Rowlandcourt Healthcare Limited

Beechwood House

Inspection report

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21 September 2016

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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

The inspection took place on 20 and 21 September 2016 and was an unannounced inspection.

Beechwood House provides accommodation and nursing care for up to 37 older people. At the time of our inspection, there were 34 people in residence. Earlier this year, the service started an agreement with the local NHS Trust for five 'discharge to assessment' beds. This meant that the beds were funded by the NHS. To minimise disruption to permanent residents, the bedrooms used for this purpose were located together in one part of the home.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives spoke highly of the care provided. At the time of our visit, the home was undergoing a major programme of refurbishment to both individual rooms and communal areas. This included redecoration, replacing of worn carpets and the levelling of uneven flooring. One relative said, "It's not looking its best but the care is fantastic, it has a nice atmosphere".

The registered manager had been in post for less than a year but had made significant changes to the service. This included increasing the number of staff on duty, improving activity provision and updating care plans. People spoke positively about the changes. One person said, "I am happy with this home and I am happy to recommend it to anybody any time. They are kind to us". A staff member told us, "(Registered manager) is making a lot of changes for the better".

During our inspection we identified some areas that required improvement. These included how medicines were managed, the monitoring of risk and the safety and cleanliness of parts of the premises. As a result, we found that the service was not consistently safe and that further work was needed. The registered manager was aware of the concerns and had already taken action in many cases to make improvements.

Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

There were enough staff to meet people's needs. Staff had received training and were supported by the management through regular supervision and appraisal.

People told us that staff treated them with respect. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food and were offered a choice of meals. Staff were attentive to people's needs and supported those who required assistance to eat or drink. People's weight was monitored and prompt action taken if any concerns were identified.

People were involved in planning their care and were supported to be as independent as they were able. Where there were changes in people's needs, prompt action was taken to ensure that they received appropriate support. This often included the involvement of healthcare professionals, such as the GP, district nurses or optician.

There were a variety of activities for people to participate in, both in groups and as individuals. This included games, visiting entertainers and attending a local coffee morning in the village.

The registered manager had a system to monitor and review the quality of care delivered and was supported by the provider. People, their relatives and staff felt confident to raise issues or concerns with the registered manager. Where improvements had been identified action had been taken or was underway.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The system in place to manage medicines required improvement, specifically in how medicines were recorded and in stock control.

Risks to people had not been always been monitored effectively.

Parts of the premises were unsafe, with an unpleasant odour in some areas. A programme of refurbishment was underway to address this.

There were enough staff to keep people safe.

Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

The service followed safe recruitment practices.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

People's care was planned and monitored to promote good health.

People enjoyed a variety of activities.

People were able to share their experiences and were confident they would receive a quick response to any concerns.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager. Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager used a series of audits to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Beechwood House

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 20 and 21 September 2016 and was unannounced.

One inspector and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed three previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

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. We looked at care records for four people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at four staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 11 people using the service, six relatives, the registered manager, the deputy manager, three registered nurses, four care assistants, the activities coordinator, the chef, the administrator and a representative of the provider. Following the inspection, we contacted two social workers and a community mental health nurse practitioner for their views and experiences. They consented to share their views in this report.

Beechwood House was last inspected in September 2014 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always administered safely and some aspects of medicines management required improvement. Records of administration contained gaps. The medicines had gone from the blister packs, suggesting they had been administered, but there was no signature on the MAR to confirm they had been given. In one case we found that a medicine had been signed for but it was still in the blister pack and did not appear to have been given. Records introduced to record the reasons for administering 'as required' (PRN) medicines and to record if a person refused their medicine were not routinely completed by staff. Barrier creams (used to reduce the risk of skin breakdown) were applied by care staff but were not recorded. This meant that we could not be certain that people received their medicines as prescribed. We found a small number of liquid medicines and creams that had not been dated on opening. The date of opening is important as a medicine can lose its effectiveness if stored for longer than recommended by the manufacturer.

Some medicines had been out of stock. On the first day of our visit, a relative came to advise the nurse that a person required pain relief. We found that their prescribed pain relief was out of stock, and had last been given at teatime two days earlier. The medicine was not available until the second day of our inspection. In the meantime the person had been offered a lower strength of pain relief from the homely remedies stock. In the Medication Administration Record (MAR) for August 2016, we identified two medicines that had been given at a reduced dose due to a lack of stock. In both cases the medicines were available at the prescribed dose the next day. Following our visit, the registered manager told us that a weekly stock check of medicines had been introduced. She explained that this would check that everyone had enough boxed medication for the week and, if they did not, allow for an order to be placed in plenty of time.

Staff carried out audits of how medicines were managed in the home. The most recent audit was conducted during September 2016. This had identified that not all liquids and creams had been dated on opening, as well as a number of gaps in the records. These concerns had been discussed with nursing staff and were on the agenda of a nurses' meeting scheduled early in October 2016. A new system of recording gaps so that they could be addressed promptly was due to be introduced. Although the audits had been effective at identifying concerns, we found that not all errors were clearly documented. For example, there was a record of when a pain patch had not been changed or of an incorrect dose but no record of medicines that were out of stock. Consistent recording would make it easier to audit and identify problems and to improve the systems in place.

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

Medicines were administered by registered nurses. There was clear guidance on how each person liked to take their medicines and on what to do if the person declined or if an error was made. We observed registered nurses as they supported people to take their medicines. This was done safely, explaining to each person what the medicine was for and staying with them until it was taken. Medication was stored in locked cabinets that were clean and well organised. The cabinets were attached to the wall by a chain and stored in

a locked room. Medicines that were required to be stored between two and eight degrees Celsius were stored in a fridge and the temperature monitored daily.

Staff understood how to support people safely and there was guidance on how to manage risks in people's care. We found, however, that improvement was required in how risks were monitored and in ensuring the safety and cleanliness of the premises. The registered manager was aware of the areas of concern and was taking action to make improvements in each of the areas identified.

Risks to people's safety had been identified and assessed but records did not demonstrate they had always been managed appropriately. Care records contained risk assessments which included moving and handling, falls, skin damage and walking into the village. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Action had been planned to minimise risk but monitoring was not always effective. We found gaps in the monitoring charts for repositioning, bowel health and fluid intake.

People's risk of developing pressure ulcers had been assessed using the Waterlow scale, a tool specially designed for the purpose. Although there was evidence of wounds healing and staff taking action to ensure that people had equipment, such as pressure cushions and boots, care interventions to reduce the risk of skin breakdown were not always recorded. For example, for one person who was cared for in bed, the planned care was that staff would support them to change their position every four hours. The records of repositioning included gaps of five and nine hours and did not demonstrate that they received consistent support to change their position at the planned frequency. Where people had been prescribed creams to reduce the risk of injury to their skin, there were no records of these creams being applied. This meant that people may not have received appropriate support to minimise the risk.

Staff used body maps to record any injuries or skin abnormalities, such as skin tears or bruising. We found that these had not been reviewed. Staff had recorded a blister on one person's hip, identified in August 2016. There was no further information as to the treatment offered to minimise the risk of deterioration and on whether any treatment given had been effective in healing the area. In some cases an evaluation form was present with the body map. The registered manager explained that this was an area of practice that she was addressing with staff and that registered nurses had been asked to check during the monthly care plan reviews. She told us, 'When people receive baths or showers care staff will collect the current body map from the care plan, they will then review the body map and either evaluate or update it if required or they will sign it off and put it into filing'.

There was a lack of detail on how to manage some risks that had been identified. Some people were prescribed 'as required' medicines to support their bowel health and minimise the risk of constipation. We looked at the records for one person who was prescribed an 'as required' laxative and was assisted by staff to use the toilet. The guidance for staff was to give the medicine, 'When there are indicators of constipation'. There was no evidence in the care plan that this person's risk of constipation had been assessed, or what action staff should take if a person did not have regular bowel movements. We found that bowel monitoring records were not always completed by staff and that some contained significant gaps. It was, therefore, unclear how staff would be alerted to any problem and how they would know when to administer the 'as required' medicine. Following the inspection, the registered manager informed us that bowel charts had been moved to people's rooms to prompt staff to fill them in.

The fluid balance charts did not always demonstrate that people had received adequate fluid to minimise the risk of dehydration. We found some that had not been completed after mid-morning, others with only

two entries and one that was blank. Following our inspection, the registered manager told us, 'We have adapted the food and fluids charts so they have a check box on them AM and PM which allows the allocated member of staff to sign the charts to say that they have been checked. We have also adapted the allocation sheets so that one member of staff will be allocated to check all food and fluid charts daily. This will then be monitored by me to ensure the effectiveness of the system'.

Some parts of the premises were not safe. This had been identified by the provider and a programme of refurbishment was underway. The works included levelling some of the flooring on the ground floor of the home and replacing old carpet. Parts of the home had a stale smell which was not present in the areas where flooring had been replaced. Due to the works, there were areas in the home and garden where equipment was being stored on a temporary basis. There were notices around the home to alert people and visitors to the works and potential risks. Staff spoke positively about the renovations. One care assistant said, "It's going to be a home to be proud of. We won't be embarrassed when we open the door".

Some people were at high risk of falling. We observed staff supporting people to move safely, walking alongside them and taking their hand as they went along corridors. In the staff allocation, one staff member was present in the lounge at all times. When we looked at the records of falls in the second half of August 2016, we noted that many falls occurred in the lounge and that approximately half of the falls were recorded as 'unwitnessed'. The layout of the lounge, with its adjoining television room and dining area, was such that it would not be possible for one staff member to monitor all areas. We discussed this with the registered manager and with staff. Following our visit, the registered manager told us, 'In reference to the staffing in the lounge area we have decided to trial putting two members of staff in the lounge in the afternoon when our falls are increased'.

There were many examples of good practice in relation to how staff managed risks associated with people's care. For one person at risk of falling, we saw that staff had checked the person's feet, footwear, eyesight and medicines. Following a fall at night, staff had trialled leaving a small lamp on in the person's bedroom overnight for safety. A nurse told us that some people who had frequent falls wore hip protectors to minimise the risk of injury. One person told us, "The girls look after us here very well. They come to me when I need something. I walk by myself but with a little help".

People told us there were enough staff to meet their needs. One person said, "Staff are here when I need them. They're very good really. Everything is perfectly OK". Another told us, "If I need help, I call any of the girls here and they are usually very good". Staff spoke of improvements in the staffing level. One referred to the staffing level and said, "It's safe and workable. It gives us enough staff to work around emergencies and we can spend that little bit more time with them. I used to feel I wasn't doing my job properly but I'm happy here now and I'm happy it is getting better". Another told us, "It has improved a lot. There are nowhere near as many agency staff and there are more nurses. It has made a big difference. (Registered manager) is the one who upped the staff and has employed new staff". The registered manager explained that dependency assessments were carried out quarterly. These were used to inform the staffing levels and skills mix at the home. As a result, there were two nurses working during the day and the number of care assistants had been increased. There had also been a change to shift times, with the day staff starting an hour earlier, to accommodate people who wished to rise early.

One person and one staff member expressed concerns about the staffing levels, saying that they were insufficient. We looked at the rotas for three weeks in September 2016 to check that staffing numbers had been maintained. Over the 21 days, we saw that the number of care assistants was lower than planned on one day (by one care assistant) and on two afternoons (once by one care assistant and on the other by two). At night, there were two nights where there was one fewer care assistant than planned. These gaps had

arisen due to sickness. One registered nurse told us, "Some days are short staffed but we (nurses) help on the floor. Most days we have seven (care assistants). If we are short they do try to get agency". We also looked at the call bell response times to check if there had been any substantial delay. We found that bells had been answered promptly. In addition to the planned nurse and care assistant numbers, the registered manager and deputy worked during the week and were able to step in and provide support. The registered manager was working to increase the number of staff employed. She explained that this would provide additional cover for sickness and annual leave, and mean that they worked above planned numbers on some days which would further benefit people.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. For nurses, their registration with their professional body was checked to ensure they were fit to practice. These measures helped to ensure that new staff were safe to work with adults at risk.

People told us that they felt safe at the home. One person told us, "I feel very safe living here. I get a lot of support from staff in all my needs". Another said, "I'm comfortable here. They're very good". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team. One care assistant described safeguarding as, "Safeguarding is about protecting the residents. I'd go to my senior; she'll act on what you say. Any concerns we've got are listened to".

Good

Is the service effective?

Our findings

People had confidence in the staff who supported them. One said, "Yes I am happy with the staff here, they seem to know what they are doing in looking after me. They treat me well all the time". Another told us, "I have no issues with the staff. They are good people and they care for me very well". Staff had attended training to equip them to provide support to people. One care assistant told us, "The training is great, it is very good quality". Another said, "I feel I've got support here. I've done quite a few diplomas. There is always training coming up and we have regular training about dementia". We received feedback from relatives and professionals which demonstrated how staff had effectively supported people. A relative had written a card of thanks saying, 'Without you all my Dad would not be as well as he is now'.

New staff attended a period of induction. This comprised a five-day induction training course run by the provider and shadowing of experienced staff. The registered manager had introduced the Care Certificate, which is a nationally recognised qualification for staff working in health and social care. Refresher training was delivered by external and internal trainers. Courses included moving and handling, fire safety, first aid, infection control, food hygiene, nutrition, health and safety, dementia and challenging behaviour. Nurses had attended additional courses including the use of syringe drivers and catheterisation. For staff who had been unable to attend the face-to-face training, workbooks were used to ensure that their knowledge was up to date. Once completed, the workbooks were sent externally to be marked. The registered manager was looking to develop staff skills and knowledge by introducing champions for dementia care and falls reduction. At the time of our inspection, the provider was looking for suitable training opportunities for the staff interested in these roles.

The home was registered to provide support to people living with dementia. Staff had received training in understanding dementia and on how to support people. During our visit we observed that staff provided effective support to people. When one person appeared distressed, they were quickly supported by a registered nurse and two care assistants. The staff provided reassurance which soon calmed the person down. Where people displayed behaviours that could be seen as challenging, staff recorded these to try and identify what had triggered the person's distress. A community mental health nurse said, "The staff have always contacted me to request a review or to discuss behaviours which they are struggling with, which I deem as a positive as this reflects that they are concerned about their residents, seeking advice and also reassurance that they are giving the correct care".

Although we did not witness people struggling to move around the service, we noted that the environment of the home was not adapted to meet the needs of people living with dementia. There was limited signage and no use of colour contrast to help people navigate independently. The registered manager informed us that they were considering ways to adapt the environment but were waiting first for the refurbishment to be completed.

Staff received regular supervision and appraisal. Supervision meetings gave staff an opportunity to discuss their achievements, training needs and any concerns. One care assistant told us, "We have supervision to see how we are doing and what we want to do". Another said, "The seniors will call you up on things straight

away and you get the guidance". Staff performance was reviewed annually during an appraisal meeting.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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). At the time of our inspection, 27 applications had been made to deprive people of their liberty and 18 had been approved by the local authority.

We checked whether the service was working within the principles of the MCA. During our visit we observed that staff asked people's permission before delivering care and involved them in decisions on how and where they wished to spend their time. One care assistant said, "I would never do anything without asking, they've got to make a choice about everything they can". Another told us, "These people have got choices and they should be asked". Information on the MCA and DoLS was displayed for staff to refer to. Staff had received training in the legislation and understood how to put this into practice.

People's care records showed that they had been involved in planning their support. Some people had signed their care plans to demonstrate their agreement, for others it had been noted that verbal consent was gained. Where people were unable to consent, representatives had been involved in agreeing the care plan, either if they had authority under a Lasting Power of Attorney or as part of a best interest decision on the person's behalf. The registered manager had been involved in setting up an advocate for one person. Advocates work with people to support them in important decisions and to provide an independent voice. We noted examples of decisions, including the use of bed rails and the covert administration of medicines, which had been assessed and agreed in line with the MCA in people's best interests. A social worker told us, "(Registered manager) is on the ball about the MCA and acting in people's best interests".

People enjoyed the food and told us that they were offered a choice. One person said, They ask me what I want to eat and where I want to eat every day". A whiteboard displayed the menu for the day, along with alternatives that were always available, such as jacket potatoes. Each day, a member of the kitchen team asked each person what they wished to eat. There were pictorial menus showing the dishes available to assist people in making choices. The chef had clear information about people's dietary needs and preferences, for example if they were diabetic or required the texture of their food to be modified to reduce the risk of choking. Fortified drinks were provided to people who were at risk malnutrition or who were losing weight to boost their calorie intake.

There was a positive atmosphere during the mealtime. Some people chose to eat in the dining areas, whilst others sat in the lounge or their bedrooms. Staff offered clothes protectors to people and informed them of the dish served. Some people used plate guards to enable them to eat independently. Others received support from staff. We observed that staff supported people at a pace that suited them and engaged with them throughout the mealtime. One person told us, "I am supported in eating my food because I have poor co-ordination". People were supported to drink enough to meet their needs. Drinks were available in the lounge area for people to help themselves. Jugs of squash or water were also available in people's rooms, along with a full glass readily to hand. When one person appeared to be struggling with their milkshake, staff responded quickly by assisting them a spoonful at a time. This reduced the person's coughing and enabled them to finish the drink.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. One person told us, "I get to see a doctor whenever I have needed one. The girls bring the doctor to me or they take me to see one". Another said, "I am diabetic and I have gone for eye screening to make sure things are fine". We noted examples of referrals to the GP, mental health team, physiotherapist and occupational therapist. Professionals told us that staff worked effectively with them to ensure that people received appropriate support. A social worker said, 'Staff took on board added input from mental health professionals and adapted their approaches accordingly'. A community mental health nurse said, 'They will make time to discuss my patients and any concerns that they have. The documentation has improved and they have taken on board as to what I expect from them to help with my assessment'.

Good

Is the service caring?

Our findings

People spoke highly of the staff who supported them. One person said, "The people here are kind and lovely". Another told us, "The carers are caring and thoughtful". Relatives were equally complimentary. One said, "The staff here are really caring people and they seem to do it with a genuine heart". Another had written a note of thanks which read, 'I knew she was receiving the best possible care, nothing was too much trouble, everyone had a smile and a kind word to say'. Throughout our visit we observed staff engaging with people. Staff appeared to know people well and talked about topics that interested them. We observed a registered nurse speaking to one person as they administered medicines, chatting about the person's daughter who had visited that afternoon. Although the person appeared to have forgotten about this visit, they smiled contentedly when reminded. Much of the feedback we received related to the nature of the staff. In response to the provider's survey, one relative had written, 'I would urge people to look past the decoration to the quality of staff'.

People were involved in planning their care. Where they were not able to do so, staff had involved people who knew them well so as to understand the person's wishes and preferences. One person told us, "Oh yes I do make my own choices: food, what I wear and when I want to go to bed". Another said, "I get involved in decision making of my care plan, for example putting bed rails on my bed and how I want them to be". A third person commented, "They listen to the things I say or ask". We saw that people had expressed their views on whether they preferred to be supported by male of female staff and under which circumstances they would wish to be admitted to hospital. Daily notes provided further examples of people's involvement. For one person we read, 'Offered him (name of pain relief) as prescribed and he declined, offered him paracetamol and he consented'.

Each person had a communication care plan which set out how to engage with them. This included whether they needed any aids, such as hearing aids, glasses or dentures or if they found it easier to communicate by writing things down. In one we read, 'I may not be able to make complex decisions, however keep me involved in every day decisions. I need staff to sometimes ask closed questions in order for me to be able to answer them easily, these may be 'Are you in pain?' 'Would you like a cup of tea?''. We observed staff using a variety of communication methods to speak with people. When a care assistant offered one person a drink they appeared unsure. The care assistant then walked with the person to the drinks so that they could see the options. The person was then able to choose. We found that staff involved people and respected their decisions.

People were encouraged to be as independent as they were able. One person told us, "Though I can do some things on my own, they do help me with so much daily". We observed staff encouraging a person to stand and allowing them time to try. When they were unable to stand independently, staff used a hoist to help them transfer. People's care plans included details on the tasks they were able to complete, and on where they required assistance from staff. For one person, who ate their meals in bed, there was detail on how the table should be positioned, 'To aid independence' and provide a comfortable position. A social worker shared an example of how a short-stay at the home had enabled one person to return home. They wrote, 'A case I worked on with the staff at Beechwood restored his confidence to such a level he returned to

his own home, as opposed to permanent placement'.

People told us that staff treated them respectfully. One person said, "They listen to me and my worries. I am happy with the way they treat me". Another person told us, "I am being looked after very well. They respect me in everything". In response to the provider's survey, one person had described the staff as, 'Courteous'. A social worker said, "They do seem to genuinely care and they treat residents with a lot of respect". Throughout our visit we observed that staff were mindful of people's privacy. They respected their choices and wishes and supported them in a sensitive manner. When one person returned to the lounge with wet trousers, a staff member quietly assisted the person out of the communal area to change. A relative said, "From what we see, it seems that all the staff here are very caring and kind people. They seem to like what they do. They treat the residents here very well and with respect".

Good

Is the service responsive?

Our findings

Staff knew people well and understood how they liked to be supported. When a person moved to the home they and their relatives were asked for information about their experiences and interests. Each person had a care folder which detailed their daily support needs. Information was arranged into sections such as communication, mobility, eating and drinking, medicines and sleep. After each care plan there was an evaluation sheet. This was completed monthly (or when there was a change) by registered nurses, often in conjunction with people, their relatives and relevant healthcare professionals. Staff told us that the care plans were useful and that they provided detailed guidance on how people wished to be supported. One care assistant said, "The care plans are good and handover gives you any new information you need to know". A social worker had written to the registered manager to say, 'Thank you and your staff for the welcome received today when I attended Beechwood to assess (name of person). Just to reiterate the care plans were all up to date, informative and comprehensive'.

Staff responded to changes in people's needs. One person said, "Being in this wheelchair, I cannot do most things by myself so I rely on them more and they are so helpful. They always ask me if I need anything done or help with anything". A care assistant told us, "You pick up on little things and you address it to the nurse. You get to know things that are a little bit out of character". We noted examples where staff had taken action to ensure that people's needs were met. For example, one person was in pain but refused to take oral medicines to counteract this. As a result staff arranged a review with the GP and a pain patch was prescribed. A social worker told us, 'I have witnessed the staff question the trajectory of care to ensure accuracy and relevance of intervention'. They gave the example of a person who was nearing the end of their life. They wrote, 'Rather than wait reactively, the staff had alerted both myself and continuing healthcare colleagues to ensure the prompt availability of palliative and end of life care'. Staff were made aware of changes in handover meetings, for example they were advised that one person was at increased risk of falls because they had started to take a new medicine that could cause drowsiness.

Care plans included details about people's life story and their interests. This was used by staff to get to know them and to engage with them. The activity coordinator used this information when planning activities. She told us, "I read all the 'This is me' when I started to find out what they did and what they like. It's finding something that they remember". As some people used to play football at a high level, there were games and activities involving ball skills. The activity coordinator said, "With the big ball (name of person) will get up off his chair and kick the ball". There were also regular armchair exercise classes. Some people enjoyed reading and there was an arrangement with a local library to regularly renew the books in the home. Others visited a local coffee morning two days a week in the village. People told us that there had been improvements in the activities, after they went some time without activity staff. A new activity coordinator had started in post two months prior to our visit. A volunteer also visited the service four days each week and ran quizzes in the morning. One person told us, "It's busy enough to keep you thinking".

People who preferred to spend time in their rooms were offered the opportunity to participate in activities. The activity coordinator had recently started working an additional day, when external entertainers were booked. This allowed her to focus on spending one to one time with people. People told us that they were

happy with the social contact. One person said, "I also like animals but I don't get involved in activities. The lady tries to do animal games in my room here which is good". Another person said, "I like sitting in my room and watching my TV and they respect that". A third person told us, "They sit and chat with me".

People felt able to raise concerns with staff or the registered manager. One person said, "I feel the communication between us and the staff is very good. I am free to ask anything I want. They will listen to me". Another person commented, "I can't think of anything to complain about as I always talk to them and make my feelings understood". A relative said, "We have not had any reason to complain of anything but if we did, we would speak to the manager. I talk to the girls here all the time". During our visit, one family came to meet with staff to discuss some concerns relating to their relative's care. The points raised were discussed and actions agreed. The actions were documented in the person's care plan for future review. The registered manager was open to receiving feedback on the service. She told us, "If I don't know about the issues, I can't address them".

The complaints procedure was displayed in the home and was detailed in an information guide about the service. This explained how to make a complaint and the anticipated timescales for response. We looked at a complaint that had been received during 2016 and found that it had been investigated and addressed. Most people told us that they had not had cause to complain. One person said, "There is nothing for me to complain about the service here. They are all good and they look after us very well". A relative added, "I have nothing bad to comment about the services that my husband gets in this home. The staff here do a good job".

Good

Is the service well-led?

Our findings

There was a friendly and welcoming atmosphere at the home. People were relaxed and engaged. People, relatives and staff told us that they were able to approach staff if they had any concerns or suggestions. In the welcome pack, people were encouraged to share their views. We read, 'Our approach is friendly, open and honest. If at any time you have cause to be unhappy with the standards of care received, for whatever reason, please (details of who to contact) and we will do our best to provide a satisfactory solution'. A social worker told us, "Beechwood are always very flexible. They have a good open door policy".

The registered manager, who was also a registered nurse, had been in post since November 2015 and registered with the Commission in June 2016. We received lots of positive feedback about the registered manager and improvements in the home. One person told us, "I don't know the name of the manager but I know who she is. She's a very lovely and caring girl". A care assistant said, "Since (registered manager) has been here there is more variety in the food and the staffing levels have gone up". Another staff member told us, "I did have concerns about continuity of care but (registered manager) has turned it around. We now very rarely use agency. It's given me peace of mind". A third staff member commented, "If we go to her (registered manager) and ask for something, she pushes for it to be changed. She listens and she works with you". Feedback from relatives included, "I must say it has come a long way as you can see there is a lot of work being done to it now thanks to the girls" and, "I feel that the home is well led especially considering where it has come from. Obviously there is a lot of work going on now and I think it is for the better".

The registered manager was supported by a deputy manager and there were regular staff meetings. In the minutes of recent meetings we saw that learning from incidents had been discussed. There was also a review of actions agreed at the last meeting and an opportunity for staff to make any suggestions. Concerns raised had been addressed, for example the lack of activity whereby a new activity coordinator had been employed and the purchasing of new equipment such as airflow mattresses. One care assistant told us, "Staff meetings are open. Everyone has a free for all". The agenda for forthcoming staff meetings was displayed and staff were able to add points they wished to discuss.

The registered manager had systems in place to monitor the quality of the service and to make improvements. People and their relatives had been asked for feedback during March 2016. The results had been analysed and actions agreed. In response to a suggestion for more information on services such as the hairdresser and chiropodist, staff had created a 'welcome pack' as a guide to the services available. Another relative commented that they were not always informed of healthcare appointments but added, 'This has changed within the last month and I have been informed about every visit and the recommendations following a visit. Recent communication is excellent'. The feedback was largely positive, the main issue appeared to be the condition of the environment which one relative described as 'depressing and drab'. This was being addressed by the ongoing refurbishment of the service.

There were regular audits of the service which considered whether they were meeting the regulations. These were carried out annually and followed the domains used in our inspections: Safe, Effective, Caring, Responsive and Well-led. There were more frequent audits of medicines, falls and infection control and six

monthly audits of the service carried out by a representative of the provider. External audits had been completed by the pharmacy and by fire safety consultants. Following each audit an action was agreed and there was good evidence of progress. For example, staff had received updates in safeguarding training, pedal bins had been purchased for the toilets and new weekly checks on the stock of controlled drugs had been introduced. In addition to her management duties, the registered manager regularly worked shifts as a nurse, including at night. This enabled her to monitor the delivery of care, review staff performance and see how the systems in place were operating.

When incidents occurred, the registered manager used a tool to analyse what had happened and to identify improvements that would reduce the likelihood of a repeat event. This is called a 'root cause analysis' tool. It had been used following incidents, such as falls or injuries and also to consider complaints that were received. The registered manager was well aware of the areas of service that required improvement and in many cases, actions were already underway to address concerns. A social worker told us, "(Registered manager) is very hands on, very proactive. If you ask her to do something she does it".

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12 (2)(g)