European Wellcare Homes Limited

Beechwood Specialist Services

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection carried out on 23 July 2015. We carried out this inspection at this time due to information we had received from the police and Local Authority regarding the safety of people living at the home.

Beechwood Specialist Services is registered to provide accommodation and support for up to sixty adults who require support with their mental and physical health. At the time of the inspection 50 people were living at the home, many of whom were younger adults.

The building is a large detached property located overlooking the seafront in Aigburth. It provides people

Summary of findings

living there with their own bedroom and shared lounges, dining areas and bathrooms. Due to the size and layout of the building it does not provide a domestic style of living for people.

The home does not have 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.

We last inspected Beechwood in July 2014. At that inspection we looked at the support people had received with their care and welfare and whether they had been supported to consent to their treatment. We also looked at the premises, recruitment of staff and how the quality of the service was assessed by the provider. At the July 2014 inspection we had found the provider had met regulations in those areas.

At this inspection we found a number of breaches related to person centred care, safe care and treatment, safeguarding service user's from abuse and improper treatment, premises and equipment, good governance and staffing.

You can see what action we told the provider to take at the back of the full version of the report.

Some of the people living at Beechwood told us they did not wish to live there. They were unable to leave the home unaccompanied and had little to occupy them during the day.

Parts of the environment were unsafe, shabby and unsuitable for the people living there.

People were not consulted about their care and did not receive therapeutic support to enable them to manage their mental or physical health.

The registered provider did not meet the requirements of the Mental Capacity Act 2005 (MCA). They had not applied for and received Deprivation of Liberty Safeguards (DoLS) for people who needed them. This meant people who did not wish to live at the home were denied their legal rights.

Systems and processes for reporting potential abuse and keeping people safe did not work effectively.

Care plans did not provide up to date information to inform staff about people's support needs. Where people's needs had changed their care plan and therefore guidance to staff had not been updated. This placed people at risk of receiving unsafe care.

Staff did not receive the support and training they needed to effectively carry out their role of supporting people with complex needs

Quality assurance systems were in place but did not operate effectively enough to ensure people received a safe, effective caring, responsive and well led service.

Staff did not receive the training, support and supervision they needed to support people with complex needs.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems and processes in the home did not operate well enough to prevent abuse occurring or to reduce the risk of it recurring.

Parts of the premises was unsafe and in need of repair.

There were sufficient staff working at the home however the way they were deployed did not always benefit the people living there.

Medication was safely managed in the home.

Staff recruitment processes were safe.

Is the service effective?

Inadequate

The service was not effective.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Proper policies and procedures had not been followed to ensure people's legal rights were protected and they were not detained unlawfully.

Staff had not received the training they needed to support people with complex needs.

Staff had not received the support and supervision they needed to carry out their role effectively.

People's needs were not re-assessed in a timely manner and guidance to staff was out of date. This meant people were at risk of receiving unsafe care.

The premises were shabby and did not meet the needs of the people who lived at the home.

Is the service caring?

Inadequate

The service was not consistently caring.

A number of people living at Beechwood did not wish to live there.

People were not consulted about their care plan, important decisions about their care, the support they received or the running of their home.

Complaints had not been acted upon in a robust manner.

People liked and trusted the staff team who supported them.

Staff treated people with dignity and respect.

Is the service responsive?

Inadequate

The service was not effective.

Written guidance for staff was not up to date or accurate. This meant that the care provided for people was at times unsafe.

Summary of findings

There were few activities or ways to occupy people living at the home. This meant that people were bored and not receiving the therapeutic support they needed to live with their condition.

People were able to make smaller everyday choices for themselves. However they were not able to make more important decisions such as whether to go out.

Is the service well-led?

Inadequate

The service was not well led.

The home did not have a registered manager in post.

No formal systems were in place for obtaining and acting upon the views of the people living at the home.

Systems and processes for assessing the quality of the service had failed to lead to improvements for the people living there.

Staff did not always feels supported when dealing with people with complex needs.

Historical issues in the home including staff sickness and absence were being addressed. A new management structure was welcomed by staff who felt this would lead to improvements to the service that would benefit the people living there.

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 23 July 2015 and was unannounced. The inspection was carried out by a team of five inspectors. The team included a lead Adult Social Care (ASC) inspector, a second ASC inspector, an ASC inspection manager, a bank inspector and a specialist advisor (SPA). The SPA was a Nurse with expertise in supporting people with their mental health.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the manager since our last inspection in July 2014. We also spoke with the police and with the Local Authority who commission services for people living at Beechwood.

We carried out this inspection at this time due to information we had received from the police and local authority regarding the safety of people living at Beechwood. Therefore we did not have a Provider Information Return (PIR) available. 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.

During the visit we spoke with nine of the people living at the home and met with several others. We spent time observing the support provided to people. We also spoke with two relatives of people living at Beechwood, 22 members of staff including the appointed manager and with three visiting professionals. We looked at shared areas of the home and visited people's bedrooms. We also looked at a range of records including 11 care plans, five staff records, medication records, and records relating to health and safety.

Inadequate

Is the service safe?

Our findings

We asked three of the people living at Beechwood if they felt safe living there and they told us that they did. People told us that they had received their medication on time and that when they needed pain relief this had been given to them in a timely manner. One of the people living there told us that staff had supported them with a recent medication change, they told us, "I am quite impressed with that."

The people living at the home told us that they would feel confident to raise any concerns or safeguarding fears that they had with staff. They said they thought staff would take appropriate action.

Staff had undertaken training in recognising and reporting abuse and they displayed an understanding of the indicators of abuse and their role in reporting this. A policy was available to provide further guidance and staff knew how to report to external authorities if they needed to do so.

Staff told us that they were aware of the provider's whistle-blowing policy and knew how to use it. Whistle-blowing protects staff who report something they think is wrong in the work place.

We looked at the safeguarding arrangements in place to protect people from harm. We saw that there were up to date safeguarding and whistleblowing policies and that these were displayed in various places in the home.

We found that in practice the arrangements for safeguarding adults living at Beechwood had not worked. The service had recently notified us about an incident alleged to have occurred in 2014 which had not been acted upon by senior staff working at the home at that time. More recently staff had failed to report concerns about another member of staff in a timely manner. This meant that vulnerable people living at the home remained at risk of a potential assault.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes in the home did not protect service users from abuse.

The report of our inspection in July 2014 stated, 'we found that the premises were secure and met the basic needs of people using the service, the standard of maintenance is low' our report said 'several areas require urgent attention to prevent them becoming risks to people's safety.' Work had since been undertaken in response to a fire risk assessment, this included replacement doors and smoke detectors. Work had also been undertaken on drainage systems and refurbishing bathrooms and shower rooms. However we found at this inspection that some areas of the home were unsafe and presented a risk to people's safety. This included a broken break glass on a fire door, missing flooring, windows on the ground floor that did not close and radiator covers that were not fixed to the wall.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the premises were not properly maintained.

We looked at the systems in place for supporting people with their medication. We found that there were safe systems in place for the ordering, receipt, storage, administration and disposal of medicines, including controlled drugs. Policies and systems were in place to provide guidance to staff on how to manage people's medication safely. We were told that one of the people living at the home currently managed one item of their own medication for themselves . We were also told that nobody else was able to manage all or part of their medications alone or with support. Assessments of people's ability to manage or learn to manage all or part of their medication had not been carried out. Being able to manage some of their medication would increase people's independence and the control they had over their own lives.

Staff knew how to record any accidents or incidents that occurred and the reasons why they needed to be recorded. We saw that accidents and incidents were monitored to establish if any patterns were emerging and / or what action could be taken to minimise the risk of recurrence. In discussion with staff they knew what actions to take in the event of an emergency, this included responding to a fire alarm or a medical emergency.

The people living at the home told us that they thought there were enough staff available to meet their needs. Staff had a different view telling us that there had been times when they had been short staffed. They told us this did not impact on the care people received but meant, "We work two or three times as hard." Staff told us that the manager was dealing with staffing issues by recruiting, using regular

Inadequate

Is the service safe?

agency staff and offering extra shifts. We saw that there were changes being made to the home's staffing structure and systems and this had been shared with the staff team at meetings.

The manager told us that staffing levels had recently been significantly increased and staff rota's showed that staffing levels had been consistent. We saw that there were high staffing levels; however there were a number of people being supported on a one to one basis. Clear records were maintained of the one to one support people were entitled to and of who had provided this support. Throughout the day we saw people receiving the one to one support they had been assessed as needing. This one to one support appeared to concentrate on keeping people safe and we saw no evidence that it was used to enhance the quality of people's lives.

We had concerns about how staff were deployed as the current arrangements did not benefit the people living at Beechwood. For example in one dining area at lunch time there were two members of staff assigned to support four people. The facilities for preparing hot drinks were located some distance away this meant one of the staff was missing for some time. This left one member of staff supporting four people all of whom required help to eat. At other times we saw staff standing up for long periods of time in the lounge areas, this could be intrusive and intimidating for the people living there.

Staff told us that there had been an on-going issue at the home with high levels of staff sickness. One member of staff explained this had recently, "Calmed down" with another member of staff explaining, "New managers are tackling sickness and lateness." We talked with the manager and he told us that a number of staff were currently under performance management procedures. We saw evidence of these on-going meetings and investigations relating to staff conduct and practice. This robust management of staff absence has led to less staff sickness and should provide more stability for the people living at Beechwood.

We looked at recruitment processes in the home and at five staff files. We saw that all the required checks had been carried out prior to the staff members commencing work in the home. We saw that all staff in the home had a Disclosure and Barring service (DBS) check completed. We also saw that the registered nurses personal identification numbers (PIN) had been checked to ensure that the nurses were currently registered with the Nursing and Midwifery Council (NMC) as fit to practice. These checks helped to ensure staff were suitable to work with people who may be vulnerable.

We recommend that the service assess the way staff are currently deployed to ensure arrangements are beneficial to the people living at Beechwood.

Inadequate

Is the service effective?

Our findings

People living at Beechwood described meals as, "eatable," and "okay." They told us that they had a choice of meals, although one person commented cooked breakfast was no longer available and they missed this. People told us that they did not wish to live at Beechwood and that they believed they were not allowed to go out without a member of staff agreeing to this and accompanying them.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The registered provider had not acted lawfully and in keeping with the latest guidance around Deprivation of Liberty Safeguarding (DoLS).

We found that several people living at the home had a DoLS in place but these had expired. For example one person's DoLS had expired in October 2014, another person's had expired in June 2015. This meant people were being cared for unlawfully, without the legal protection they were entitled to. The manager told us that they were aware of this and had begun the process of applying to renew the expired DoLS.

We spoke with five people who told us they did not to wish to live at the home, three of whom told us they did not know why they were living there. They also told us they were not allowed to go out of the home without staff accompanying them. One person told us they were unsure of why they could not go out and added, "They don't let people out of here." Another said, "No, can't go." When we asked people what prevented them going out they told us, "Staff."

We looked at records for two of these people. One person had a DoLS that had expired in October 2014. We were told the second person also had an expired DoLS but the paperwork could not be located. This person's care plan said they were at risk of absconding, were not safe to leave the building alone and must be accompanied. We saw no legal basis for either of these people having to stay at the home without their consent or to be informed they were not able to leave unaccompanied. The lack of clear care planning and an agreed Deprivation of Liberty Safeguard for people meant that their legal rights were not being protected.

Two of the people we spoke to had been assessed as not needing a DoLS to live at the home. However one person told us, "I am escorted everywhere, I don't want to live here, I want to move on, I don't know the codes to the doors to get out." This means that the person may be being deprived of their liberty unlawfully and should have had an application made for a DoLS in order to protect their legal rights.

This is a breach of of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people were being deprived of their liberty without lawful authority.

Staff told us that they had undertaken on-line training. However they also told us that they did not feel this had been of great benefit to them. One member of staff commented "It doesn't stick in your mind."

We asked nine members of staff if they had received training specific to the needs of the people living at Beechwood. As a specialist service they support people with a variety of complex needs, this includes people who have Huntington's disease and a number of people who have Korsakoff syndrome. Staff told us they had recently had training in diabetes and end of life care but other than that they had not had recent training in specific conditions people living at the home required support with. One member of staff told us, "I haven't done any," and another commented, "We don't have any." Other staff told us that they had some specific training but this was many years ago. Staff told us that they would welcome more specialist training in order to understand the needs of people living at the home better.

We looked at staff training records and saw that the home had achieved 91% compliance with the provider's staff training requirements. We could see that staff had received training however we had concerns regarding the quality of the training. We saw from the training records that staff covered a number of complex subjects in one day. For example we saw that one staff member had completed

training in 13 subjects on one day, another member of staff had completed training in 11 subjects on one day and a third member of staff on six subjects in one day. These had included dementia, conflict resolution, Deprivation of Liberty, fire safety, first aid, food safety and moving and handling and had been via on-line learning.

This raised concerns with us about the quality of the training and how much staff had benefitted from the training. Beechwood provides specialist services to adults with differing and complex needs. It is therefore important that staff are provided with up to date information and knowledge on the affects the condition may have on the person, their health and their behaviour and the differing support they may need.

We asked about staff supervision and were told that this did not currently take place. The manager told us that they had identified this and they were in the process of setting up a system for supervision. We asked to see previous supervision records and were told that there were none available. This caused us considerable concern as staff were supporting people who had very complex needs and we could not see that they were receiving appropriate support to do so.

This is a breach of of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff were not receiving appropriate training and supervision to enable them to carry out their duties.

Two visiting health professionals told us that staff had appropriately contacted them to support people with health issues. They also confirmed that staff had followed any health instructions they had been given. A third visiting health professional told us that staff were good at recognising when people's needs had changed and informing them.

During the lunch time meal we observed one person beginning to choke. Staff told us that this person's health had recently deteriorated and they were giving them a soft diet and thickened fluids. However when we looked at the person's care file we could not find a nutritional plan for supporting them. We saw that a dietician had assessed the person in March 2015 and at that time had said no nutritional support was required. We saw no evidence that an urgent re-referral had been made to provide staff with guidance on how to safely support this person with their meals. We also observed that staff moved this person in a way that was unsafe for the person and themselves. We were told that a referral had been made for advice on moving this person but no up to date guidance had been provided for staff to currently follow. This meant that the person's safety was at risk.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because care and treatment was not being provided in a safe way.

Adapted bathrooms and shower rooms were available through the home and we saw that corridors and lounges provided sufficient space for people who used a wheelchair to get around.

The appointed manager told us that a large scale refurbishment and re-design of the premises had been agreed by the provider and this was confirmed by senior staff from the organisation. This plan included splitting the building into four separate units, each would cater for up to 12 people and would include facilities to promote people's independence, such as smaller kitchens people could cook in.

Our inspection report from July 2014 states, 'The property was in need of refurbishment, both internally and some external areas. We saw that a major refurbishment programme had been approved and funded by the provider. The manager told us that implementation was due to commence in the following few weeks and would include replacing furnishings and fittings.

A refurbishment plan was also shown to us during our inspection in June 2013 and we were told then that work was due to begin in the near future.

During this inspection we found that neither plan had been fully implemented and that the design and layout of the building was unsuitable for the people who lived there. We saw no evidence that it was designed to support people living with dementia to find their way around easily, we also saw no evidence that the building met good practice guidance in providing a homely environment for younger adults and for people living with dementia.

We found it difficult to locate which part of the building we were in easily, signage was poor and bedrooms doors were not clearly labelled in a way that would support people to find their bedroom. Dining rooms and lounges were large

scale and appeared institutional rather than homely. We saw that one lounge was painted a very dark purple, the people using this lounge had dementia and appeared frail. The television set in this and another lounge had not worked for several weeks and people were spending their day sat in a dark, dismal room with little in the way of relief apart from a radio which crackled. Staff told us that both lounges upstairs had not had working televisions for several weeks. Following the inspection senior staff informed told us that the television had broken on 15 July and replacements had been ordered on that date, arriving at the home on 30 July 2015.

We saw one person's bedroom which had a missing curtain pole and no curtains at the windows. Another bedroom had a hole in the wall, paintwork throughout the building was stained and chipped, ceiling tiles were missing, parts of flooring was missing, table cloths were stained and we saw that gloves, aprons and clinical waste bags were on display in a bedroom and bathrooms. This gave a clinical appearance to the home and did not promote people's dignity.

Overall the home appeared institutional with care provided on a large scale for people. It did not promote the principles of care associated with supporting people living with dementia or supporting people with enduring mental health needs.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the premises and equipment were not suitable for the purpose they were being used for.

We observed the lunchtime meal in four of the dining areas within the home. We saw that people were offered a choice of meals and drinks, support was provided discreetly and people received the support they needed.

A relative told us that staff had addressed their relatives weight loss by following guidance received and ensuring the person had a higher calorie intake, for example by having full fat milk.

The majority of the care records we looked at contained a nutritional risk assessment and evidence that the person had been regularly weighed.

Staff told us that there was an on-going issue in the home with cutlery and crockery. They explained that although this was re-ordered regularly there were times when there had been insufficient amounts available in the home for everyone to eat their meal at once. Their comments included, "We struggle at mealtimes for spoons, simple things like this, sometimes there is only two mugs for four people,", I've washed a fork before having to use it twice" and "Staff members brought bowls in from home at the weekend." "This happens quite a lot."

Inadequate

Is the service caring?

Our findings

People living at Beechwood told us that they liked the staff team. Their comments included, “Staff are really good, not nasty," and "All people really look after you." One person told us that they trusted the staff team and the advice they gave and another person commented, "This place is wonderful. They really do help."

we spoke with nine people living at the home, six of those people told us that they did not want to live there, one person told us they were happy living there and the other two people did not discuss their view. Their comments included, "I wish they would let me out, it’s good for older people" "I’m telling my social worker, telling him I don’t want to be here" and "I don't like living here."

We asked 14 members of staff if they would be happy for someone they cared about to live at the home. Several members of staff chose not to answer and two members of staff said they would. However six members of staff told us they would not place someone they cared about at the home at the present time and a further three told us it would depend. Staff said this was because of the current layout of the building and the environment. Their comments included, "It depends on what part of the building you are in," and " I’ve been to worse nursing homes." One member of staff commented, "They (the organisation) are doing something about the environment."

We saw little evidence that people living at Beechwood were involved in planning the care they received or in the running of their home. One person told us that there was a residents committee but when we asked how this worked they responded, "I don’t know. They ask you questions. Half the time the questions they ask us I don’t care about," we asked how this committee worked and they told us "It's not working."

We asked for minutes of any meetings with the people living at the home but these could not be produced. One of the people living there told us they would like a weekly meeting to be arranged so they could discuss the things they did and did not like. Following receipt of the draft report the provider forwarded a copy of a meeting held on 3rd July 2015 with people living at Beechwood. This did not contain detailed minutes of the meetings but did contain a list of activities that people had discussed. The meeting record did not demonstrate that people had been asked for their views of the service nor did it contain any information on the action the provider intended to take as a result of the meeting. Following receipt of the draft report the provider pointed out that they had taken part in an external quality assurance survey to find out peoples views of the service they received. This MORI survey found that 85 percent of people who responded were satisfied with the care and service they received. This was not reflected in our findings on the day of the inspection.

We asked three people if they had a key worker and if so what their role was. Their responses were, "Don’t know, hardly see them," "I don’t have one," and "I think they are quite good." Staff told us that a key worker system had recently been set up and "We were just told," who they were keyworker for. They said the people living at Beechwood had been told who their keyworker was but had not been consulted as to who this would be. The role of a keyworker is to build a relationship with the person and provide support to them, it is therefore important that the person likes and trusts them. Not consulting with the person as to who their keyworker is means the relationship has less opportunity to work successfully; it also shows a lack of respect for the person and their right to make decisions about their care.

A relative we spoke with told us that they had been told they could look at their relatives care plan if they wished and they said that they had been kept informed of any changes to the person's health or support needs. Three of the people living at Beechwood told us that they had not seen their care plan and had not discussed it. A senior member of staff explained to us that people living at the home, their relatives and staff were involved in planning the person's care. However they said, "At the minute most of the care plans are not involving the service user as much as liked." We did not see any evidence within care plans that the person or their relative had been consulted about their care plan or the contents.

We were told by a senior member of staff that people had received support from advocacy services including an Independent Mental Capacity Advisor if needed. However we saw no evidence that advocacy services had been regularly used within the home to support the people who lived there.

The manager told us that he was aware some of the people living at Beechwood may be able to move to more

Inadequate

Is the service caring?

independent living accommodation. He told us that he intended to work with people in the future to support them with this. At the time of the inspection no plans were in place for anybody to move on and we saw no evidence that people were being supported to maintain or to gain independent living skills. Staff told us that this was difficult at the present time as they had, "No facilities" to support people. They said that once the planned refurbishment of the building took place this would improve. We asked staff if they felt some of the people living at Beechwood would benefit from a more independent environment and they told us that they did. Their comments included, this is not the right environment for some of them' and that some people were, "stuck" living there. The majority of the people we spoke with who lived at the home told us that they wanted to live elsewhere.

Three of the four care records we reviewed contained a "do not attempt cardio pulmonary resuscitation" (DNA CPR) form. They were signed by the GP and the name of the family member who had been consulted was given. The UK resuscitation council recommends that these decisions should be communicated and explained to the person. Otherwise there should be clear documentation of the reasons why that is impossible or inappropriate. We were not able to locate evidence that this recommendation had been followed.

These examples showed us that people were not consulted about their care.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because care and treatment was not designed with a view to achieving service user's preferences.

Throughout the inspection we saw staff provide people with privacy, knock on their door and await permission before entering the room and provide support with meals in a way that supported the person's dignity.

Relevant staff had received training in providing end of life care and care records showed that people had been referred for appropriate medical support. This included the involvement of the community matron and a GP with a particular interest in supporting people through this stage of their lives.

Inadequate

Is the service responsive?

Our findings

Care plans we looked at contained a document titled, 'My Health Passport' which gave a brief summary of the person's care needs, presented in a format that was clear about risks to the person as well as their needs and preferences, and how they should be met.

Care plans also contained comprehensive assessments for assessing risks such as nutrition, mobility and activities of daily living. Not all of these had been recently reviewed. We looked at a plan for one person whose health had deteriorated recently, this had significantly impacted on their activities of daily living and the plan had not been updated for two years.

During the lunch time meal we observed staff responding to a person who was choking on their meal. We saw that staff used poor manual handling techniques and when we asked we were told that the person's health had deteriorated rapidly and they were currently being assessed for manual handling lifting aids but none were currently in place for the person. Their care plan did not contain a manual handling plan to guide staff and we also found that their mobility care plan was out of date.

A second person told us that they no longer had their walking frame and staff confirmed that they had been assessed as unsafe to use this. However their care plan dated February 2015 stated they used their walking frame.

The inaccurate and out of date information within care plans meant that staff did not have up to date guidance to follow in order to support people safely.

Some of the relatives we spoke with told us that they had in the past raised issues with staff and that these had been addressed. They told us that they felt comfortable raising their concerns. The people living at Beechwood also told us that they would feel comfortable raising concerns with staff and that they were confident staff would help them sort their concern out.

The home had a complaints policy that was on display for people to access, this was up to date and had been reviewed. We asked about a complaints record and saw that there had been only two complaints recorded. We had concerns about the complaint log which we shared with the manager. They agreed with us that complaints had not been recorded or properly managed. We were also aware of a number of complaints that relatives had told us about that had not been recorded or resolved to their satisfaction.

T**hese are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes did not operate effectively enough to assess, mitigate and monitor risks relating to the health, safety and welfare of service users and feedback from relevant people had not been listened to, recorded and acted upon appropriately.**

During the morning of our inspection we did not see any of the people living at the home engaged in meaningful activities. We asked the people living there what they did with their time and their responses included, "Watch TV, don't do nothing," "Boring," and "I spend most of my time in my room." People told us they would like to take part in activities such as fishing, visiting family and generally going out. In the afternoon some people went out on the mini bus to a welsh village.

Staff told us that the home had recently purchased two new mini buses and two people carriers. Transporting people in a mini bus on outings with groups of other people is not in keeping with the principles of care for younger adults including promoting ordinary lifestyles within their local community and being involved with the running of their home, including everyday tasks such as gardening, laundry and cleaning.

Two of the lounges upstairs were used by people who needed more support due to their health. The televisions were broken and a radio in one lounge crackled. A member of staff told us that during the afternoon they turned people's chairs around to watch the ships on the river outside as other than that there was little visual stimulation for people.

People told us they were able to make everyday decisions for themselves with one person explaining, "What time we get up, those kind of decisions." However they said other decisions such as how to spend their time and if they could go out were not made by them. People did tell us that their families could visit whenever they wanted.

Inadequate

Is the service responsive?

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the care and treatment provided for people did not meet their needs or reflect their preferences.

Inadequate

Is the service well-led?

Our findings

No formal systems for obtaining the view of the people living at Beechwood, their relatives and staff were in place. We saw that some staff meetings had taken place but these had been inconsistently held. We were told that there had been meetings for the people who lived in the home but when we asked there were no records of these available,. The provider has since forwarded a copy of one meeting that took place in July 2015 with people living at the home, this did not contain evidence that they had been asked their views of the service provided. We asked about meetings for relatives of people who lived in the home and we were told that none had been held but there were plans to introduce them. We asked about quality questionnaires and again we were told that none had been circulated but there were plans to introduce them.

We asked to view copies of audits of the home that had been carried out and were given a copy of a lengthy quality audit that had been recently completed by the provider and reviewed three days before our inspection. The provider had identified that the service was severely lacking in a large number of areas and identified a vast number of outstanding actions that needed attention. We could see that no effective quality assurances processes had been in place within the home resulting in a very poor score of 53% by the provider. We could see that there was an action plan in place to address these issues. Following receipt of the draft inspection report the provider informed us that an internal quality audit had been carried out in November 2014 with a score of 71%. a further internal audit carried out in March 2015 had given them a score of 50% with this increasing to 57% in an audit they carried out in July 2015. We were very concerned that the home had been able to drop its standards to such a poor level of compliance before the provider had recognised this. This included health and safety issues with the environment, people's legal rights not being upheld and protected via Deprivation of Liberty Safeguards, a lack of therapeutic interventions and lack of quality staff training in areas relating to the people living at Beechwood.

Staff described the manager as, "Fair but firm" and told us they were pleased he was dealing with some of the historical issues the home had, this included staff sickness and staffing levels as well as the plans that had been discussed for re-designing the home.

Staff told us that at times they did not feel supported particularly when they had been injured at work or had been supporting someone who was challenging. They said that they were not asked how they felt after these incidents and that a staff welfare office or member of staff to liaise between them and senior management would be of benefit.

The home currently has an appointed manager who has applied to register with the Care Quality Commission (CQC). Beechwood is currently registered to provide three activities. These are 'accommodation for persons who require nursing or personal care', 'treatment of disease, disorder or injury' and 'diagnostic and screening procedures'. The appointed manager has only applied to register for 'accommodation for persons who require nursing or personal care'. We discussed this with the manager and senior staff from the organisation. They told us that they would ensure the manager applied to register for 'treatment of disease, disorder or injury' and that they intended to apply to remove the regulated activity 'diagnostic and screening procedures' from their registration. It is important that services are correctly registered with CQC and that a registered manager is in post for all regulated activities so that CQC can ensure suitably qualified and experienced people are leading and are accountable for that service.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes did not operate effectively to improve the quality and safety of the service provided.

The provider told us that they had recognised that the management and leadership in the home was insufficient and they were changing the management structure accordingly. The home had a manager and a deputy manager both relatively new to the service and were currently recruiting two clinical lead nurses to improve leadership and accountability within the home. The new management structure was welcomed by staff who felt this would lead to improvements to the service that would benefit the people living there.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care and treatment provided for people did not meet their needs or reflect their preferences and was not designed with a view to achieving service user's preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff were not receiving appropriate training and supervision to enable them to carry out their duties.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes in the home did not protect service users from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes did not operate effectively enough to assess, mitigate and monitor risks relating to the health, safety and welfare of service users and feedback from relevant people had not been listened to, recorded and acted upon appropriately.