Four Seasons (DFK) Limited

Beechcare Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23 and 24 October 2018. The inspection was unannounced.

Beechcare Care Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beechcare Care Home provides accommodation and support for up to 40 older people. The provider was in the process of refurbishment and one whole area with 10 bedrooms was undergoing significant changes to provide more accessible accommodation. There were 27 people living at the service at the time of our inspection due to the refurbishment work. People had varying care needs. Some people were living with dementia, some people had diabetes, had suffered a stroke or had Parkinson's disease. Most people required some support with their mobility around the home and some people were nursed in bed due to their poor health.

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

At our last inspection on 12 and 13 September 2017, the service was rated as 'Good'. At this inspection, we found improvements were needed.

People did not always receive care and treatment that was responsive to their needs or that took into account their personal preferences. Care plans did not always detail the individual and personal information needed about people, using a consistent approach. Activities did not always suit the needs of people who had greater difficulties with understanding or who were at risk of social isolation.

People's records such as daily records and care recording charts, including nutrition and fluid charts were not always completed accurately to show that people had received the care they needed to maintain their health and well being.

The provider had a range of audits to monitor the quality and ongoing safety of people, with an identified route for action and improvement. However, some of these were not robust enough and did not identify the areas of concern found during this inspection.

The provider had a dependency assessment tool to evidence the amount of staff needed each week to provide the assessed care needs of people living in the service. However, people, their relatives and staff told us there were not enough staff to give time to chat and engage in activity other than care tasks.

Processes were in place to maintain people's basic rights within the principles of the Mental Capacity Act 2005. The processes were not always appropriately followed to ensure people's rights were upheld at all

times. Staff understood what the Act meant for them within their role supporting people on a daily basis.

Staff had the personal equipment to prevent the risk of cross infection. Laundry bags were in use in the communal corridors throughout the inspection which increased the risk of infection. We have identified this as an area that needs improvement.

Documentary evidence was not available to show staff had received the one to one supervision they needed to carry out their role and to support their personal development as set out in the provider's policy. We have identified this as an area that needs improvement.

The registered manager investigated, recorded and responded to formal complaints by following the provider's policy. Verbal complaints were not always recorded to show where lessons had been learnt and improvements made as a result. We have identified this as an area that needs improvement.

People felt safe and were protected from the potential risk of harm and abuse. Nurses and care staff had been trained to understand the potential signs of abuse and knew the action to take if they thought abuse had taken place.

Potential risks to people to maintain their safety had been assessed and mitigated. The premises were well maintained and equipment had been regularly serviced to ensure it was in good working order.

Medicines were observed to be administered safely by registered nurses and senior care staff. Systems were in place for the ordering, obtaining and returning of people's medicines. Nurses and senior care staff had received training in the safe administration of medicines and their competency had been assessed.

People's needs were assessed prior to them receiving a service. Guidance was in place to inform staff of how to meet people's needs whilst encouraging and promoting their independence.

People were supported to maintain contact with people that mattered to them. People's relatives were invited to eat a meal with their loved one if they wished and were able to stay overnight if their relative was unwell or near the end of their life.

Nurses and staff knew people well and were able to describe their care. People thought staff were kind and caring and there were affectionate interactions between staff and people. Staff respected people's privacy and dignity.

Appropriate referrals were made to health care professionals when concerns had been identified. The nurses and management team worked in partnership with external organisations to ensure people remained as healthy as possible.

People were supported to express their views and the provider analysed the results, developing actions to take to make improvements as a result.

People, their relatives and staff described the management team as approachable and were known to people. The registered manager and management team worked in partnership with external organisations to promote best practice.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

People and their relatives thought there were not always suitable numbers of staff deployed sufficiently to meet all their needs. The provider continued to follow robust recruitment practices.

Accidents and incidents were recorded and monitored by the registered manager and provider. The risk of infection was not fully controlled.

The assessment of individual risk had been considered and risks mitigated to keep people safe.

The administration of medicines were managed by registered nurses and trained staff to provide a safe service.

The registered manager and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure the basic principles in relation to the Mental Capacity Act 2005 were followed.

Staff did not always have the opportunity to have one to one supervision meetings with their line manager.

People were happy with the food provided.

Nurses and staff received the training they needed to make sure they had the skills and knowledge to provide the care and support people were assessed as needing.

Registered nurses provided people's nursing care needs and people had access to advice and guidance from health care professionals.

Is the service caring?

Good

The services was caring.

People were able to receive their visitors when they wished and where they chose.

People and their relatives thought the staff were kind and caring in their approach.

People were supported to maintain their independence.

Staff were aware of providing care that preserved people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place to record the information required to provide people's care and support, however, the information about people's specific care needs was inconsistently recorded at times.

People did not have access to a full range of activities to meet their needs and preferences, although the provider had plans in place to improve.

End of life care plans did not always fully address people's individual needs and preferences. People's cultural and spiritual needs were not always addressed through care planning.

Formal complaints were acted on and recorded appropriately. Verbal complaints were not always recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's records were not always accurately documented to ensure they received the appropriate individual care to maintain their health and well being.

Although a comprehensive quality audit and monitoring process was in place, it had not been effective in identifying the areas that needed improvement.

Positive comments were received about the registered manager and management team from people, relatives and staff.

People, their relatives and staff were asked their views of the

service and the results were analysed by the provider.

Beechcare Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 and 24 October 2018. The inspection was unannounced. The inspection was carried out by two inspectors, one assistant inspector, a nurse who had specific experience of providing nursing care to people living with dementia and an expert by experience. The expert by experience had personal experience of using or caring for someone who uses this type of care service.

We carried out this inspection as we had received information of concern from the Local Authority safeguarding team about the care provided. There had been an allegation of neglect. Before the inspection, we reviewed the information received from the local authority and asked for their feedback. We used this information to help us plan our inspection. Although the local authority investigated and closed the case, we carried out this inspection to make sure people were safe and were receiving the care they needed. We also looked at notifications about important events that had taken place in the service which the provider is required to tell us by law.

We spoke with five people who lived at the service and four relatives, to gain their views and experience of the service provided. We also spoke to the registered manager and seven staff including nurses, care staff, domestic staff and the chef. We received feedback from two health care professionals, a local authority commissioner and the local Kent Healthwatch.

We spent time observing the care provided and the interaction between staff and people in the communal areas such as lounges and dining room. We looked at nine people's care files, medicine administration records, eight staff records including recruitment and training, as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

In addition, 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 lived with dementia and who could not speak with us.

We asked the registered manager to send us some information by email after the inspection and they did this in a timely fashion, within the time limits requested.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Beechcare Care Home and knew who they would speak to if they had concerns. People and their relatives said they would speak to the registered manager and also told us names of nurses they would speak to. One relative said, "After five and half years if something was wrong with the care we would know."

Following the concerns raised and recent safeguarding investigations we found at this inspection that people were safeguarded from abuse. The registered manager told us since the concerns raised they had developed a good working relationship with the local hospital safeguarding lead which had led to improved communication and liaison when people were admitted to hospital. Staff had received training in keeping people safe and had a good understanding of their responsibilities in protecting the people in their care from abuse. Not all staff knew who they could go to outside of the organisation if they had concerns they needed to raise. However, we saw staff meeting notes that showed whistleblowing (telling someone externally about concerns) was discussed and who staff could go to, such as CQC and the local authority.

Risks were assessed using recognised tools to determine the level of risk, given people's individual circumstances. These included the risks associated with people's moving and handling needs, their pressure areas and their nutrition and fluid intake. Nurses and qualified care staff reviewed risk assessments every month, or sooner if people's needs changed. Where people's assessment of their care needs identified a risk, these were individually managed to keep people safe. For example, when people were frail or their health condition meant they were at risk of choking or of malnutrition, or they had a medical condition such as diabetes or Parkinson's disease. People who were nursed in bed every day and needed staff to help them to change their position to prevent pressure sores had a risk assessment in place which showed how often their position should be changed. People's daily charts were completed, recording each position change and within the time required.

The provider used a tool to assess people's care needs each month. This was used by the registered manager on an ongoing basis to determine if they had enough staff to provide the care people needed. We reviewed the assessments, both individually and the analysis of dependency levels for all people living in the service to check staffing levels. We found the staffing rota matched the assessed needs of people. However, people and their relatives thought there were often not enough staff. One person told us about staffing levels, "Sometimes there are enough, not always, you have to wait a little time to go to the toilet." Relatives told us there had been times their loved ones were not able to get out of bed and were told by staff this was because there was not enough staff. A relative said, "I don't think there is enough staff." Staff told us staffing was better than it had been in recent months but they still did not have the time to be able to sit and chat with people or do extra activities. Evenings were the time they may be able to spend some one to one time with people but this was often not possible. Staff said that lunchtime was also difficult as 16 people needed assistance with eating their meal at the present time. Activities staff helped out at mealtimes as it was such a busy time.

Although staff said hello and were friendly to people as they passed through the lounge area, they did not

always stop to spend time with people. One person asked to go to the bathroom at 14.25. At 15.00 they were still waiting and had moved to the end of their recliner chair in a bid to get out as they were quite anxious. Their relative was visiting and stopped them getting up and called for help. Two staff members arrived to assist and while they were getting the hoist to help the person to the bathroom, the registered manager sat with the person to make sure they were safe from falling.

A regular survey of people by the provider, although mainly positive, highlighted that people had raised concerns about staffing. One question asked, 'Do staff listen to you?'. Five out of five people responded with the answer, 'Sometimes'. Comments left included, 'Sometimes they do' and 'Sometimes rushed and unable to stay to talk'.

The local Healthwatch visited the service in January 2018. Following feedback from people and relatives they spoke with during their visit, they made a recommendation, 'Ensure there are adequate staff numbers to ensure that they have enough time to stop and chat to residents and are aware of their needs and preferences'.

The registered manager told us they had recruited a number of new staff recently so the staffing situation had improved, however, they did still have staff vacancies and agreed recruitment was difficult. They said they used agency staff when there were staff absences if permanent staff were unable to pick up shifts at short notice. An agency member of staff was on duty on the day of our visit.

The failure to ensure suitable numbers of staff are employed and distributed to ensure the needs and preferences of people are met is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administration of people's medicines was still managed well, keeping people safe from the risks associated with prescribed medicines. The ordering, storage and returns of medicines were completed in a safe way. The necessary checks were carried out on equipment and room and fridge temperatures taken to make sure they remained within safe limits. Some medicines need to be stored within a safe temperature range to maintain their effectiveness. A risk assessment ensured measures were in place to prevent harm from the risks associated with people's medicines. Medicines were administered to people by registered nurses or trained senior care staff who had their competency checked regularly. Guidance was available for staff who gave people their medicines. For example, PRN (as and when necessary) protocols were in place which clearly showed the reasons medicines such as Paracetamol were prescribed and when they should be administered.

The provider employed ancillary staff such as domestic cleaners, laundry staff and a maintenance person. Kitchen staff, including a chef and a cook were employed to manage the kitchen and provide the food for all meals including breakfast and tea. This meant staff were not required to complete tasks other than their caring role.

Staff were provided with appropriate protective equipment such as gloves and aprons and we saw these being used as they should. Laundry bag trolleys were left in corridors all day where people and visitors were walking up and down regularly throughout the day. This posed a risk of cross infection. When we asked staff about this, they had not identified any concerns about the risk of cross infection. This is an area identified for improvement.

Staff reported all accidents and incidents on the provider's electronic system. The registered manager reviewed all incidents and electronically signed them to show this. Incidents were reviewed and analysed at

the provider's head office, alerting the registered manager to any themes and advising of the action to take. For example, if the number of falls had increased or if incidents of falls were at a similar time of day or within the same area of the service.

Safe recruitment practices were followed to ensure that staff were suitable to support people living in the service. The appropriate checks such as Disclosure and Barring service (DBS) and references were completed. A DBS check highlights any issues there may be about staff having criminal convictions or if they are barred from working with people who need safeguarding.

People had an individual personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical, communication and equipment requirements that each person has to ensure they could be safely evacuated from the service in the event of an emergency. Servicing of fire equipment and regular fire alarm tests and fire drills were carried out to keep people safe.

All essential maintenance works and servicing were carried out at suitable intervals by the appropriate professional services including gas safety, electrical wiring, moving and handling equipment and legionella testing. A maintenance person was employed by the provider to maintain the premises and grounds, making sure repairs were carried out without delay.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager had made DoLS applications to the local authority where appropriate and was awaiting responses. They had kept the applications and authorisations under review. Nurses and senior care staff were not all aware of who had a DoLS authorisation in place. This meant people may not always receive the appropriate care and treatment to maintain their basic rights.

Mental capacity assessments had been undertaken where it was understood people may not have the capacity to make 'less complex decisions' such as, agreeing to their care plan. Best interest's decisions were recorded, however it was not always clear what involvement others had, such as relatives and health care professionals to support the best interest's decision making process. One person had a DNACPR (do not attempt cardiopulmonary resuscitation) form in place. This had been completed by the relevant healthcare professional when the person lived in a different care home, with the involvement of their relative. The nurses completed a best interest's decision record to determine if the decision continued to be in the person's best interests. The person's relative's name was recorded as having been consulted, however, the record was not complete as it did not say if the relative was actually present and did not record their views.

Consent was sought from people to take their photograph as a record for their care plan and their medicines administration record. This was reviewed and updated with people each year to check they were still happy for their photograph to be used for these purposes. Some people were unable to sign their name due to their health conditions. Where this was the case, it was clearly recorded in their care plan that they had given verbal consent.

Some people needed to be given time in order to make choices and decisions. Staff were guided by the care plan to make sure they were patient so people had the opportunity to take the time to respond as they could. However, this was not always appropriately applied. Relatives or friends had signed some people's consent forms without the appropriate authorisation such as a Lasting Power of Attorney in place or an explanation why the person had not signed themselves. One person's records showed they had the capacity to make their own decisions although preferred to have the support of a friend for bigger decisions. They had given verbal consent for some decisions made as they had difficulty signing their name. On 23 May 2017

the person gave their verbal consent to having bed rails on their bed to prevent them falling out of bed. However, one week earlier, on 14 May 2017, staff had asked a friend to record in the person's review record, 'I give permission to strap (person's name) in their chair'. Although this was a decision taken to make sure the person did not fall out of their chair, it could also be seen as a form of restraint if the person had not given their permission. The person's friend did not have the authority of a Lasting Power of Attorney for health and welfare decisions to sign consent on the person's behalf. No explanation was given in the care records why the person's friend had been asked to give their permission rather than the person. People were at risk of receiving care that did not protect their basic rights.

The failure to ensure people's rights under the principles of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed and their care was planned to ensure their needs were met. People and their relatives told us they had been involved in their assessment before moving in to the service. One person told us, "Yes, it was like an interview" and a relative said, "The manager came around and went through everything." The registered manager and nurses carried out an initial assessment before people moved in to the service. The assessment covered the person's needs in relation to their, mobility; personal care; eating and drinking; history of falls; medical diagnoses; communication. The assessment identified what support was needed and this was used to develop the care plan. This enabled the registered manager and nurses providing nursing care to make an informed decision that the staff team had the skills and experience necessary to support people with their assessed needs.

Nurses assessed people's nutritional needs and incorporated this into the care plan to give the guidance staff needed to provide the appropriate care and assistance. The chef and kitchen staff were informed of people's needs as well as their likes and dislikes as soon as they moved in to the service. Where advice and guidance changed, the kitchen staff were informed of reviewed needs straight away. The chef confirmed this was the case and told us they also visited people promptly after they moved into the service to discuss their needs and preferences in more detail. Some people were advised to have a soft diet, or a pureed diet, others needed a high calorie or low sugar or low salt diet. The chef was aware of each person's need, including those at risk of malnourishment, as they were kept informed by nurses and staff. People were provided with healthy, nutritional and well balanced meals. People's relatives could eat with their loved one if they wished. One relative told us, "We've been invited to have dinner with her, the food is good."

Where people had a wound or pressure sore that needed attention and dressing, comprehensive notes were kept enabling ongoing care with good communication. One person had a small sore on admission from a local hospital. Nurses photographed the wound and added a detailed description into their care file. Records were kept every time the dressing was changed to make sure the next nurses on duty were aware of improvement or deterioration. Photographs continued to be taken regularly to show the progression of recovery and to aid external healthcare professionals to make a judgement about ongoing treatment.

Nurses contacted healthcare professionals regularly for advice and guidance regarding people's health and medical concerns. These included GP's, dieticians, the local hospice team and speech and language therapists. A healthcare professional told us they found the staff very helpful and felt they had a good relationship. They also said staff asked for advice when they needed to and followed any advice given.

New staff completed an induction period where they completed training and shadowed more experienced staff members. Although new staff were not completing the care certificate, a new training package had been started and staff were being signed up to complete this. The care certificate is a set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care

sector. Staff are expected to complete the certificate within their induction period to equip them to provide care to people. A senior care worker had an additional role of providing mentoring support to new staff, to sign off their training and carry out observational assessments of their work within the probationary period. This meant new staff had a point of contact to support their increased knowledge and understanding of their new role. There was only one senior care worker to undertake this work and ten new staff to provide mentoring support to, which meant that not all new staff were being formally observed as regularly as planned.

The registered manager sent their supervision matrix following the inspection as requested. Supervision is a process where staff are given the opportunity to meet with their line manager to discuss any areas of concern in a constructive and supportive way and to plan their professional development. The matrix showed that all staff had dates recorded for four supervisions through the year. This was in accordance with the provider's supervision policy. However, we found no written records of staff supervision in the four staff files we looked at. The registered manager showed us a record of practice observation for one new member of staff, however, this was part of their induction, not of the supervision process. Six staff members had one supervision which was recorded exactly the same for each, regarding food and fluid and position change charts. These were dated between June and September 2018. These meetings were group supervisions when the registered manager wanted to ensure all staff were made aware of areas of concern and their responsibilities. This type of supervision was not described in the provider's policy as being one of the four individual supervisions a year staff could expect. This is an area identified as needing improvement.

Nurses received the training necessary to update their skills and knowledge and maintain their professional registration certificate. One nurse told us they had recently updated their training in, syringe driver management, catheter care, taking blood, wound management and tracheostomy care. Care staff had completed the training they required to carry out their role, most of their training was accessed on line. Staff told us this suited them well and they felt they had received the necessary information to be confident in their knowledge.

Good

Is the service caring?

Our findings

People and their relatives were complimentary and positive about the staff who provided their care. One person said, "Oh yes very kind, staff are wonderful really and the nurses are wonderful." One person's relative commented, "Yes, when I'm here I witness it" and another said, "Even the cleaners and the caretakers, they can't be more helpful. Everyone's lovely, the nurses will come up and chat."

Nurses and staff kept in regular contact with people's relatives to keep them informed of concerns they had such as a deterioration in health or if people needed personal items such as new glasses.

Nurses and staff could tell us about people's needs and the nursing care and support each person needed. Most people had a number of nursing, healthcare and support needs but were supported to maintain their independence as long as possible. One member of staff gave us an example of this, "I was feeding a person today. I let her have a go at feeding herself because she used to be able to and I don't want to take that away until that's the way it has to be."

A theme of respecting people's privacy and dignity was recorded throughout people's care plans, reminding staff and ensuring they knew people's preferences. People told us that staff respected their privacy and dignity. Staff knocked on people's bedroom doors and waited for a reply before entering. Staff gave examples of how they protected people's privacy and dignity whilst offering them care and support. For example, closing doors, covering people up with a towel following personal care and closing the curtains. Relatives confirmed this too. One relative said, "Yes they do knock on the door. They are all quite respectful."

People were supported to maintain as much contact with their friends and family as they wanted. Relatives and visitors told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. The service offered relatives the opportunity to stay overnight if their loved on was unwell or nearing the end of their life. The relatives we spoke with confirmed this was the case and one relative told us they had been offered this facility.

Carers were tactile, being affectionate with people as they walked through communal areas. A member of staff was speaking with one person, checking they hadn't been waiting too long for the hairdresser who was visiting. The member of staff had their hand on the person's shoulder, bending down speaking to them at eye level. The member of staff was making the person laugh.

Information about people was treated confidentially. The registered manager, management team and administrators were aware of the new General Data Protection Regulation (GDPR); this is the new law regulating how companies protect people's personal information. People's care records and files containing information about staff were held securely in locked cabinets or offices. Computers were password protected.

The provider had a comprehensive and easy to read service guide which set out all the information people and their relatives would need before moving into the service. Information such as how to make a

complaint, what services people could expect to find and how much the care and extra services cost.

Requires Improvement

Is the service responsive?

Our findings

The registered nurses and senior care staff had developed a range of care plans to describe people's assessed care and support needs. Care plans recorded the assistance people needed with all elements of their personal care throughout the day including, their nursing care needs; how they communicated; their personal hygiene needs; their medicines and their mobility. Care plans were reviewed every month, however, we did not find regular involvement of people and/or their family members.

There were inconsistencies in some people's care plans. Information in one part of a care plan was not always referred to in other relevant parts. One person had difficulties in communicating verbally at times due to their health condition. A speech and language therapist (SaLT) had visited on 7 September 2017. They advised the use of an alphabet board and facial exercises to aid the person's communication. The person's communication care plan did not refer to the alphabet board and how staff should use it. The care plan had been reviewed every month, referring to the person's slow speech and the need to give time. However, the alphabet board or the facial exercises, advised by the SaLT were not mentioned in any review. This meant the person may not have been receiving the most beneficial support with their communication. Another person was diagnosed with depression and was prescribed anti-depressant medicines. Although the nurses knew this when speaking to them, there was no specific care plan in place to provide guidance for staff in how to support the person if they suffered an episode of depression.

One person was being cared for in bed, although they did get up and sit in the lounge some days. The person's mouth was left with food on their tongue after being assisted with their lunchtime meal. As they were sleeping with their mouth open this was evident. Lunch was served at approximately 12.30. We brought the state of the person's mouth to the attention of the registered manager at 14.40. The person had therefore been without a drink following their meal and had not been visited by a member of staff in this time even though hourly checks should have been in place. The person's care plan clearly showed how they were very proud of their appearance and always liked to look nice and well presented, checking themselves in the mirror before leaving their room. The same person had confirmed they did not want male staff to provide their personal care. A male member of staff was providing their care with a female agency staff member throughout the day. The person's personal preferences were not adhered to on the day of our visit.

People's religious, cultural and spiritual needs were not fully identified within their care plan to make sure staff knew what was important to them and what support they may need from staff. A 'Church' service was held every Wednesday morning, the service was led every week by one of the activities coordinators. There was good attendance and people were appreciative. However, people who had a different spiritual need were not always catered for. One person who said they were Roman Catholic commented, "A priest here would make me happy." Staff could not tell us if people were living in the service who practiced a religion other than Christian or who did not identify as being heterosexual.

Although the service was not providing care to anyone near the end of life at the time of inspection, the local hospice nursing care team visited some people who had been referred for end of life care. Some people had an end of life care plan and had been asked what their wishes were for the end of their life, such as whether

they wanted to go into a hospice or hospital or remain at the service. However, not everyone had an end of life care plan that was individual and addressed their specific needs and choices. People's cultural and spiritual needs at the end of their life were not always recorded. This would be a very important element of care for people who followed a specific religion or belief.

Care plans were nursing and care task orientated with little information or a sense of individual people, their lives and emotional needs. Although sections of the care plan were available in relation to cognition, behaviour and communication these were not always fully completed to highlight the needs and preferences of individuals with these difficulties.

Nurses told us that out of the 27 people living in the service, 21 people had been identified as living with some form of cognitive impairment and nine people who had been diagnosed as living with dementia. Meaningful stimulation was not apparent for those people who may struggle to keep up and join in. A bingo session was in progress which some people enjoyed, however, the pace was very quick and some people were not able to fully engage with the activity. Two people had cards in front of them that remained blank as they did not get the support to cross the numbers out. We saw little evidence of activities planned for people who were slower to understand and respond.

Some people were at risk of social isolation. One person was hearing impaired and reference was made in their care plan to a whiteboard used for communication in their bedroom. There was no record of when or if the whiteboard was used or if it was successful. Staff told us they do sometimes write on it but the person doesn't usually read it. The only activities recorded for the person were a hand massage on 12 October 2018 and another hand massage on 18 October 2018. The person was known to become anxious during personal care particularly when using the hoist for movement. Their care plan advised staff to spend time comforting and reassuring the person. However, the behaviour records completed showed that staff instead took a break from the task when the person became upset and went back later to try to support again. It was unclear which was the best plan for the person or if all staff were following the same guidelines to give consistent care.

The activity schedule displayed on the wall was for the previous week's activities not the current week. We asked the activity person if cooking was planned for the afternoon as this was on the schedule. We were told instead that bingo was planned as the wrong week was on display. This meant that people did not have the correct information to make a decision about the activities they would like to take part in.

A discussion was held at a heads of department meeting in July 2018 about activities and the need for change and improvement. As a result, an activities meeting was held in August 2018 and an extra part time activities coordinator had started in post. Three part time activities coordinators were now in post, covering different days and times each through the week.

The provider was in the process of changing the care planning and recording system for people's support and engagement with activities. They were planning a more person centred approach using a booklet to capture all the personal details about each person. The new approach had not yet started. In the meantime, we were told by the registered manager that people's life history, likes and dislikes and personal preferences were recorded through a section of their care plan or in a 'journal'. Some people did not have this section in their care plan or a journal, so a record was not kept for every person. A consistent approach was not used which meant it was not evident if people had been supported and encouraged to take part in activities that would interest them.

The failure to ensure people's needs and preferences are met is a breach of Regulation 9 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they chose when they had their care, for example what time they got up or went to bed, however, other people did not feel they had that choice. One person said, "I have to have cream so I have to wait for them to come to me, you have to wait your turn. Bed time I have to wait for them to come and take me." Another person told us, "I go to bed what time I like."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Care plans showed that some people had specific communication needs and these were addressed in the care plan for some of those people. This was meant to ensure people who lived at the service had information in the most accessible format. However, although one person had a whiteboard and another an alphabet board to help them to communicate, there was little evidence that these were being used consistently as reported above.

People and their relatives told us they knew who they would go to if they had a complaint. Relatives said, "I would email the manager. I have done and got a response, it was noted and changed. On the whole I'm happy here"; "I would go to the manager or admin assistant. If it's a major complaint, put it in writing. At the moment we are tickled pink."

The complaints procedure was clearly available in the service for people and their relatives to access. Seven complaints had been received since the last inspection. These had been dealt with and recorded by the registered manager in accordance with the provider's complaints procedure. The registered manager was required to log all complaints on the electronic recording system which added another layer of monitoring to ensure responses were appropriate and timely. The registered manager had recorded where they had learnt lessons from the complaints received and shared with staff as necessary. Although relatives told us they had raised concerns about staffing levels, we did not find these complaints recorded.

Requires Improvement

Is the service well-led?

Our findings

People knew the registered manager – they knew who they were and knew them by name. People told us they would stop the registered manager and ask to speak to them if they needed to. People told us they thought the service was well managed.

We had received information from the local authority safeguarding team regarding concerns raised by family members and other healthcare professionals about people's care. The local authority and police had investigated the concerns and were satisfied they did not need to take any further action. The local authority safeguarding team had made some recommendations, to improve communication and the robust identification and response to poor fluid intake. The registered manager and provider had responded positively, supporting the investigation and responding to requests for information. The provider had also carried out their own comprehensive internal investigation which was reported in May 2018. The investigation detailed the areas found that required improvement. Daily records made by staff were found during both investigations to show that staff did not accurately record the personal care and support given. Food and fluid charts and the totalling of fluids on a daily basis were identified as areas to improve to make sure they could be monitored closely and concerns picked up quickly. However, we found that these areas identified for improvement by the local authority and the provider's own investigation were still a concern.

Some people had healthcare needs that meant staff were expected to record the food and fluids they had through the day so nurses could monitor their intake. This may be because they were frail and needed encouragement and help, they had an infection and had been advised to drink more fluid, or were at risk of malnourishment and needed support to eat more food. People's food and fluid records were not always up to date or maintained to a good standard. The amounts of fluids people had to drink were not always recorded and when they were, they had not always been totalled up through the day. A member of staff and the registered manager told us the night staff had the responsibility of totalling the fluid records and flagging concerns. The fact that this was not happening had gone unnoticed by the nurses and the registered manager. A relative commented, "The biggest issue is his fluid is not monitored."

When we totalled up each day's fluid records, some people had drank far less than recommended. One person's care plan documented they should be aiming to drink 1500mls of fluid a day as they had a urine infection. We reviewed their fluid chart from 16 to 23 October 2018 and found, 16 October 850mls; 17 October 450mls; 18 October 1200mls; 19 October 1500mls; 20 October 1400mls; 21 October 1250mls; 22 October 375mls and 23 October 350mls. This meant the person fell short of their recommended amount of fluids 6 days out of eight placing them at risk of prolonging the infection.

Food charts stated food supplements must also be recorded on the food and fluid chart when given. This was not always the case, one member of staff did this but others did not. Although food supplements were signed for on the medicines administration record, nurses and staff were not following the direction given on the providers records. This meant that staff who did not administer medicines may not be aware if people had their food supplement as recommended. One person was advised by the dietician to have between1500 – 1700 calories a day. Their food chart did not always indicate the amounts they ate at each

mealtime. Staff often recorded 'mouthfuls' taken. The food chart did not indicate to staff how they could determine if they were meeting the recommended daily amounts of food set by the dietician. A nurse told us they regularly checked food and fluid charts, however they did not record this anywhere or record action taken.

The provider had a range of recording sheets for staff to complete to document the care given to people each day. A daily task tick box record was in place. The letter 'A' was used to show when the person was 'assisted'. This record was not accurately completed to show the care people had been given. Many days were not completed at all and other days showed some tasks were ticked and others not. One person's record showed staff had not completed the boxes to show if they had assisted the person with their mouth care and cleaning their teeth. Only one record had been made in October 2018. Staff had recorded with an 'x' on two dates, however, x was not listed as a code staff should use. This meant nurses and staff could not be sure the person had received the care they needed to keep their mouth and teeth clean. No recordings were made for any tasks on the sheet between 7 and 11 October 2018 with no explanation why. We checked the person's daily records and these did not document if the person had been assisted with their mouth care either.

Daily records, although completed each day, did not always provide the information needed for the registered manager to be sure people were receiving the care they had been assessed as needing. One person's care plan stated staff must inform the nurse in charge if they did not have their bowels opened for more than three days. We saw that no record was made between 7 and 18 October 2018. The records did not show if the nurse in charge had been informed or if any action had been taken. Care plans and daily records did not always reflect what we saw during our visit. One person's care plan clearly recorded they were at high risk of falling as they were quite shaky. This risk was mitigated by the person always having one member of staff walking alongside them at all times. However, we saw the person walking freely around the service with no staff assisting them. Staff told us the person should have one to one support when they were walking around but this had not been allocated that day. There was no record in the person's care plan or daily record why this was the case. Staff did not approach the person and ask them to sit down and wait to be accompanied.

The failure to ensure accurate records were kept of the care people required to maintain their health and well being is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system to monitor the quality and safety of the service which included audits carried out by the registered manager and staff working in the service, senior regional managers and staff from their head office. An electronic system was in use for staff to record any events or incidents in the service such as safeguarding incidents, accidents, falls, complaints, pressure areas, wound care, medicines errors. All records were monitored at the provider's head office. The level of risk determined the level of involvement at head office. The recent safeguarding alert raised and investigated by the local authority and the police was responded to by the chief operating officer who set up a teleconference in order to be given an update by the registered manager and regional manager. The registered manager and the regional manager were given actions to complete each month to make improvements or investigate themes with timescales to record their findings. A comprehensive health and safety audit was completed each year by the providers central health and safety department with a report and action plan for improvement sent to the registered manager and the regional manager.

A complete range of audits were carried out by the registered manager or nurses, including, care plans; medicines administration and management; infection control; health and safety. The regional manager

visited regularly and used one of their visits, every two months, to carry out an audit. They looked at a selection of areas such as care plans, risks, completed audits and incorporated areas identified as possible concerns or themes by head office monitoring. Although audits were completed regularly and action plans developed to make improvements, the areas of concern we found during this inspection were not identified and dealt with in a robust manner to ensure the continued safety and quality of the service.

The failure to ensure systems to monitor the safety and quality of the service are effective is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been in post since before the last inspection so knew the service well. They had been registered manager of a different service run by the provider in another area before taking up this post so had the experience necessary to manage Beechcare Care Home. The provider and the registered manager understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly and without delay.

Staff found the management team approachable and said they were comfortable taking any issues to them. One member of staff said, "Yes, they are approachable, you can always go to speak to them." However, some staff we spoke with thought the management team were slow to tackle staffing issues. Such as staff who did not always complete the tasks they were responsible for, for example completing the daily records.

Regular staff meetings were held. As well as formal planned meetings with the registered manager, staff had the opportunity to attend 'flash meetings' organised by nurses on shift with any staff available that day. One of the nurses told us they would hold these when they had messages they wanted to share or examples of good or poor practice to aid communication and quality of care. The records we looked at confirmed that these were held when necessary, sometimes daily and other times weekly.

Staff were invited to take part in a satisfaction survey once a year. Each part of the provider's business produced an action plan as a result, focusing on the local service results, the regional results and the national results. The most recent staff survey showed areas to improve, staff training and pay and reward.

The provider used an electronic system to record the feedback of people and any visitors to the service, including relatives or health and social care professionals. Electronic pads were available and accessible near the front entrance. The results were accessed by a team at the provider's head office where the results were analysed. The registered manager was sent the analysis on a regular basis with the areas they needed to address and make improvements.

The registered manager, management team and nurses worked in partnership with other agencies to provide people with a joined-up delivery of care. There was contact with the hospital safeguarding lead when people were admitted to hospital from the service and ongoing liaison during their stay; links had been developed with the local hospice team, who delivered 'end of life' support and advice to the nurses and care team; contact was maintained with commissioners who funded peoples' care.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating on their website and in the reception area.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to ensure people's individual needs and preferences were fully met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure people's basic rights within the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure people's records were accurately documented and that their quality auditing and monitoring systems were effective in identifying areas of concern.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure sufficient staff were deployed to meet people's needs and preferences.