Beechwood (Liverpool) Limited

# Beechwood Specialist Services

## Inspection report

Beechwood Road
Aigburth
Liverpool
Merseyside
L19 0LD

Tel: 01514273154

Date of inspection visit:
17 April 2018

Date of publication:
08 June 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 17 April 2018 and was unannounced.

Beechwood Specialist Services provides nursing and residential care to up to 60 people with a variety of mental and physical health needs.

Beechwood Specialist Services is a 'care home'. 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. At the time of the inspection there were 45 people living in the home.

A new manager was in post. They had not started the process to become registered with the Commission at the time of the inspection, but since the inspection has confirmed they have submitted an application. 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.

Not all safe staff recruitment practices were followed to ensure staff were suitable to work with vulnerable people.

Plans were in in place to support people who presented with behaviours that could challenge, however some lacked detail as to how risks should be managed.

Chemicals and objects that could pose risks to vulnerable people were not always stored securely. We discussed this with a staff member who arranged for all of the toiletries to be stored securely straight away.

We saw that the electrical certificate had expired. The electrics had been checked recently and following the inspection, we received a copy of the electrical certificate which showed they had been assessed in March 2018 and were un-satisfactory.

Staff were aware of people's individual dietary needs, however we found that records had not always been updated to reflect current needs. Feedback we received regarding the food varied. Most people told us they enjoyed the meals, but not everybody.

Although staff told us they received regular training, records available did not reflect this as training records had been lost when the provider took over the company in 2017.

There were no records to show that staff had completed a formal induction to ensure they had the required knowledge to fulfil their roles. A new contract had been secured to provide training and induction. Records

showed that most staff had received regular supervisions, though not all staff had received a supervision within the past three months.

Care files showed that plans were in place to support people's needs, however not all plans were detailed. Planned care was not always recorded as provided, such as when people were supported to reposition.

Systems in place to monitor the quality and safety of the service were not always effective as they did not highlight all of the issues we identified during the inspection and did not show what actions had been taken when issues had been highlighted. There was no evidence of provider oversight.

Most people we spoke with told us they felt safe living in Beechwood and their relatives agreed. Staff were knowledgeable about safeguarding and were able to clearly explain how they would report any concerns they had. There were enough staff on duty to meet people's needs.

Care files showed that risk to people was assessed. This included personal emergency evacuation plans (PEEPs). These were detailed and provided information to staff on what support people would need in the event of an emergency evacuation and what equipment would be needed.

Medicines were stored securely and we saw that they were administered safely and as prescribed.
Staff were able to explain when medicines prescribed as and when required should be given, however this information was not written down to ensure they were administered consistently.

Applications had been made to deprive people of their liberty appropriately and a system was in place to monitor this process. When able, people provided to consent to the care and treatment. When people lacked mental capacity to provide this consent, we saw that the principles of the MCA were followed when seeking consent.

People we spoke with told us staff arranged a doctor quickly if they were unwell and records showed staff made referrals to other healthcare professionals for advice.

People living in Beechwood told us that staff were kind and caring and that they were treated with respect by staff. We observed interactions between staff and people living in the home to be warm and genuine. We heard staff speak to people in ways each person could understand and we saw staff protect people's dignity when providing care.

Friends and relatives visited throughout the inspection and all those we spoke with told us they were always made welcome. For people who did not have friends or family members to support them, details of advocacy services were available.

Care plans were centred on the person and reflected how they wanted their support to be provided. This enabled staff to get to know people as individuals and provide support based on their needs and preferences.

There was a complaints policy available and the manager maintained a complaints log. People living in the home knew how to raise any concerns and relatives told us their complaints had been dealt with to their satisfaction.

A minibus was available for people to go out on trips and we were told people often went to the city centre or to local pubs. We observed a small group of people going out for a pub lunch on the day of the

inspection. External entertainers also regularly attended the home and the manager was in the process of recruiting an activity coordinator.

Staff were trained to support people at the end of their life, as well as their families and discussions regarding care provided to people reflected best practice guidance.

Policies and procedures were available which guided staff in their role. Staff we spoke with were aware of these policies and told us they could access them at any time.

Meetings took place and surveys were completed in order to gather feedback regarding the service. Records showed that actions had been taken based on the feedback received.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Chemicals and objects that could pose risks to vulnerable people were not always stored securely.

The electrics had been assessed as un-satisfactory and a date had been scheduled for the required works to be completed.

Not all safe staff recruitment practices were followed.

There were enough staff on duty to meet people's needs in a timely way.

Risk to people was assessed and managed.

Medicines were managed safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Not everyone was satisfied with the meals they received and records regarding dietary needs were not all up to date.

Staff told us they received regular training; however records available did not reflect this. There were no records to show that staff had completed a formal induction.

Applications had been made to deprive people of their liberty appropriately. The principles of the MCA were followed when seeking consent.

Referrals were made to other healthcare professionals for advice in order to maintain people's wellbeing.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and caring and treated people with respect by. Interactions between staff and people living in the home were

warm and genuine and people's dignity was maintained.

Staff were guided to support people to be as independent as possible.

We saw that care files and other confidential records were stored securely in order to protect people's privacy.

Friends and relatives could visit at any time and they were always made welcome. For people who did not have friends or family members to support them, details of advocacy services were available.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Plans in place to support people's needs were not all detailed. Planned care was not always recorded as provided.

Care plans were centred on the person and reflected how they wanted their support to be provided.

Complaints regarding the service were managed appropriately.

Some activities were available, though these could be developed further.

Staff were trained to support people at the end of their life.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective.

There was no evidence of provider oversight.

Policies and procedures were available which guided staff in their role.

Systems were in place in order to gather feedback regarding the service. Records showed that actions had been taken based on the feedback received.

A manager was in post and since the inspection has applied to the Commission to become registered.

# Beechwood Specialist Services

**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 17 April 2018 and was unannounced.

The inspection team included an adult social care inspector, an assistant inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the Local Authority to get their opinions of the service.

We used this information to plan how the inspection should be conducted.

During the inspection we spoke with the manager, the finance director, an occupational therapist, the chef, six people living in the home, three relatives, a visiting health professional and five other members of the care team.

We looked at the care files of six people receiving support from the service, five staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

Many of the people living in Beechwood Specialist Services were unable to share their views with us, due to memory difficulties. 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.

Requires Improvement

# Is the service safe?

## Our findings

We looked at plans in place to support people who presented with behaviours that could challenge. We found that the plans were in place, but did not always provide detailed information to ensure staff were aware of how to best manage the risks. For example, one person's plan reflected that they could become agitated and hit out at staff and other people living in the home. The plan informed staff to use diversion techniques to manage these situations. There was however, no information on what diversion worked well for that individual, any potential triggers for the behaviours or how to identify early signs in order for staff to be able to recognise them and take action to prevent them leading to a physical incident. This meant that staff may not have access to information on how best to support people.

Whilst looking around the home, we saw that chemicals and objects that could pose risks to vulnerable people were not always stored securely. In one bathroom we observed a basket of toiletries, including a razor, left out. Another bathroom contained a cupboard with a variety of toiletries within that were accessible to people. A staff member told us the toiletries were safe as there was a 'child lock' fitted. This was a small plastic device that was simple to override. This meant that vulnerable people living in the home may be able to access the cupboard and could be at risk of harm. We discussed this with a staff member who arranged for all of the toiletries to be stored securely straight away.

We looked at the electrical certificate and saw that it had expired. A member of the maintenance team told us the electrics had been checked recently and they were waiting for a certificate. Following the inspection we received a copy of the electrical certificate which showed they had been assessed in March 2018. However, it also showed that the electrics were un-satisfactory and urgent action was required to ensure they were safe. Since the inspection the manager has confirmed that a contractor has been booked to complete this work and the dates the work will be completed by.

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

Systems were in place to help ensure the environment remained safe and secure. For example, records showed that regular internal checks were made in areas such as water temperatures, fire alarm testing, fire doors, wheelchairs, profiling beds, emergency lights and emergency exits. External contracts were also in place to make regular checks on the gas, water safety, passenger lift and lifting equipment.

We looked at how staff were recruited to the home and saw that safe recruitment practices were not always followed. For example, out of the five staff files we reviewed, two did not have the required photographic identification of the staff member. All of the files contained evidence of a Disclosure and Barring Service (DBS) check, however these were not always completed prior to the staff member commencing in post. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

When risks had been identified through the recruitment process, we saw that a risk assessment had been completed; however this did not reflect that the risks had been assessed, or whether the person was suitable to work with vulnerable people. This showed that the risk assessment was not sufficient in identifying, assessing or managing the risk.

The files we viewed contained references, however we found that the most appropriate references were not always sought. For instance, one file contained two character references from the same person, but no reference from their last employer. Another file also contained gaps in the staff member's employment history. Records showed that a full check of all staff files had recently been completed and an allocated staff member was working through the actions this check had identified.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they felt safe living in Beechwood and their relatives agreed. Comments included, "I feel [relative] is really safe here knowing that there is always a member staff available if anything were to happen" and "I feel very safe here and never had a problem with anything." Another person told us that they felt much safer in the home than where they used to live.

Staff we spoke with were knowledgeable about safeguarding and were able to clearly explain how they would report any concerns they had. A safeguarding policy was available to guide staff in their practice and contact details for local safeguarding teams were on display within the home. We saw that safeguarding referrals were made appropriately and a log was maintained to help the manager review any incidents. One staff member told us, "Even if I was not sure if an allegation was true, I would always speak to the manager and they would then refer it. We still have to protect the service users, and the member of staff."

The provider also had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions. Staff we spoke with were aware of how to raise their concerns and we saw information regarding whistleblowing advertised on noticeboards around the home.

An equal opportunities policy was also in place. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The manager told us they used interpreters when required, and we found that informal systems were also used to support people when necessary, to ensure their needs could be met.

We looked at how the home was staffed. The manager told us that a number of staff had left the home recently so there were a number of vacancies and they were in the process of recruiting new staff. The manager had arranged bank and agency staff to cover these vacancies, to ensure there were enough staff on duty to meet people's needs. People we spoke with did not raise any concern regarding the numbers of staff on duty. One person told us, "Staff are always there when I need them." Staff we spoke with told us there was always enough staff. Staff also told us that when there was bank or agency staff on duty, they were usually the same staff members so were able to get to know people and provide consistent care. During the inspection we observed there to be adequate numbers of staff on duty. We saw that call bells were answered in a timely way and staff were available to support people when they requested their help.

Care files showed that risk was assessed in areas such as falls, moving and handling, skin integrity and nutritional needs. Risks specific to people's individual needs had also been assessed. For instance, one person who smoked had a smoking risk assessment within their file. This provided staff with detailed

information as to how this risk should be managed and minimised. Another person's file contained a bed rail risk assessment, to ensure it was safe for the person to use these.

Care files contained personal emergency evacuation plans (PEEPs). We found that these were detailed and provided information to staff on what support people would need in the event of an emergency evacuation and what equipment would be needed. We saw that the assessed evacuation equipment was available within the stairways.

We looked at how medicines were managed within the home. Medicines were stored securely within locked rooms and the temperatures of these rooms were monitored and recorded regularly. If medicines are not stored within the correct temperature range, it can affect how they work. A medicine policy was in place which provided guidance to staff and records showed that staff had completed training to enable them to administer medicines safely.

We observed a drug round and saw that medicines were administered safely and as prescribed, including those administered via a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG is a tube inserted straight into a person's stomach to enable fluid and nutrition to be provided if they are unable to swallow.

Controlled drugs were stored securely and their administration witnessed and recorded by two staff members. Controlled drugs are prescription drugs that have controls in place under the Misuse of Drugs Act and associated legislation.

Medication Administration Charts (MARs) had been completed fully each time medicines were administered, they included details of any allergies people had and recorded when people were given medicines prescribed as and when required. Staff we spoke with were able to explain when these medicines should be given, however this information was not written down to ensure they were administered consistently. We discussed this with the manager who agreed to ensure protocols were put in place.

People living in the home told us they got their medicines when they needed them and were happy with how they were managed.

Accidents and incidents that had occurred within the home had been recorded. A log of all incidents was maintained and these were reviewed monthly to look for any potential themes or trends. These records showed that when a risk was identified, action was taken to minimise the risk. For instance, a person was found unaccompanied in the kitchen and was at risk of injury from equipment within the kitchen. Although a key code pad had been in place, this was replaced with a key. This meant that risks to the person was minimised as they could not enter the kitchen unaccompanied. Relatives we spoke with told us they were informed of any accidents or incidents straight away.

The home appeared clean and was free from odours during the inspection. Bathrooms contained paper towels and liquid hand soap in dispensers, in line with infection control guidance. Personal protective equipment (PPE), such as gloves and aprons were available to staff and we saw that these were used at appropriate times, such as when providing personal care. Hand gel was available to staff within locked offices, as it posed a potential risk to vulnerable people.

Requires Improvement

# Is the service effective?

## Our findings

We looked at how people's nutritional needs were met within the home. Staff we spoke with were aware of people's individual needs; however we found that records had not always been updated to reflect current needs. For example, the chef told us about one person's needs and this information was the same as that recorded in the plan of care. The information held in the kitchen however, had not been updated since their needs had changed. We raised this with the manager and saw that this was updated before the end of the inspection.

Feedback we received regarding the food varied. Most people told us they enjoyed the meals and always had a choice. Their comments included, "I am happy with the food that is given to me, it is very filling", "The meals are pretty good. Breakfast is a cooked breakfast, cereal or toast" and "The food is good that we have, but I enjoy eating out as well." A relative told us, "The food is alright and [relative] can cook whatever they want with support from staff."

We found however, that not everybody enjoyed the meals. Records showed that a complaint had been made regarding the quality of the food and some relatives we spoke with told us the food was not good. They described the meals as, "Bland", "Not very nutritious", that there was a lack of choice at times and the portion sizes were not always sufficient. One relative told us their family member had been given the same meal for three days in a row. Another relative told us their family member was provided with a meal that was not suitable for them due to their dietary needs, so they had to request another meal.

We joined people for lunch during the inspection and sampled the meal available. The meal did not match what was advertised on the menu board. The portion size was adequate; however it did not look appealing and lacked taste. We discussed the quality of meals with the manager who told us they were aware some concerns had been raised and had plans in place to improve the quality by adopting systems that were working well in another of the provider's services.

We recommend that the provider reviews its practice to ensure people's nutritional needs and preferences are met.

We saw that when people were at risk of malnutrition, their weight was recorded regularly and advice was sought from the dietician. The chef had access to information regarding specific cultural and religious diets, although they told us they were not supporting anyone that required this type of diet at the time of the inspection.

We spoke with staff about how they were trained and supported in their roles. Staff told us that they received regular training. One staff member told us, "I have had different training, some of it is face to face, and some of it is e-learning." Staff told us they had completed training in areas such as nutrition, use of thickening agents, dementia awareness, fire marshal, infection control, safeguarding, falls prevention, neurological rehabilitation, de-escalation and Mental Capacity Act 2005. Manual handling was also provided by an in house trainer.

Although staff told us they received regular training, records available did not reflect this. There were gaps in training that would be considered mandatory for the type of support staff provided. We discussed this with the manager who told us the training records were held electronically and they could not access them on the day of the inspection. Following the inspection the manager provided additional records, however there were still a number of courses that staff were not recorded as having attended. The provider explained that when they took over Beechwood last year, the training records from the previous provider were lost. A new training provider had been contracted and courses had been booked to help ensure staff remained updated and had the skills required to support people safely. A visiting professional told us they felt staff at the service were well trained.

When staff started in their role they worked with more experience staff to get to know people who lived in the home and how best to support them. There were no records to show that staff had completed a formal induction to ensure they had the required knowledge to fulfil their roles. The manager told us the newly contracted training company would be completing the care certificate with all staff. The care certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff.

The manager explained they aimed to hold individual supervision meetings with staff every six to eight weeks and staff confirmed these usually took place. Records we viewed showed that most staff had received regular supervisions, though not all staff had received a supervision within the past three months. The manager told us that since they had been in post, a new schedule had been put in place and more supervision meetings had been scheduled in the coming months.

During this inspection we looked to see if the service was working within the legal framework of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager maintained a system to record all applications made to deprive people of their liberty, dates they were authorised and due to expire and dates when they were reapplied for. This showed that applications were managed well. For people who had an authorised DoLS in place, we saw that this was clearly recorded within plans of care to ensure staff were aware of this information.

When able, people gave their consent to the care and treatment that was planned for them. This was reflected through signed consent forms within their care files and evidence of discussions held with people regarding their care.

When people lacked mental capacity to provide this consent, we saw that the principles of the MCA were followed when seeking consent. For example, one person's care file showed they received their medicines covertly (hidden in food or drink). An MCA assessment showed that they lacked the capacity to understand the impact refusing their medicines could have. A best interest decision had been made in consultation with family, the GP and the pharmacist and this had all been recorded and signed.

Staff we spoke with all had a good understanding of the MCA. One staff member told us, "Capacity fluctuates and someone could have the capacity to make decisions for some things, but not for others. We also need to

think just because the person is making what we think is an 'unwise decision' does not mean they lack capacity. We always need to review their capacity."

Care files included care plans in relation to people's mental, physical and social health needs. This showed that people's needs were assessed holistically. Care files also recorded when people had been referred to other healthcare professionals for advice in order to help maintain their wellbeing. These included referrals to the GP, optician, dietician, speech and language therapist, diabetic specialist nurses, chiropodist and social worker. The service also employed an occupational therapist, who assessed people to establish what aids and adaptations could help them to remain safe, improve practical living skills and to maximise their independence.

Although information regarding these referrals could be found within the care files, they were not always recorded in the same place so could be difficult to find the information. We discussed this with the manager who agreed to ensure all referrals or advice from healthcare professionals was recorded clearly in one place.

People we spoke with told us staff arranged a doctor quickly if they were unwell. One relative explained how equipment arranged by the occupational therapist had not only helped their family member stay safe, but also enabled them to access the local community.

Systems were in place to ensure that people received consistent care when they transferred between services. For example, hospital passports were available and included information on what staff must know about a person, what is important to the person and how the person would like to be supported. These passports are used when people are admitted to hospital, along with medication administration charts. This enabled people to receive care from staff that knew how to support them safely.

We looked to see if the environment had been adapted to suit the people living there. The building contained wide and bright corridors with contrasting hand rails to help people see them clearly and prevent falls. The finance director shared with us the plans for further development and refurbishment of the home, including a wellbeing garden. The manager told us they had discussed with the provider how the environment could be further improved to support people living with dementia to remain safe, orientated and as independent as possible.

Good

# Is the service caring?

## Our findings

People living in Beechwood told us that staff were kind and caring and that they were treated with respect by staff. Their comments included, "Staff go out of their way to help us as much as they can", "The staff are fantastic, really good down to earth people they now how to talk to us in a way we understand", "All the staff are good people", "Staff always treat me with respect, they understand my illness and help me in the best way they can" and "It's a good service with great staff." Relatives we spoke with agreed that staff were kind and caring and always available to support people.

We observed interactions between staff and people living in the home during the inspection and saw that they were warm and genuine. We heard staff speak to people in ways that were appropriate to the individual and in ways each person could understand. People living in Beechwood had a variety of mental and physical health needs and staff told us they had received training on how best to communicate with different people.

We saw that when staff were supporting people, they did so in a way that maintained their dignity and privacy. For instance, we heard staff always asking for consent before providing support, we saw that staff knocked on people's doors before entering their rooms and personal care was provided in private rooms with the door closed.

It was clear from speaking to staff that most knew people very well, including their needs and preferences. For instance, when we spoke with staff regarding people's dietary needs, they were able to tell us who required specific types of diet, or how they preferred their drinks to be made.

Staff also told us that they encouraged people to be as independent as they could be. The service also employed an occupational therapist who worked with people to improve their skills and assist them to move to more independent living situations if possible. Care plans informed staff what people were able to do for themselves and what they required support with. One person's care plan showed that since moving into the home, their need for one to one support from staff had greatly reduced and they now only required regular checks to ensure they were safe and well.

Equipment was also in use to enable people to maintain their independence, whilst helping to ensure their safety. For example, one person used a plastic cup with a lid and handles to drink from as they were unable to use a standard cup safely. Other people who were at risk of falls, had sensors in their room which alerted staff when they got out of bed. This meant they could still get up whenever they wanted to, but staff could go and support them to help prevent falls.

The service user guide for the home also reflected that people would be supported to maintain their independence and the equality and diversity action plan stated the provider aimed to establish systems to increase independence for people living in Beechwood.

Care plans reflected that people had been involved in the creation and review of the plans. This was evident

through signed consent form and involvement in regular reviews, although not all people we spoke with remembered seeing their plans of care. Relatives also told us that they were aware of the care plans and were kept up to date if anything changed.

The service user guide and statement of purpose, which were available within the home, contained information about the service. This included what could be expected when a person moved in, how to make complaints and information regarding safeguarding processes. This showed that people were given information and explanations regarding the service.

We saw that care files and other confidential records were stored securely in order to protect people's privacy.

Friends and relatives visited throughout the inspection and all those we spoke with told us they were always made welcome. We were told that people could visit at any time; however meal times were protected to try and encourage people to maintain their dietary intake. A relative we spoke with told us they had made arrangements to visit each lunch time to support their family member with their meals. This encouraged people to maintain relationships they had built in the community before moving into the home and helped people to maintain relationships that were important to them and prevent isolation.

For people who did not have friends or family members to support them, details of advocacy services were available. One person's care plan we reviewed showed that their advocate had been involved in the last review of their plan of care.

Requires Improvement

# Is the service responsive?

## Our findings

Care files we viewed showed that plans were in place to support people's needs in areas such as medication, personal care, healthcare, dietary needs, continence, mobility, mental health, maintaining safety and sleeping. We found however, that not all plans were detailed. For instance, one person's file reflected that they had a wound that was being dressed regularly. There was a wound management plan in place which described the type of wound and the size. We found however, that it lacked clear guidance on how to manage the wound, such as what dressing to use or how often to change it. The staff we spoke with were aware of how to manage the wound and daily records showed that it had been renewed regularly, however clear records had not been maintained.

We also found that planned care was not always recorded as provided. For example, one care plan stated that the person was unable to reposition themselves and a staff member we spoke with confirmed that the person required staff to support them to reposition every few hours in order to prevent them developing a pressure sore and that this care was being provided. We found that there were no records maintained when staff assisted the person to change position.

Another person's diabetes care plan showed that their blood sugar should be monitored on a weekly basis. Records showed however, that although it was monitored regularly, it was not always recorded on a weekly basis and had been two weeks at times.

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

There were specific plans in place regarding people's health needs. For example, one care file included a care plan regarding diabetes management for a person and another showed that a person had epilepsy and informed staff how this should be managed. We also saw care plans regarding people's mental health and breathing difficulties.

Other care plans were informative and were centred on the person. For example, one person's file included a dementia care plan and this focused on how to empower the person. Files also included a 'getting to know me' document. This provided information regarding people's preferences, such as what made them happy, favourite films, music, books, pets the person had, their family members, favourite places, people they want to assist with their care, examples of privacy they want and preferences in relation to clothes and toiletries. This enabled staff to get to know people as individuals and provide support based on their needs and preferences.

One page summary plans were also in place to enable new staff, or agency staff, to read them quickly and discover the most important details about caring for each individual. Staff we spoke with told us they get to know people well and spoke about people as individuals. One staff member told us, "Everyone is so different. You cannot treat [people] all the same. When it comes to engagement for example, some people just want their own space."

We saw that care plans had been reviewed regularly by staff and every six months people and their representatives were included in the review if appropriate.

There was a complaints policy available and the manager maintained a complaints log. We saw that five complaints had been made in 2018 and four of these had been investigated and details of the investigation and the outcome had been recorded. Only one complaint did not include a full investigation and this was due to it only being received the week prior to the inspection.

People living in the home told us they would speak to staff if they wanted to make a complaint about anything, however those we spoke with had not had to make any complaints. Relatives we spoke with all agreed that any concerns they had raised, had been dealt with to their satisfaction.

We looked at the social aspects of the home and what activities were available to people. For those people who required continuous support from a staff member, they had individual activities arranged for them depending on their preferences.

There was no activities coordinator at the time of the inspection due to sickness; however the occupational therapist tried to plan various activities for the staff to implement with people. The manager told us they were in the process of recruiting another activities coordinator.

A minibus was available for people to go out on trips and we were told people often went to the city centre or to local pubs. We observed a small group of people going out for a pub lunch on the day of the inspection. External entertainers were regularly brought into the home, such as musicians, pet therapy and the animal safari. This included rabbits, a meerkat, snakes and a skunk. Staff told us that people really enjoyed the animals. The occupational therapist told us the musicians were particularly enjoyed by people living with dementia and often involved lots of singing. They also told us, ""I want to focus more on people having a day filled with meaningful things they enjoy; because we know if people are happy they have fewer incidents. It is when they are not, that we see behaviours [that can be challenging]."

The manager told us staff took people to church if they wanted to go and a local priest would visit if requested. They told us that although there were a range of activities available to people, this was an area they wanted to develop further.

We looked at systems in place to help support people at the end of their life. The manager explained that one of the qualified nurses had completed additional training to enable them to support people effectively at the end of their life and was the link nurse for the home. They would take the lead if anybody required end of life care and liaise with the palliative care team and community nurses to meet people's needs at these times.

We spoke with staff about the support they provided to people at the end of their life. They described care and support that was in line with nationally recognised best practice guidance and told us that relatives were also supported during these times. For instance, they were offered bereavement advice, chaplaincy, advice and regular refreshments.

Requires Improvement

# Is the service well-led?

## Our findings

During this inspection we looked to see what systems the provider and manager had in place to monitor the quality and safety of the service and drive forward improvements. We looked at whether the provider maintained oversight of the service to ensure they were aware of what was happening in the service, including any areas that required improvement. The manager told us that the regional manager visited two or three times each week to provide support, but did not conduct any formal audits or record their visits. The manager told us they had agreed to produce a monthly clinical governance report for the provider which would provide them with updates regarding all aspects of the home. They had not yet completed the first report; however the proposed system would then see the regional manager holding a monthly supervision with the manager to review the action plan created from the governance report.

We saw that audits had been completed in areas such as care planning, health and safety, medicines management, staff recruitment, infection control, accidents and incidents and applications to deprive people of their liberty.

We found that some audits clearly highlighted any issues and recorded what action had been taken to address them. For instance, the infection control audit from March 2017 contained a number of actions and each one recorded what had been done to address the issues and had been signed off. We found however, that not all audits showed what had been done to rectify the issues identified. For example, a care plan audit from March 2018 showed that there was no photograph of the person in the file and the hospital passport had not been completed. The action plan identified who was responsible for addressing this, but there was no timeframe and no evidence as to whether it had been completed.

We also found that audits did not always identify all of the issues we had highlighted during the inspection. For instance, the staff recruitment audit tool did not include all of the safe recruitment practices required by legislation. This meant that the tool was not effective.

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

A new manager was in post, who had previously been the deputy manager. They had not started the process to become registered with the Commission at the time of the inspection, but since the inspection has confirmed they have submitted an application. We asked people their views on how the home was managed and feedback was generally positive. A visiting health professional described the manager as "Really good and on the ball." Staff told us the manager was, "Approachable" and "Definitely has an open door policy." One person living in the home said, "The manager is very approachable and easy to talk to."

The manager told us he received support from a regional manager two or three times a week and that this support was quite good. Not all staff we spoke with felt completely supported by the management systems and one staff member told us, "There have been a lot of changes [in management]. It does not always feel consistent. But for us it is 'politics at the top end', but we still look after people. If I managed to make one

person smile today, then I have done my job."

Policies and procedures were available which guided staff in their role. Staff we spoke with were aware of these policies and told us they could access them at any time. Staff told us they enjoyed working at Beechwood and that everyone worked well together.

Systems were in place to gather feedback from people about the service. Records showed that a staff survey had been completed in January 2018 and a plan of action had been created based on the findings. A service user and relative survey had also been distributed in December 2017. This showed that people were generally happy with the support they received, however some people would like more options on the menu.

Records showed that action had been taken based on the findings. For example, one relative had stated staff could not always provide an update on their relative's condition over the last few days, as they had not been supporting them. The manager had implemented a new written handover process to help ensure all pertinent details regarding people living in the home were captured and shared with all staff.

People living in the home told us that meetings were held each month, but not everybody chose to attend. Records showed that staff meetings also took place. The last full team meeting had been held in March 2018 and it was evident that staff were kept updated regarding changes within the home and had the opportunity to share their views. There had been a number of senior support worker meetings and the manager was also in the process of developing daily head of department meetings. He told us this would enable staff to discuss any issues or concerns and have them addressed straight away.

The Care Quality Commission (CQC) had been notified of all events and incidents that had occurred within the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Beechwood.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The environment was not always safely maintained. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems in place to monitor the quality and safety of the service were not always effective.<br><br>Care plans did not all provide sufficient detail regarding people's needs and how they should be managed.<br><br>Planned care was not always evidenced as provided. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Not all safe staff recruitment processes were followed. |