Pretim Singh

Beechwood Residential 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 12 July 2017 and was announced. The provider was given 48 hours' notice as the service is a small home and people are often out during the day. We needed to be sure someone would be in.

Beechwood Residential Home is a five bedroom care home for adults with learning disabilities. It is based in an adapted house in a residential area. At the time of our inspection four people were living in the home.

The home was last inspected in May 2015 when it was rated 'Good.'

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left in November 2016. The provider was in the process of recruiting a new registered manager.

People's care plans and risk assessments were detailed and personalised. There was detailed information about people's communication and preferences within the care plans. Care plans and risk assessments had been reviewed annually. However, parts of the care documentation had not been updated and there were discrepancies including about people's end of life wishes.

People told us they felt safe in the home. Staff were knowledgeable about safeguarding adults from harm. Incident records showed the provider had taken appropriate action when incidents happened.

Recruitment records did not show staff had been recruited in a safe way.

Staff received the training and support they needed to perform their roles.

The home supported people to take their medicines. The home completed regular audits of people's medicines to ensure they were correct. However, the home was not always following the prescriber's instructions for when medicines should be taken.

The home was working within the principles of the Mental Capacity Act 2005. Where people lacked capacity to make decisions appropriate best interests processes had been followed. Staff supported people to make their own choices where they were able to do so.

People told us they liked the food. The home encouraged people to be involved in choosing the menu and supported people to eat a healthy, balanced diet in line with their preferences.

Records relating to people's health and the support they needed to access healthcare services was old and

out of date. They had not been updated since 2015.

People and staff had developed strong, caring relationships with each other. Staff supported people to maintain their dignity and respected their privacy.

Care plans contained details of people's religious beliefs and people were supported to practice their faith if they wished to do so.

People were supported to maintain their friendships and relationships. Care plans considered people's sexuality and their support needs in relation to their sexuality.

People attended regular one-to-one and house meetings where staff listened to and responded to their feedback about the service. The home had a complaints process in place that was accessible to people who used the service.

The provider had not identified that health and safety checks were not being completed as required, or that some records were no longer being maintained. The provider had not identified that some information in staff and care files was out of date, incomplete or inconsistent.

We found breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we asked the provider to take at the back of the full version of this report. We also made two recommendations about supporting people to have their healthcare needs met, and identifying and recording people's end of life wishes.

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. Staff had not been recruited in a way that ensured they were suitable to work in a care setting.

People were supported to take their medicines. The home was not always following the prescriber's instructions for medicines.

People told us they felt safe in the home. Staff were knowledgeable about safeguarding adults from harm.

Risks to people had been assessed and there were robust plans to mitigate risk.

Is the service effective?

Requires Improvement

The service was not always effective. Information about people's health and the support they needed to access health care services was old and out of date.

Staff received the training and support they needed to perform their roles.

The home was working within the principles of the Mental Capacity Act 2005.

People were supported to eat and drink enough to maintain a balanced diet.

Is the service caring?

Good

The service was caring. People and staff had developed strong, caring relationships with each other.

People were supported to practice their religious faith.

People were supported to maintain their significant relationships.

People were supported to maintain their privacy and dignity.

Is the service responsive?

Good

The service was responsive. People's care plans were detailed and personalised.

Care plans were reviewed and updated annually.

People were involved in making decisions about their activities.

People had meetings where they could provide feedback about the home.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had not identified or addressed issues with the quality of records.

The provider had not identified or addressed that health and safety checks were not being carried out as scheduled.

People, staff and visiting professionals completed feedback about the quality of the service.

Beechwood Residential 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.

The inspection took place on 12 July 2017 and was announced. The provider was given 48 hours notice as the location is a small care home and people are often out during the day. We needed to be sure people would be in. The inspection was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service. We sought feedback from the local authority monitoring team and the local Healthwatch.

During the inspection we spoke with two people who lived in the home. We spoke with four members of staff including the nominated individual, the acting manager, and two support workers. We also spoke with two external professionals who worked with people who lived in the home. We reviewed two people's care files, including care plans, risk assessments, health information and records of care. We reviewed two staff files, including recruitment records, training, supervision and appraisals. We also reviewed various documents, meeting minutes and records relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

One member of staff had been recruited since our last inspection in May 2015. The recruitment file did not contain the information required to demonstrate safe recruitment practice had been followed. There was no record of the interview, no employment or personal references, not all the required documentation to ensure their right to work in the UK had been checked and the criminal records check certificate in the file was from their previous employer. The service had no record they had checked if this person was signed up to the update service. The acting manager told us they had not been involved in the recruitment of this staff member as it had been completed by their predecessor. The provider established the staff member had signed up for an update service with the criminal records checking service and was able to show us the result of a check. The provider also contacted the staff member who confirmed they had provided references when they had been recruited. However, the information was not in the file. This meant the service had not demonstrated they had followed safe recruitment practice. After the inspection the provider sent us a copy of an interview record. The staff member had since completed their induction and had demonstrated they were suitable for work in a care setting through their performance.

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

People who lived in the home told us they felt safe. One person said, "I feel safe in my own way." Professionals who worked with people outside of the home told us they thought people were safe living at the home. Staff were knowledgeable about the different types of abuse people might be vulnerable to and told us they would report any concerns they had. One support worker told us, "I'd report [allegation of abuse] to the manager. It's my job to protect people." Another support worker said, "I'd report it on. We can't turn a blind eye to that kind of thing. We have to report it."

Incident reports were reviewed. These showed there had been no incidents that were allegations of abuse since the last inspection. The provider had a policy regarding adult protection, which provided details on the different types of abuse and how staff should escalate their concerns. However, this had not been updated to reflect that the home did not currently have a registered manager. The policy did not contain details of the local safeguarding team where concerns would be raised. This meant there was a risk staff did not have access to the information they required to raise safeguarding concerns on behalf of people living in the home.

People's care plans contained a range of risk assessments to mitigate risks they faced in their daily lives. These had been reviewed annually and staff signed to indicate they had read and understood the risk assessments. Staff told us they would inform the acting manager if they thought someone's risks had changed and they needed more or less support. One support worker said, "I am involved with doing the risk assessments. If I see changes I will go through it with [acting manager] and we'll amend the plan."

Risk assessments in place included measures to ensure people could use the kitchen safely, access the community, and maintain their personal hygiene and health. There was enough detail for staff to know

exactly how to support people. For example, one person was at risk due to behaviours which could harm themselves or others. Their risk assessment contained a detailed description of their behaviours and early indicators that they may be becoming distressed as well as strategies for minimising the risk of incidents. For example, staff were instructed to use pictures, signs and symbols to prepare the person for new experiences and appointments to reduce the risk of them becoming distressed. This meant risks to individuals were managed so people were protected.

The provider supported people to manage their finances. There were robust systems in place to ensure the monies held in the service were accounted for. The provider and acting manager both checked bank statements against monies brought to the service which ensured there were no withdrawals that were unaccounted for. All transactions were recorded in an individual finances book. Monthly audits of people's finances were completed to ensure all money had been correctly accounted for. A check of the monies held for two people found the balances in the records matched the funds in the service. Prior to May 2017 staff had completed daily counts of people's money during handover. However, staff had stopped recording this in May 2017. The provider told us this was because they had run out of the sheets used to record this information.

One person told us, "Staff help me with my tablets. In the morning, at lunchtime at before bed. Sometimes they give me paracetamol if I have a headache." The home received people's medicines and pre-printed medicines administration records (MAR) from the pharmacist. People's medicines were delivered in monitored dosage system where each day's medicines were individually packaged. Staff were confident in describing how they supported people to take their medicines and knew what to do in the event of a medicines error. Staff told us they were able to identify individual medicines that people took. MAR and medicines were checked and the records showed people had taken their medicines daily. The acting manager recorded regular stock counts and audits on the back of the MAR. A check of medicines stocks found the correct amount of medicines in the home.

It was noted that one person was prescribed a medicine which had the prescription instruction that it should be taken before food. They had been prescribed another medicine with the prescription instruction that it should be taken with, or after, food. It was not clear from the records whether this prescription instruction was being followed. Discussion with staff showed this person was supported to take all their morning medicines together, before they had personal care and breakfast. This meant the home had not identified they were not following the prescribers instructions for all of this person's medicines. The acting manager contacted the pharmacy to arrange for medicines and MAR to be amended to reflect the prescribing instruction.

Within care files the medicines people took and the support they required to take them was recorded in various different places. There was a specific care plan for medicines, a list of medicines in the one page profile at the front of the file, medicines information in missing person's profile and a medicines list in people's health files. The information in the care files had not been kept up to date and did not match the information in the MAR. For example, discontinued medicines were still on these lists, dosages had changed for other medicines. This meant there was a risk that out of date information would be taken to health appointments, or shared in the event of an emergency and people may be given medicines they no longer use. This was discussed with the provider who advised they would ensure medicines information was up to date in all locations in care files.

Requires Improvement

Is the service effective?

Our findings

Staff told us they completed training courses relevant to their job roles. One support worker said, "We have done a lot of e-learning." Another member of staff said, "We do training, there are so many trainings." Records showed staff received training in health and safety, fire safety, first aid, safeguarding, managing violence and aggression. Staff had also completed training in areas specifically related to the support needs of people such as epilepsy and autism. Records showed new staff completed a comprehensive induction period over three weeks, which included an introduction to the service and time to familiarise themselves with people's care plans and support needs. New staff were in the process of completing the Care Certificate. The Care Certificate is a nationally recognised qualification that provides staff with the fundamental knowledge required to work in a care setting.

Staff told us and records confirmed they had regular supervisions and annual appraisals with the acting manager. One staff member said, "I have monthly supervisions with [acting manager]. We talk about how I feel, what I'm going to do next and what I've learnt. I had an appraisal. We talked about what my achievements were and what I'm going to be next." Supervision records showed staff discussed their training needs, and the needs of people who lived in the home. Appraisal goals were specific and related to people's career progression. Records showed staff had achieved their goals from previous appraisals. This meant staff received the training and support they needed to perform their roles effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Where people lacked capacity to consent to their care and support, and their care plans were restrictive due to the nature of the support they received, the service had made appropriate applications to deprive them of their liberty. Records showed the service followed appropriate best interests decision making processes when people were faced with decisions they lacked capacity to make. There was guidance within care plans to inform staff how to communicate decisions to people in a way that would facilitate their understanding and ability to make decisions. For example, two people who lived in the home were resistant to medical appointments and interventions. One care plan explained that for one person photographs and social stories could be used to facilitate their understanding. Social stories are a way of framing a situation using a short narrative to support people to understand what is going to happen. The second care plan contained guidance for visiting health professionals about how to support the person to engage with health appointments.

Staff demonstrated they understood the application of the MCA as they described how they supported people to make decisions and choices in their daily lives. One support worker said, "[Person] can decide what he wants to eat. For example, he might ask for cereal for breakfast, even though it's beans on the menu. If he's asked for cereal he has the cereal." Another support worker told us, "[Person] can make his own choices. As long as it's not dangerous it's fine. He can do what he wants. We're careful not to be restrictive. He can take risks, but we have to be careful that it isn't too dangerous."

People who lived in the home told us they liked the food. One person said, "The food is tasty." Care plans contained details of people's dietary preferences and any special health related dietary needs that people had. The home had a pictorial menu on display in the kitchen to support people to understand the menu options available to them. Care plans contained details on how to encourage people to eat a healthy diet while recognising that people's preferences were for unhealthy food. Both the support workers we spoke with explained how they tried to encourage people to eat more healthily. One support worker said, "We try to put in more vegetables. Sometimes we try to sneak them in, but she's not really having it." House meeting minutes showed people were involved in choosing what meals were available. The home kept a menu record book to record what meals had been prepared. This showed people were supported with a variety of different menu options. This meant people were supported to eat and drink enough and maintain a balanced diet.

Care plans contained information about how to support people to access healthcare services. This included details of how to reduce people's anxiety about healthcare appointments and interventions. Each person had a dedicated health folder which contained a copy of a health passport and health action plan. Health passports and health action plans are recognised as being good practice for people with learning disabilities as they are documents that ensure that all information relevant to people's health is in one place which is accessible to health professionals as needed. These documents are meant to be accurate and up to date reflections of people's health needs. Although the health passports and health action plans were detailed, they had not been reviewed or updated since 2015. The medicines information contained within the documents was out of date, and one person's documentation had not been updated to reflect the progress they had made with their health condition following a successful operation. In addition, their next of kin details had not been updated following a family bereavement. This meant people's health was at risk as health professionals involved in their care, particularly in emergency situations, did not have up to date or accurate information.

We recommend the service seeks and follows best practice guidance from a reputable source about how to support adults with learning disabilities with their healthcare needs.

Good

Is the service caring?

Our findings

Throughout the inspection observations showed staff interacted with people in a kind and compassionate way. At one point, a person who lived in the home was heard telling staff, "I like you." Another person told us, "I like the people that work here. The staff are kind." Staff spoke about the people they supported with kindness and affection. For example, when talking about one person a support worker said, "She's such a pleasant person, that when she's upset it's upsetting for me. I have a few tricks up my sleeve that can bring her round, shopping trips are usually a good idea."

The people who lived at the home had not changed since our last inspection in May 2015, and only one new member of staff had joined the team. This stability for people and staff meant people and staff had the opportunity to develop close relationships. One support worker said, "I got really close to [person] as I key worked with them for a couple of years. We've got a good bond now." Observations during the inspection showed this person sought and received reassurance from the support worker throughout the day.

Care plans contained information about people's religious beliefs and cultural background. People were supported to attend religious services in line with their preferences. A support worker told us, "Oh yes, I support [person] to attend [place of worship]. They really enjoy it there." Another support worker said, "They practice their faith. They go to [place of worship] every week. They know, they know it's Sunday and that's the day we go."

Staff told us that some people who lived in the home had friendships and relationships with people outside the home, their families and friends from their day services. The service supported people to maintain their relationships with family members. It was noted in one person's monthly reviews that they needed to be supported to prepare for and attend a family event and party.

Care plans contained a section called, "Expressing sexuality." These care plans contained information about people's preferences for their appearance as well as significant relationships and how they expressed their sexuality. This included where people lacked capacity to consent to sexual relationships, but still maintained significant relationships. One plan included, "I have a male friend at [day service]. I would not understand about different types of relationship and could be taken advantage of." Staff told us they facilitated people's relationships and social lives and recognised this was important to people living in the home.

One person told us they were able to have private time when they wanted it. They said, "I can chill out in my room when I want." Staff told us how they supported people to maintain their dignity during care, by ensuring doors and curtains were closed. Some people who lived in the home did not have a good awareness of how to maintain their own privacy and dignity and did not always shut bathroom or bedroom doors. This information was included in care plans with instructions for staff to ensure people's dignity was maintained and instructed staff to give people private time when they wanted it. Staff told us they encouraged and supported people to ensure their dignity was promoted and their privacy respected.

People had been supported to consider their wishes for the end of their lives. However, there was conflicting information within the care files. For example, one person's file stated that in 2002 they would like to die at home and be buried in a coffin. However, the most recent end of life wishes document, dated March 2011 stated the person wanted to die in hospital and be cremated. The conflicting information meant there was a risk the person's end of life wishes were not clear and they would not be supported to die in their place of preference. It was noted people who lived in the home were not unwell or known to be approaching the end of their lives.

We recommend the service seeks and follows best practice guidance from a reputable source about supporting people to plan for the end of their lives.

Good

Is the service responsive?

Our findings

The home operated a key working system where a member of staff led on the support for each person who lived in the home. Records showed keyworkers met with people on a monthly basis and completed monthly reports on the progress people had made, including activities they had attended, health appointments, and any incidents or accidents that had occurred. People had detailed care plans that related to the different areas of their lives. They had been reviewed and updated annually.

Care plans contained details of the support people required in different aspects of their lives. These included personal care, health, finances, nutrition, emotional and psychological needs, leisure activities, keeping safe, sleeping and communications. The care plans were detailed and personalised for each person and included which aspects of tasks people could complete for themselves. This ensured people's independence was promoted. For example, one person's care plan for personal hygiene stated, "I can dress and undress myself but need support ensuring I am dressed appropriately. I like to look smart. I need you to run the bath and check the temperature for me." The care plan then detailed which aspects of washing the person needed support with.

People who lived in the home had specific needs in relation to their communication as they did not all use speech as their primary way of communicating with others. Care files contained detailed information on how to facilitate communication with people. One person's care file showed the home had worked with the person's day service to develop a comprehensive communication passport which included details of how they used different behaviours and sounds to communicate their needs and feelings. This meant the service was supporting people in a personalised way.

Three of the four people who lived in the home attended day services regularly. Care plans included details of other activities they liked to do both inside and outside of the home. Records showed people were supported with a range of activities from playing board games, a visiting music session, and attending local community events. Staff told us that attendance at regular day services was very important to people who lived in the home as their needs meant routine was very important to them. Support workers told us people became distressed if their usual routines were broken and described how they attempted to arrange appointments and activities so they did not disrupt people's usual routines. One support worker said, "It's a bad day for [person] if they can't go to the centre. We try to arrange appointments for the evenings so it doesn't disrupt their routine. If we can't move it, we'll make sure we put in something fun for after the appointment, like going out for a meal."

The home held regular house meetings. Records showed these were used to plan activities for people including attendance at local shows and birthday parties for people who live in the home. One person confirmed to us they had had a birthday party recently. In addition, meeting records showed people were supported to consider different ways they could stay safe both inside and outside the home as well as fire safety measures. This meant people were involved in making decisions about their lives.

The home had a complaints policy which included details of how to make complaints and expected

timescales for investigations and response. In addition, the home had a pictorial version of the process to support people who had difficulties with reading to make complaints. The provider had not received any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

The home had not had a registered manager since November 2016. The provider told us they had attempted to recruit a new registered manager but had not yet found a candidate with suitable skills and experience. At the time of the inspection the provider was advertising the post and told us after the inspection they had an interview scheduled. The management of the home was currently being carried out by the acting manager with support of the provider. Staff told us the provider visited the home to check how things were going. One member of staff said, "[Provider] pops in now and again." Another member of staff said, "I will hear she has visited the home. She's available if there is a problem."

People, staff and visiting professionals were invited to complete annual surveys about the quality of the service. It was noted with the provider that staff had to complete their names on their surveys and this may limit their willingness to be open about their feedback. Although most of the feedback was positive, there was no record that survey responses had been analysed or responded to.

The provider had a schedule of quality monitoring tasks, including ensuring health and safety checks such as water temperature checks and fire alarm testing were completed regularly. During the inspection the water temperature recording book could not be located. The provider told us this had been lost and staff had stopped recording water temperature checks as a result. Likewise, fire alarm tests were meant to be carried out weekly, but records showed these had been carried out monthly since March 2017. Food in the fridge was not labelled as required to ensure good food hygiene practice. These issues had not been identified or addressed by the provider.

The provider had not identified that key care plan documents, such as profile pages and health action plans, had not been updated since 2015. They had not identified the inconsistencies in medicines lists, or end of life care wishes documentation. Nor had they identified or addressed that daily handover sheets had not been completed since May 2017.

The local authority had completed a monitoring visit to the service in February 2017. The report from this visit included the action that incident forms should be stored centrally to facilitate monitoring. During the inspection copies of incident reports were requested but could not be located in either the central incidents file or the person's file. The provider located them and submitted them after the inspection. The local authority action plan also included an immediate and thorough audit of all care files. There was no record this audit had been completed and issues with the completeness and consistency of care files remained.

The provider had completed a management audit in February 2016. This had identified the need to review and update policies and procedures. However, the complaints policy remained out of date as it contained reference to old regulations and the safeguarding policy did not contain all the information required. There was no record of checks completed by the provider other than financial management checks. The provider had not reviewed the recruitment files which meant the issues with the safety of the recruitment practice in the home had not been identified by them.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not identified or addressed issues with the quality and safety of the service. They had not identified that records were insufficient. Regulation 17(1)(2)(a)(b)(d)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records did not show staff had been recruited in a safe way with their identity and suitability for care work being assessed. Regulation 19(2)(a)(3)(a)