Four Seasons (DFK) Limited

Beechcare Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 September 2017. The inspection was unannounced.

Beechcare Care Home is registered to provide accommodation and personal care with nursing for up to 40 people. There were 33 people living at the service at the time of our inspection.

Most people living in the home had complex health conditions that required nursing care, such as recovering from a stroke, respiratory illnesses or living with dementia. Some people had limited mobility and could walk around with support, whilst others relied on a wheelchair or full staff support to get around. Some people were nursed in bed and some people required support to communicate their needs and wishes.

Beechcare Care Home is a purpose built property that is spacious. The provider has refurbished some areas and had plans for further improvements to the premises. The service is set in a quiet location away from busy main roads and with pleasant gardens with flowers, shrubs and trees.

A manager was in post however, they had not yet registered with the Care Quality Commission (CQC). The manager had made their application and was going through the CQC registered manager application process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had previously been registered with CQC at this location. However, they had changed the legal entity of this service and this required them to apply for a new registration with CQC, which commenced on 08 July 2016. The service had continued within the same premises and with the same staff team and registered manager. This was the first inspection under the new registration, however, you can find previous inspection reports on the CQC website.

People were kept safe by the provider's systems and procedures, in place to protect people from abuse. Staff understood their responsibilities in keeping people safe and felt confident to raise any concerns they had with the management team. Staff told us they were sure any concerns they had would be taken seriously but they knew who to go to outside of the organisation if they were worried.

The risks faced by individuals had been identified and control measures put in place to minimise the risk, to help keep people safe. Medicines were managed safely and effectively by registered nurses. People had comprehensive care plans that provided detail of the individual support required to maintain their health and well-being. People and their family members were involved in developing and reviewing their care plan.

Safe recruitment practices were carried out by the provider to ensure people were only supported by staff

who were suitable to work with the people living in the service. The service supported people with complex health care needs that required nursing care. There were enough registered nurses and care staff in post to support the assessed care needs of the people using the service at the time of inspection. However, people, relatives and staff gave mixed views about whether they thought there were enough staff.

A timetable of activities was in place that people could take part in, however these were not suitable for some people living in the service and alternatives were not always considered. We have made a recommendation about this.

People were happy with the food provided and could choose to sit in a light and airy dining room to eat their meals. People's specialist nutritional needs were met and communication was good between the kitchen staff team and the nursing and care team to make sure this happened. People were supported to maintain their health by registered nurses and where they needed extra advice and support this was sought quickly from the appropriate healthcare professional.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider, management team and staff understood their responsibilities under the Mental Capacity Act 2005.

Environmental risks of the premises and grounds had been assessed and measures were in place to minimise risks and keep people, staff and visitors safe. All essential maintenance and servicing of equipment had been carried out. Fire safety had been carefully considered and all appropriate measures to prevent fire and to minimise the risks to people in the event of a fire had been undertaken.

Staff at the service were friendly and welcoming. Staff knew people well and were able to take this into account when providing individual care, supporting people to maintain their independence as long as possible.

Not all staff had received regular one to one supervision with their manager as the manager was new in post. However, this had been identified as an area to improve by the manager and the provider and a plan was in place. Staff had received the training necessary to carry out their role well. Additional training was available to support the development of staff.

People, their relatives, friends and visiting professionals were asked their views on a regular basis. This was made easy to do by an electronic tablet system. Feedback was analysed by the provider and used to improve the service provided.

There were many compliments about the management and leadership of the service. We received positive comments about the manager from people and staff. Improvements had been made and staff felt confident this would continue. Health and social care professionals gave positive feedback about the manager and the improvements made since they were in post.

The provider had a robust approach to quality assurance, making sure systems were in place to check the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely. There were enough nurses and staff to provide the support people needed.

Staff were trained and kept up to date in safeguarding adult procedures, and knew what action to take to keep people safe.

Individual risk assessments were in place to protect people from harm or injury. Accidents and incidents were monitored to identify any specific risks, and how to minimise these.

Medicines were managed well by registered nurses to ensure safe administration.

Is the service effective?

Good

The service was effective.

A plan was in place to ensure one to one supervision meetings and annual appraisals took place. Staff received the on-going training they required to carry out their role.

People's human and legal rights were respected by staff. The management team and staff had knowledge of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People had choices to make each meal time from a menu. People were supported with their specialist nutritional needs.

Nurses were knowledgeable about people's health needs, and supported people to maintain their health and mental well-being.

Is the service caring?

Good

The service was caring.

Staff at the service were friendly and welcoming and knew people well.

People were involved in making decisions about their care and staff took account of their individual needs and preferences.

Staff protected people's privacy and dignity. Staff were encouraging and supportive to help people maintain their independence.

People were happy and told us they were well supported by staff who cared.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were provided but there were not always clear opportunities available for people who were unable or did not want to take part.

People's care and support needs were assessed before moving in to the service and care plans showed how people wanted their support.

People, their relatives and friends were given the opportunity to give their views of the service provided and these were used to make improvements.

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

Is the service well-led?

Good

The service was well led.

There was an open and positive culture. Staff spoke highly of the management team and felt they were listened to.

The provider had robust quality assurance and monitoring procedures in place. The results of surveys were used to drive improvement to the service provided.

Records were clear and robust.

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 12 and 13 September 2017 and was unannounced. The inspection was carried out by two inspectors, one specialist nurse adviser, who is a specialist in dementia care and one expert by experience who has experience of a family member living in a care home. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with nine people who lived at the service and three relatives, to gain their views and experience of the service provided. We also spoke to the manager, the deputy manager, the provider's regional manager, the provider's resident experience support manager and six staff including registered nurses. We received feedback from two health professionals and one local authority commissioner .

We spent time observing the care provided and the interaction between staff and people. We looked at ten people's care files, medicine administration records, four staff recruitment records 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.

Good

Is the service safe?

Our findings

People told us they felt safe living at Beechcare Care Home. One person showed us the emergency call bell they had and how it was positioned where they could easily reach it. They said, "We have an emergency bell for if we are not very well. We've got an emergency nurse". Other comments we received from people included, "I get wonderful care" and "It's my home. It's very good".

People told us they would speak to the staff or the manager if they had any concerns or worries. Staff had a good understanding of their responsibilities in keeping people safe from abuse. The guidance and advice they needed to refer to if they had concerns they needed to raise about people's safety was available in the provider's safeguarding procedure. Staff told us they would have no problem raising any worries they had and although they felt they would be listened to and action taken, they were aware of who to contact outside of the organisation should this be necessary.

Individual risks in people's daily lives had been identified and control measures were put in place to help to minimise the risk. For example, some people could not move around independently and needed the assistance of staff and some people required a hoist. One person required the assistance of two staff and a hoist when getting out of bed and into a chair. Their care plan and risk assessment gave detailed information to staff how to do this safely to minimise the risk of injury to the person and to the staff. The size of the sling required when using the hoist was highlighted as was the specific sling for each individual to help avoid cross infection. Where people required bed rails to keep them safe when they were in bed, potential risks had been identified and checks were made each time they were used to ensure risks were minimised. Some people were at risk of falling over. Falls risk assessments were in place to determine the level of risk and to identify measures to keep people safe while not undermining their right to maintain independence. Accident and incident records showed that one person had fallen more than once without injury. Their care plan showed they had been identified as being at high risk of falls. The person liked to be as independent as possible. Risk assessments were in place with control measures to minimise the risk of falls to try to keep them safe while respecting their wish to maintain their independence. One person's choking risk assessment identified they were at high risk of choking. The risk assessment guided staff when to contact speech and language therapists (SaLT) for advice and they had been appropriately referred. The advice had been put into effect and care plans and risk assessments reviewed. All risk assessments were reviewed regularly and if there was a change in circumstances, for example when people's needs changed and their health or mobility deteriorated.

People received their medicines as prescribed from registered nurses. Medicines were kept safe and secure at all times within a locked medicine room. Systems were in place for the ordering, obtaining and returning of people's medicines following the provider's policies and procedures in relation to the administration of medicines. Temperature checks were taken to make sure medicines were stored within the correct temperature range to ensure their continued efficacy and safety. During the medicines administration round appropriate checks and recordings were carried out to ensure that people received their medicines at the right time. Staff signatures and records made on the medicines administration record (MAR) were neat and legible errors were more easily identifiable. We found no errors in the records.

The premises were maintained to ensure the safety of people, staff and visitors. A fire risk assessment had been carried out to ensure processes and maintenance plans were in place to prevent a fire on the premises. The servicing of fire equipment and alarms had been undertaken and were all up to date. People had a personal emergency evacuation plan (PEEP) located in the fire file and a copy kept within their care plan. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. Fire evacuation drills had been carried out regularly and records were made of the response and improvements required. The equipment used to assist people with their personal care needs, such as hoists and bath lifts were serviced and maintained to ensure they were in good working order. Regular checks and servicing of all other installations such as gas and electricity had been undertaken to ensure the premises remained safe and well maintained.

A team of staff were available to meet the needs of people living in the service. Registered nurses managed and directed people's day to day health and care needs. Senior carers and care staff made sure people's personal care needs were met. One chef and two kitchen assistants planned and made the meals and ensured people's dietary needs were met. Two domestic assistants were responsible for keeping the service clean and a laundry assistant took care of the dirty laundry each day. Two activities coordinators planned individual and group activities from Monday to Friday each week.

There were mixed views about whether there were enough staff available in the service each day. Some people, relatives and staff said they didn't think there were enough staff on shift. One person told us, "The only thing they're short of is staff. You only wait for care if there is an emergency". A relative told us, "I think at weekends and holidays, they're a bit short staffed. I would say they need one extra person". Other people were happy with the numbers of staff, one person said, "I am very happy with the care. I get 24 hour care. It's good. It's the best. I always get help in good time, day and night". A health and social care professional said, "They could possibly do with more staff, but that is the same everywhere, it is definitely no worse here".

Staff had not managed to support people to get up from bed until late morning on both days of our inspection. Some of the staff we spoke with suggested this was due to there being low staff numbers. One staff member told us "You don't get enough time to do what you want to do with the residents". Another member of staff said, "We could do with more staff, probably one more, but the staff are very good and work well together as a team". Some people who required assistance to eat their meal waited up to 30 minutes for a staff member to assist them as staff were busy serving meals.

The provider used a dependency assessment to calculate the numbers of staff required in the service based on the assessed needs of people. An individual dependency assessment was completed with people to calculate their level of need for each area of their care plan. For example one person's dependency assessment showed they had low care needs within the area of consent and capacity and high needs for medicines administration and high needs for mobility. All assessments were collated into the provider's dependency assessment tool for the service where the numbers of staff required to provide people with the levels of care they needed was calculated. On discussion with the manager and the provider's regional manager, they confirmed they were actively recruiting staff. They also told us they were looking at ways to relieve the pressure at busy times of the day, for example, having extra staff on shift at these key times. However, they assured that they had enough staff to meet the needs of the present numbers of people living in the service based on their dependency assessments. The dependency assessments completed each month showed that the numbers of staff on the rota and in the service during the inspection were sufficient to meet the needs assessed.

The provider used an electronic recording system for staff to record accidents and incidents, documenting

detail of the incident itself, who was involved, the outcome and the action taken. The manager reviewed incidents, checking that appropriate action had been taken and following up on outstanding actions. The manager used the information to make improvements to keep people safe. The regional manager and the provider's health and safety team could access the records to review and make recommendations to learn from trends and mistakes made in relation to incidents.

The service had robust staff recruitment practices, to ensure that staff were suitable to work with people living in the service. Staff told us that they had been through an interview and selection process before they started working at the service. Checks had been made against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with people who needed safeguarding. Application forms were completed by potential new staff which included a full employment history. The manager had made sure that at least two references were checked before new staff could commence employment. All the nurses Nursing and Midwifery Council (NMC) PIN numbers were recorded and a system in place to check when the nurses registration with the NMC was next due. The provider was following safe recruitment policies and guidance when employing new staff to the service.

A recent outbreak of infection had been identified in the service. Evidence recorded in people's infection control care plan showed how this had been managed to minimise further risk and spread of infection. The manager had liaised closely with Public Health England to ensure the correct control measures were put in place to minimise further risk. All people and staff had been checked for infection and preventative medicine given. People and relatives had been informed and reassured. The incident was reported for each person separately through the provider's electronic recording system as a specific infection control incident to be monitored and reviewed through the organisation. A healthcare professional said, "They dealt with it quickly, proactively and were transparent". People, staff and visitors were kept safe by a quick and open response to the identified risk.

Good

Is the service effective?

Our findings

People thought the staff understood their needs well and had the knowledge to support them appropriately. One person told us, "They help me tremendously. The carers [staff] know everything. Even if you ask them something you're not sure of, they know about it. Obviously they have studied it".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care plans for people who lacked capacity showed that this had been clearly recorded and decisions had been made in their best interests, each decision being treated individually and separately recorded. People told us they made day to day decisions and made choices such as what clothes they decided to wear or where to sit in the lounge areas.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager understood when an application should be made and how to submit them. Care plans demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted. One person had been advised to stay in bed by healthcare professionals due to concerns around pressure areas and fragile skin. The person told us they were not happy staying in bed and suggested this had an effect on their well-being. They said, "When I ask to get up, they're [staff] pretty good and they come and help me". The person told us they had been up that day to have their hair done. The manager told us that although they encouraged the person to stay in bed as much as possible, as advised for health reasons, the person had been assessed as having capacity to make their own decisions. The manager and staff therefore respected their decision to want to get up out of bed at times.

People's rights, consent and capacity were assessed as part of the care planning process and within the principles of the MCA 2005. This was reviewed regularly in case people's circumstances had changed. People's individual level of need around making decisions was explored with them, and family members where relevant. People's care plans clearly stated if people were able to make their own decisions without support and that staff should respect their wishes, even if they didn't always think it was wise. For example one person's care plan stated they may refuse to attend appointments with a mental health professional and this must be respected as they had the capacity to make this decision. People signed to say they gave their consent where this was relevant. For example, to have their photograph taken to use in their care plan, or to have bed rails in place for their own safety. One person who had bed rails in place had asked staff to sign on their behalf as their hand was shaky, this was clearly recorded and dated. Where people wanted family members involved with more complex decision making, this was recorded.

New staff had a period of induction and this was recorded and kept in their staff record. Following induction, new staff shadowed more experienced members of staff until they got to know people well and what was expected of them in their new role. Some new staff had a longer period of induction than others if they had little or no experience of working within a caring role previously.

Within the service some support staff had been through the provider's new Care Home Assistant Practitioner (CHAP) role. This was developed as part of an initiative to provide development and additional training to care assistants who wished to have additional responsibilities. The development opportunity was intended to assist ambitious care staff to take on more responsibility and develop their skills and careers. The manager was in the process of delegating extra responsibilities to senior care workers to ensure daily documentation was kept in good order. For example one of the senior care staff was going to be responsible for checking the records for topical creams and another senior care worker was tasked with the mattress check records. The manager told us these staff would follow up poor recording with the staff responsible and ensure staff had the skills to complete records appropriately. This meant that people's daily records would be kept in better order and it served as a development opportunity for staff. A member of staff told us, "I like working here, there are opportunities to develop".

The provider gave staff the opportunity to increase their skills and responsibilities by being a 'Champion'. A 'Champions tree' was in place listing which staff had been designated a champion for which area. For example, the housekeeper was the infection control champion and there was also a dignity champion, a pressure area care champion and a nutrition champion.

The manager had been in post since April 2017 and told us they had not had the opportunity to ensure one to one supervision meetings with staff had been carried out as regularly as the provider's supervision policy stated as they had other areas of work they needed to prioritise. This had been picked up in the monthly audits carried out by the provider's regional manager. An action plan had been agreed with the manager to undertake every staff member's one to one supervision by the end of September 2017. There was evidence that the plan had commenced. The manager sent evidence following the inspection that this had now been completed and all staff had received one to one supervision meetings with their manager and had dates planned for the next meeting. All staff had their annual appraisal booked for October 2017 which would give them the opportunity to discuss their personal development needs for the next year and reflect on their practice over the last year.

People living at the service required nursing care. It was important the staff supporting them were led by qualified registered nurses who had the professional credentials to make sure people got the right care. The nurses were supported with their Nursing and Midwifery Council (NMC) revalidation requirements and had been provided with a folder to keep their evidence of continued training and development to hand and also current.

People's needs were met by well trained staff. Staff training was delivered through a mixture of face to face training and e learning. Additional training that was required was provided as and when needed. The provider employed an in house trainer who visited services in the region to provide specific training. The in house trainer also trained staff within the service to deliver training to their colleagues. For example, two staff at Beechcare Care Home had completed train the trainer training to deliver moving and handling training to staff. They were due to deliver their first training session the day after the inspection. This provided a valuable resource for the service as well as creating a development opportunity for staff. Staff demonstrated a good knowledge of their work and how to keep people safe and receive the care and support they required. People were supported by staff who were well trained to provide appropriate care and treatment to improve their health and well-being.

People were supported to maintain their health through a nutritional assessment resulting in a care plan. The support people required with their assessed needs and the risks associated were detailed within the care plan. For example, some people were at risk of malnutrition and their level of risk was identified by using a specialist tool which guided staff to the level of intervention they required. Some people were diabetic and required a special diet to help to control the risks of high or low blood sugar. Some people had food and fluid charts to record their intake. Although these were completed when food and fluids were taken, the amount of fluids were not always totalled at the end of the day or as a running total to make it easier to check that the amount of fluids taken were suitable. This meant it may not have been obvious during the day that people were not taking enough fluids. Care plans also recorded people's favourite foods and those foods they did not like. One person liked egg and bacon and fish and did not like sweet things or sausage, tuna and cheese. At lunchtime the person said they were not hungry and did not want their lunch. Encouragement was given by staff and then the chef came out and asked if they would like fried eggs or an omelette instead but they said no, they had eggs for breakfast. The chef had known their preference for eggs and used this to try to encourage the person to eat some food. The chef then told the person if they got hungry later to let them know and said they would make something for them.

People chose their meals from a menu with two choices available for each mealtime. People were asked to make their choice the day before. However, people could change their mind if they wished, or if they didn't like either choice they could ask for something different. The chef was aware of people's dietary requirements and likes and dislikes. This was provided by the nurses who kept the record updated to ensure good communication between departments. The head chef told us they had control of food ordering without intervention from the manager or head office. Whenever they requested replacement equipment this was provided. The dining room had recently been refurbished and the chef had plans to include other new ideas now this was finished, to create a restaurant atmosphere. People had access to drinks through the day and people told us this was always the case. One person said, "We've always got drinks and they're changed all the time", another person told us, "We get tea and juice and you can ask for a cup of tea when you want it. There is a bowl of fruit on the table and you can help yourself". One person commented about the food, "We get a choice. They come round every day and ask you for two meals. They give you a choice and it's up to you. They do family cooking, for example yesterday we had scrambled egg and beans for tea and for lunch we had steak and kidney".

People received consistent healthcare from a local GP who visited regularly. When they visited, people clearly knew them well, calling out their name asking to speak. One person told us, "I always see a nurse or doctor when I need to". All appointments, visits or correspondence by fax or telephone with healthcare professionals were recorded in people's care plans. For instance, visits from the GP, dentist or chiropodist. . A health care professional said, "Since the new manager has been in post, observations and checks are now completed and staff make contact if they are concerned". Comprehensive records were kept when people had pressure areas that required treatment and monitoring. For example, regular photographs were taken of the wounds so the nurses could check the progress and plan treatment accordingly. Hospital appointments were documented, including when people refused to go. One person decided they did not want to go to an appointment with a Rheumatologist and a record was made to show the nurse had informed the hospital and made a new appointment straight away. The manager spoke to one person to let them know they had spoken to the chiropodist who was going to make an appointment as requested. The manager assured the person they would keep them informed. People's relatives were kept informed of any concerns or changes to their loved ones health care. One relative told us, "I feel informed. If the doctor has been in, they've phoned us or told us about it when we are here".

The service was going through a refurbishment programme and new flooring being planned. As an added enhancement to the service we would recommend following an environmental assessment tool from a

reputable source to gain advice about creating a dementia friendly environment. If the service fully met the needs of those living with dementia, it would meet the needs of others.

Good

Is the service caring?

Our findings

People and their relatives spoke highly about the caring nature of staff. The comments we received from people included, "The staff here are very caring, I feel they know me and they know how I like things to be done", "Staff give me a little cuddle when I'm very sad" and "I'm happy here. Everyone is friendly and warm". One relative told us, "The carers are very good here" and another said, "The girls are lovely".

Staff interacted with people in a caring and compassionate way. One person preferred not to eat their lunch in the dining room with others. A member of staff sat with them in the lounge whilst they ate and told us this was because they knew the person didn't like to eat alone. There was a good rapport between people and staff. People were confident to speak up and ask for support. People asked staff for help or drinks or just wanting to chat, as staff were walking past. Staff were attentive and stopped to respond to requests throughout the day. One person told us they had lost their glasses and they were worried about this. They told us they thought they had been left in the hairdressing salon. A staff member went to look for the glasses and told the person that other staff had also been looking. The hairdresser also spoke to the person to tell them they had looked for the glasses but they weren't in the hairdressing salon. All the staff worked hard to reassure the person and lessen their agitation. A staff member told the person they would make sure their daughter was told the glasses had been lost and offered to move the person nearer to the TV. One person asked for breakfast when sitting in the lounge. A staff member checked if they had already had breakfast and the kitchen staff confirmed they had. The staff member said to the person, "Do you want more of your favourite, porridge?" The person confirmed they did. The staff member went to get another bowlful. The staff member told us the person often had more than one bowl of porridge as it was their favourite. Staff knew people well and knew what was important to them. A health and social care professional told us, "The carers [staff] are caring, they know people well and have a good attitude".

People were involved in the planning and review of their care. Care plans were detailed, were reviewed regularly and kept securely in an office. People's likes and dislikes were recorded in their care plan. People and their relatives were encouraged to complete sections of the care plans which detailed their personal history and background as well as how they wanted to be supported and what they were able to do for themselves. This helped staff effectively plan their care. Relatives told us their loved ones were encouraged to personalise their bedroom. One relative told us they were really pleased with their loved ones room, they said, "They've let us do her room nice" and "She has a nice view from the room". Another relative told us that their loved one was able to bring in some of their own possessions and was encouraged to treat the place as their own home.

People were encouraged to be as independent as possible. One person told a member of staff that they had forgotten to put on their belt when getting dressed in the morning. The member of staff collected the belt from their room and suggested the person put the belt on themselves which they were very happy to do. During lunchtime staff encouraged people to cut up their own food and eat independently where possible. A member of staff told us about one person who had once choked on food before moving into the service and had initially been reluctant to eat without support. The staff member said they sat with the person during lunch, and this had given them the confidence to eat independently.

People were treated with dignity and their privacy was respected. Two members of staff were given extra responsibility and designated 'Dignity Champions'. It was their role to promote dignity within the home. One person told us, "The carers [staff] will knock on the door before coming into the room". A relative said, 'The carers [staff] will ask me to leave the room when they change [my relative's] pad. And I've noticed they always close the curtains when supporting her". A staff member told us, "When I'm due to help someone with personal care I'll ask if they want a wash, or if they want to wash themselves. And when I wash one part of their body I'll always make sure I cover the other half with a clean towel". This meant people's privacy and dignity were respected by staff.

People were well presented and looked well cared for. One person was very proud of the clothes they were wearing and told us their son had bought these for them. All the staff knew this, commenting on the person's appearance. One person's relative told us, "She's always nice and clean. She's dressed nicely and she's always dry. She's always up when we get here. I think she's happy here".

Requires Improvement

Is the service responsive?

Our findings

People told us there were opportunities to go out to a local shopping centre or the theatre in the minibus belonging to the service. Some people told us they had been involved in these trips. One person said, "I've been to the theatre. We go as a little group. Entertainers come here". Another person told us, that they liked to play bingo and enjoyed flower arranging and cooking.

A timetable of activities was in place that people could take part in, however these were not suitable for some people living in the service and alternatives were not always considered. Regular activities included bingo, singing and music sessions, arts and crafts and puzzles. Newspapers were delivered every day and people confirmed they received the newspaper they wanted. A hairdresser visited once a week. A dedicated hairdressing salon was available. People were having their hair done and the hairdresser clearly knew people well, chatting and laughing together. Many people chose to have a hair appointment, it was a busy morning where people were enjoying being pampered. Although this was a 'pamper day', it was all females who were taking the opportunity to have their hair done and their nails painted. There was no alternative for people who did not want to take part in 'pamper day'. There was a lack of variety and individual choice with the meaningful activities on offer.

Some people preferred to stay in their room and this was recorded in their care plan. One person often chose to stay in their room and staff were advised to encourage them to go into the communal lounge for a period of time. The person was sitting in the lounge on the first day of our inspection but had chosen to stay in their room on the second day. Other people were nursed in bed due to their specific health needs. The activity coordinators spent time providing one to one sessions with people in their rooms. Although there was some evidence of this happening, the activities documentation was not always up to date so it was not clear how often people received one to one time for meaningful activity. This had been identified by the manager during their care plan audits on 12 September 2017 and action had recently been put in place to improve the documentation. The regional manager had also identified that the planning of meaningful activities required improvement during their audit on 08 September 2017. The audit action plan recorded they had spoken to the activities coordinators and the manager outlining the need for improvement by the next monthly audit. A member of staff said, "I don't think there are enough activities, it's not consistent".

People nursed in bed and those who choose to stay in their room are at greater risk of isolation. However this was not specifically addressed in care plans. We spoke to the manager about this who said this should be recorded in the care plan called 'Psychological and sleep'. However, we did not find any evidence that this area had been addressed. The manager said they would bring this to the attention of the nurses as a matter of priority.

We recommend the provider seeks advice and guidance to increase the opportunities for people to take part in meaningful activities either as a group or individually, drawing on people's personal interests and preferences.

An initial assessment was undertaken with each person before a decision was made that the service could

meet their assessed needs when they moved in. The assessment led to the development of people's individual care plan. People's care plans were set out well to make sure information was easily accessible for staff. The areas of daily living where people had been assessed as requiring nursing, care and support included; consent, capacity and rights, medicine administration, mobility, skin care, infection control, behavioural needs, mental health and well-being, communication and personal care. For example, one person had low and high moods and sometimes displayed behaviour that may challenge others. Their care plan detailed how staff should respond in these situations to provide a consistent approach. Care plans provided the detailed information staff required to support people with their assessed needs and as they wanted. For instance, if they liked a full body wash or if they preferred a bath or a shower. Some people were able to undertake some elements of their own personal care and this was documented to ensure people maintained their independence where possible.

Staff were helped to have a good understanding of the lives people had led before moving in to the service and the people who were important to them through a life story record within their care plan. Documentation was kept in people's rooms with the daily charts staff needed to complete throughout the day. For instance, food and fluid recording, position change charts and bed rail checks. Staff recorded in the daily notes booklet within the room file, documenting the contact and intervention they had with each person throughout the day and night.

Staff communicated with each other at the beginning of each shift to make sure important information was exchanged. The discussions that took place included changes in people's health and care needs, accidents and incidents or visits by health care professionals. A detailed handover record was completed and added to before the next shift handover as necessary.

People were actively involved in the service and decisions about the things that affected them. A 'Residents action group' (RAG) was held most months with good attendance recorded. People who lived at the service led the meeting, one person was 'Residents advocate' and another person was 'Coordinator'. Relatives were welcome to attend and some usually did. At a meeting in February 2017 and again in May 2017 concerns were raised about levels of staffing. The meeting in July 2017 recorded that the levels of care staff had improved. Issues had been raised at more than one meeting about the cleanliness of the mugs used for drinking from. This had improved with a change in dishwashing tablets. The residents advocate was monitoring the situation. They told us, "Residents tell me their complaints and I pass them on. For example, the dishwasher doesn't clean very well and we had dirty cups and glasses. I take in the cups and glasses to the kitchen whenever we find them dirty". The chef joined the RAG meeting in July 2017 to discuss menus and to ask for feedback about the recent menus and food quality. Therefore, people's views were listened to and acted on.

People, their relatives and friends were asked to complete a questionnaire about the service whenever they wished via an electronic tablet device that was available at all times. For example, questions such as, 'Do the staff treat you with respect?', Do you feel you are treated as an individual?', 'Did your relative appear well cared for today?' and 'Do you feel your relative is safe within the care home?'. As well as these general questions, the provider followed a themed survey once every three months. The most recent theme had concentrated on the food and mealtime experience. The results of questionnaires were automatically collated by the provider's head office. Results were analysed and used to develop a plan to pass on to the manager with the expectation that improvements were made to the service where highlighted.

People knew who to speak to if they had a complaint. One person said, "If I'm not happy, I feel comfortable to speak to [the manager] and he sees what he can do". Relatives told us they would speak to the manager if they had any concerns. The provider had a complaints policy in place and contained a statement about how

the provider would meet its duty of candour obligations. The policy gave clear details of what people needed to do, the details required and what people could expect in terms of responses and time scales. The policy also gave the details of the local authority, Care Quality Commission and Local Government Ombudsman. Complaints received had been dealt with in accordance with the policy and within the time scales set. All complaints had been fully investigated and responded to appropriately. Records had been kept of the investigation and outcome.

Many compliments had been received, mainly in the form of thank you cards from relatives of people who had lived at the service. These included, 'He enjoyed the banter with you all' and 'Once again, thanks for making [person's name] final tribute a success. We will always remember Beechcare and the staff with grateful thanks and appreciation'

Good

Is the service well-led?

Our findings

People told us they felt the service had improved since the new manager had started in post. All the people we spoke with knew the manager. The comments we received included, "He [the manager] listens and is very good. Things have improved lately, for example the decoration of the lounge and dining room" and "He seems to be ok".

Comments from health and social care professionals included, "[The manager] has made a big difference. He is open and has made a lot of changes, including to the environment. I am very happy with the care here now", "It is still early days and I think it will continue to improve. Put it this way, I would be happy to be here", "They have a new manager and a new deputy manager who have seemed to turn the service around" and "There has been a lot of involvement from the senior management in the service and it has turned around significantly".

Staff told us they were very happy in their role and felt the interaction with the manager and the provider's senior management team was very good. Staff were asked their views throughout the year by accessing the electronic tablet device to complete a staff survey when they wished. The majority of feedback through this system was positive. Staff meetings were held, the manager had held two staff meetings and one separate nurses meeting since they commenced in post in April 2017. The first staff meeting was an open discussion so that staff had the opportunity to raise issues important to them. The nurses meeting on 13 July 2017 discussed issues the manager had found with care plans and documentation.

Staff were very happy with the new manager, many positive comments were made about them, including, "I find [the manager] very supportive", "There has been a big improvement since [The manager] is here. There is a much better atmosphere", "I definitely feel I'm being listened to now, we are making suggestions and being included in helping to make the changes", "Staff morale is much better" and "I feel it is much better run and managed. I feel confident improvements will go further, we are all working really well together as a team".

The results of all surveys were sent to the manager and senior management team by the provider's head office. Where survey responses showed dissatisfaction and were not acceptable the management team were tasked with making improvements within a timescale, feeding back to the provider the action taken showing improvements made as a result of feedback.

The provider had a staff award system, recognising staff or teams of staff for their achievements. The staff team at Beechcare Care Home won the provider's 'Rock gold award' following a letter of compliment sent to the provider's head office from a very grateful family following the death of their loved one. Their comments included, 'We want to personally thank each and every one of you for being such wonderful, caring people' and '[Manager's name] you should be very proud of the staff that you have and the way your care home is managed'. The manager told us of one person who had recently passed away. Their parent had lived at the home for many years and when the person became unwell their wish was to move in to Beechcare Care Home as they had good memories of the quality of their parent's care.

The manager had been in their role since April 2017 and was still in the process of making changes they felt necessary to improve the quality of the service provided. The provider had in place a booklet called 'My journal' which was kept in the room documentation file. This was in place to record the important personal information needed to understand the individual. A booklet called 'My choices' was another document the provider expected staff to complete. Both of these booklets were not always completed, some had information recorded, others had small amounts of information and others had not yet been completed at all. The new manager was aware of the areas that required improvement within the care planning system and had plans in place to make changes. The full completion of 'My Choices' and 'My Journal' were amongst their plans for improvement. The manager was in the process of auditing all care files, recording the action required for each to bring them up to the standard expected.

The provider had a robust system to regularly monitor and audit the quality and safety of the service provided. A range of audits were carried out by different staff, some staff working in the service and others from the provider's senior team. These included; care plan audits by the manager and also by the regional manager; health and safety by the manager; weekly medicines by the manager and daily medicines by the nurses; housekeeping by the housekeeper; weight loss by the weight loss champion and a full audit encompassing all areas once a month by the regional manager.

Action was seen to have been taken in response to areas that required improvement. For example, a consent form was found not to have been signed for the use of bed rails for one person in the September 2017 care plan audit. Action was taken immediately by a nurse who asked the person's relative to come in to discuss and the consent form was signed following discussion the next day. In the August 2017 audit a care plan monthly review had been found not to have taken place since June 2017. Action was taken to ensure the review was undertaken and completed by 08 September 2017. Areas that required action to improve during the regional manager's care plan audit on 8 September 2017 were seen to have been attended to straight away. The area of activities we noted as requiring improvement had been identified through the provider's auditing processes. The regional manager had reviewed the environment while completing the full audit on 08 September 2017 and identified that flooring in the corridors and communal areas needed replacing. The manager was asked to obtain quotes and this was being pursued.

The manager was responsible for reviewing the information recorded on the electronic system every month. This included how many people had; falls, chest infections, pressure ulcers and weight loss. The number of medicines errors identified were also reviewed at the same time. The manager was able to collate the information into graphs or pie charts to enable a visual context to the information. For example the number of falls in a month could be broken down into the time of day that falls occurred or days of the week. This enabled the manager to check trends and investigate further to put measures in place to improve outcomes for people.