was for staff to receive supervision at least once every two months. We were told this could be in one to one meetings, in groups or linked with formal observation of practice. Regular supervision of staff is essential to ensure that the people at the service are provided with the highest standard of care by supporting staff to develop in their roles. We reviewed the record of supervision for 2015 and 2016. Most staff had received their supervision on time, some that had not were due in part to the staff member having been off sick or on annual leave. The manager explained that they now closely monitor supervisions to make sure staff receive this support in a timely manner on their return to work.

The deputy manager is the clinical lead supervises the nursing staff and makes sure they receive the training they need to maintain their nursing qualification. Nurses undertake the same training as care staff, plus specific training they need to undertake there role, and keep their nursing qualification with the NMC. For

example a course that kept nurses up to date with current treatment of wounds. The nurses we spoke with confirmed that they are given sufficient training to carry out the role and maintain their qualification with the NMC.

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing.

People were enabled to see specialists such as an optician and dentist for example when necessary. Vaccination against influenza was carried out when people or their legal representatives had provided their consent. People's appointments with healthcare professionals were booked, recorded and followed up by staff to ensure people attended and had effective care which followed the guidance of these professionals. We spoke to the local GP who said that he found the staff very caring and he had confidence that they carried out any treatment they advised. They said "The nurses are very good at informing us when a person is unwell or they have concerns. I know if they ask for a visit then I need to attend the home, they never call me unnecessarily".

Good

Is the service caring?

Our findings

Relative commented as follows, "Staff are lovely and both the deputy manager and registered manager are very friendly", "Staff are very friendly and I feel involved in his care", "She is happy here. A big fresh air", "Every time I go home, I know I have left him in good hands" and The staff are extremely kind and called him by name".

Healthcare professional said that "The staff in the home are very caring and have always treated the patients with respect, and the support they offer is good. I find the nurses spend time with people and they listen to what they say".

Staff were visible around the home, chatting to people and assisting them with things such as drinks and meals. Staff clearly knew people well, relaxed and chatting together. Staff were able to talk about people and what and who was important to them.

Family members were visiting at various times in the day, without restriction. Some popped in for a short time but many stayed for a few hours. Staff were chatting to family members, it was clear they knew them and knew about their relationship. There was a lively and friendly atmosphere around the home, staff were chatty and open.

People were involved in providing the information about themselves to enable the staff to develop their care plans. Where people were not able to do this for themselves, their family members were involved in order to gather as much personal information as possible. Care plans were person centred including personal information about people such as their life histories. This enabled the staff to converse with people about the things that interested them such as their family or where they were brought up.

People advised if they were happy for a family member to sign documentation on their behalf if they were not able to. This may be the case for example if a person had suffered a stroke and had a weakness down one side. We did not see that people or their family members had signed care plans. However, people had clearly been involved as the level of personal information was evident. Several families spoken with told us that they had been involved in the care plan and one relative told us "I was very involved from the beginning and I am aware of what is in the care plan, they still hold reviews to see if we are happy with the care provided to mum". We saw that e-mail conversations had taken place with some family members and copies were kept in peoples care plans. The staff encouraged close involvement of family members in their loved ones care.

Staff knocked on people's bedroom doors before entering and spoke to people when entering their room. They then went on to explain what they had come in to their room for. For example, to help people to get out of bed, or to help them with their meal. Bedroom doors were closed when personal tasks or conversations were taking place. People's preference around female or male support when personal care was being given was recorded. Respect was shown to people by staff who were careful to maintain their dignity and privacy.

Staff were guided within the care plan to offer reassurance to people and to always explain exactly what they were going to do. They were told to gain people's permission before carrying out any task and to make sure they were comfortable throughout the process.

Staff knew how to support people who were distressed and upset. For example, people missing their family members and not understanding why they were not with them. Staff spoke very kindly to people and took their time talking to them and encouraging them to do something to distract them. For instance, getting ready to go into the dining room and talking about what they had chosen for their meal, or talking about a hobby they may have had.

There was an emphasis on supporting people to maintain their independence. Care plans included how to support people to realise their ambitions. The care plans clearly instructed staff to give people the time to be able to do things for themselves if this was their wish and what they were capable of doing normally. In one care it described how a person needed to be supported to stand up and take steps following a period of inactivity in order to maintain and increase their mobility.

We spent time and observed how people and staff interacted. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. Staff checked on people's welfare when they preferred to remain in their bedroom or not to take part in the activities. One person was very anxious and staff provided much needed reassurance. With a member of staff sitting with them gently stroking their back and talking with them to provide comfort and reassurance. This showed that staff were knowledgeable about how to care for people.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

Good

Is the service responsive?

Our findings

People spoken with told us that generally they were satisfied with the service. They commented for example "It's independence really, they treat you good halfway, they treat you ordinary, like you still got all your marbles." "I miss being at home but I know I can't look after myself. They are very good, from the time I get up to the time I go to bed everything I need they give me." Another also said "Staff always ask what they can do for me and new staff are always introduced. I'm happy to be here, comfortable. A relative said "They adjust the blinds in rooms and the dining rooms when its sunny – little things that are so important".

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. A relative told us, "We are informed and involved every step of the way". Another said, "I feel very involved in his care" and "The nursing team are fantastic. They have empathy and always responded to his needs".

Family members told us they were involved in planning their loved ones care. One family member told us, "Yes I was involved in the care plan", and "I'm satisfied with my care plan – they involved me". The deputy manager carried out comprehensive initial assessments before people came to live at the home. They gathered the information necessary to determine whether the home would be able to care for the person and meet their needs. The registered manager would not accept people to live in the home if they assessed that they would not have the staff with the skills necessary to support an individual well. The assessment was recorded in order to use the information to develop a care plan for people if they did move in to the home.

Care plans were comprehensive, containing all the information necessary for the staff to be able to provide individual care. Information in the care plan was person centred and told a story about the person. Equality and diversity was covered in people's care plans and it details people's preferences and individuality. For example one person likes to be called a certain name at certain times and other times, another name. We observed that staff called them these preferred names. Religious and cultural needs are also taken into consideration and in one person's care plan it said 'Likes to attend when there is a service in the home'. People's likes and dislikes, how they liked things and what was important to them were recorded within each area of the plan. For example, to be able to get a good night sleep, what were the important factors to the individual person. What time they liked to go to bed, what type of nightwear and how much bed linen they liked, the window open or shut or the door open or closed.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone, visits, meals and birthday celebrations. People attended church services of their faith when they wished.

People were able to express their individuality. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items

they could relate with based on their choice.

Family members had been able to supply important information to include in the care plan. For example, around previous issues that could once again be a cause for concern if not included in the care people received. Such as ensuring people's feet and legs were elevated whenever they were sitting in a chair. Information from family members was crucial in enabling staff to provide the best on going care for people. Care plans were reviewed on a monthly basis. Comments were made at each review with updates of information recorded. These included what people had achieved that month or if they had been unwell. Either of these instances would inform the care plan for the following month. Daily recordings were kept well, recording personal care tasks that had been carried out. Including overnight checks such as regular changes in position for example, to ensure people did not acquire pressure areas. Good communication and recording was essential in making sure people got consistent and safe care.

The deputy manager contacted other services that might be able to support them with meeting people's health needs. This included referrals to the Speech and Language Therapist (SALT) and the falls clinic, guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

People had a folder called 'My choices' in their room. This held personal information about who the person was, their likes and dislikes and important information about themselves. Within the folder was a booklet called 'my journal'. This invited visitors or staff to write in it and make comments, record what they had done or spoken about with people. Comments included if the person had been happy that day and what they had spoken about.

The home employed two activities co-ordinators and a third had recently been employed to work weekend days. Between them they planned and organised the activities within the home. An activities board in the lounge area displayed information for people living in the home. The activities on offer for the week were shown on an activities poster. Activities on offer included a sing along, a jewellery display and a church service. A hairdresser was available once a week and the opportunity to have a 'pamper', such as manicures. Flower arranging was available on occasional months and people living in the home who had a skill in this area were involved in teaching others.

Although there were group activities available as posted, there did not appear to be individual activities for people who did not want to take part in the activity on offer on a particular day. People who wished to stay in their room or who were being cared for in bed did not have the opportunity to take part in meaningful activity. The staff did go into people's rooms and chat with people, as did the activities co-ordinators at times. Otherwise people watched TV. A 'lifestyle activities plan' was in place for each person within their 'my choices' folder. The purpose of them was to plan people's individual activities and how to encourage and support them to take part. However they were used by the activities co-ordinators to record the activities people had taken part in over the previous month. We saw that some people did not have the opportunity to take part in meaningful activity on a regular basis. People we spoke to about this gave us mixed views and gave examples of what they did like to do for example, "I like knitting best", "Exercise to music once a week, I join in", "I paint and do colour co-ordination", "I play letto/bingo". Another person told us "It's not regimented at all, which is nice, but we do have special times for special things, like singing" and "I get books from Sharon, I read a lot". We were also told "Activities here are few and far between, there should be more occupation" and "They've asked someone to come in and do activities but yesterday but it was too busy and

she had to do other duties". The manager explained that they had recognised that not all people were being stimulated particularly if they choose to remain in their own rooms. This has been reviewed and more hours have been included on the rota. Activity co-ordinators said that they had just been given some more hours and they intended to make sure that all people were given the opportunity to take part in something they liked to do, in both group or on an individual basis.

The home had held regular residents meetings previously, however had recently rejuvenated this. A new residents group call the 'Residents action group'(RAG) had recently been set up. They had held one meeting and were due to hold the next. People were very involved in the running of the group, one person was the residents advocate and another was the coordinator. At the meeting in March, the residents raised the fact that there were unpleasant smells in one area of the home. The registered manager had informed the group that this was due to some carpets needing to be replaced and these had been ordered. Items that had been raised in previous residents meetings were seen to have been actioned by the registered manager. The registered manager listened to what people had to say and took action to improve the home accordingly.

The registered manager explained how people could leave their views following each visit to the home. Families were shown how to use an electronic device typing in their experience of that visit. This meant that if visitors were not happy about any aspect of their visit the manager would have immediate feedback and could take action straight away. This information was sent to head office and the registered managers response was monitored to make sure the feedback had been used to improve the service. We were shown the spread sheet where the information is recorded and could see that concerns and complaints had been responded to in a timely way.

Good

Is the service well-led?

Our findings

One person told us "I'm the Resident's Advocate, we've started having meetings. I hope the residents will come to me and let me know if they are not happy so I can bring that to the meetings. The meetings were working, "I check the mugs every day to make sure they are clean and I send the dirty ones back. We had twenty dirty ones when I started and now only two!" Another person said "At the residents meeting I made a suggestion for a buzzer". The registered manager explained the buzzer now sounds as an emergency if it is not answered quickly, one visitor said "this has improved the response". Other families explained how they are encourage to be involved in the home one relative said "I've tried to get involved in things here, it's good. I was Father Christmas last year".

People and relatives told us that the registered manager and the deputy manager are always very approachable and responsive. One person said "The managers are good, they listen and we get answers", and another said "all the staff are brilliant, always easy to talk to, nothing is too much trouble". A relative told us, "communication is very good, I like the way we are welcomed by all the staff when we visit, we can come any time, and they always keep us up to date with how mum is doing". Another said "You only have to mention something, mum had a stiff neck, so they changed her bed position in the room, the manager is very responsive, staff are so easy to talk to".

Staff told us that they found the management approachable and supportive. They said that the communication in the home was good between all grades of staff. Several staff said that they find the morning meeting useful to bring issues to the fore or report what has gone well. We saw the notes from these meetings and saw that they cover a wide range of what is happening with the in the home.

Communication within the home was facilitated through six weekly heads of department management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

A healthcare professional said, "The staff are very knowledgeable about people's needs, and communication is very good".

The provider aimed to make sure they maintained the dignity and individuality of each person living in the home as a top priority. Our observations showed us that these values had been successfully cascaded to the staff and nurses who worked in the home. Staff demonstrated these values by the way they spoke to and supported people in a very person centred way. One staff member said "most people would not chose to live in a home, it is important for us to show them that they still make the decisions and that we see them as a person in their own right".

The management team at Beechcare Nursing Home included the registered manager and the deputy manager who was also the clinical lead for the nurses working at the home. Support was provided to the registered manager by the senior manager, in order to support the home within the organisation. The

registered manager oversaw the day to day management of the home, while the deputy took responsibility for the nursing staff and the work undertaken by them within the home. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the senior manager who provided support to ensure the effective operation of the service. The senior manager visited the home at least twice a month and audited systems to make sure the home was providing a quality service.

The registered manager had effective systems in place for monitoring the home, which had been fully implemented. They completed daily, weekly and monthly audits of all aspects of the home, such as medicine, care plans, nutrition and learning and the development of staff. They used these audits to review the home. Audits routinely identified areas that could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken.

Care staff and nurses told us that they found the management approachable and supportive. They said that the communication in the home was good between all grades of staff. Several staff said that they find the morning meeting useful to bring issues to the fore or report what has gone well. We saw the notes from these meetings and saw that they cover a wide range of what is happening with the in the home.

The home worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we spoke with told us that the home always liaised with them. A healthcare professional said, "The staff and management always phone if there is a change in a patient's condition or any other relevant changes, the communication is good". This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were part of their quality assurance system. The registered manager explained the computer systems used, it made it easy to see if actions were on track, it describe the action that need to take and when this should be completed by.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.