Beech Care Limited

Beechcare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new process being introduced by the CQC which looks at the overall quality of the service.

This was an unannounced inspection. Beechcare provides care and support to six people with learning disabilities some of whom have lived there for a number of years. There were six people living in the home during the inspection.

This service requires that a registered manager be in post. The provider had appointed a suitably experienced and qualified manager to manage the home and an application to register them had been submitted to the Care Quality Commission (CQC) registration department at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were unable to tell us about their experiences of care because of their communication difficulties, but our

Summary of findings

observations showed them to be in positive relaxed moods throughout the inspection, and interacting with staff or objects that interested them or were particular favourites.

A management structure was in place and staff benefitted from having a clear understanding of their role and accountability. A comprehensive quality assurance process that included audits of incidents, risks and care plans, helped to ensure that people received a consistent service.

Staff told us that they were happy in their work and showed a commitment to the wellbeing of the people they supported. The provider ensured there were enough suitably trained staff to meet people's needs. A thorough recruitment process ensured that appropriate checks were made of new staff before they commenced work. Staff told us that there was a low staff turnover because they felt well supported and involved.

Staff understood how to safeguard people from harm and implemented the requirements of the Mental Capacity Act 2005 and DoLS. There were appropriate arrangements in place for the induction, training supervision and appraisal of staff, but staff did not always put what they had learned into practice.

Throughout our inspection we saw that people were treated with respect and dignity. Their care plans were personalised and kept updated to reflect changing care and treatment needs. People's immediate care and treatment needs were addressed and kept under review, and they were provided with the equipment or adaptations they needed. Staff demonstrated an awareness of advocacy services and ensured that relatives and relevant professionals were kept informed and consulted. Relatives were encouraged to visit.

We identified some areas for minor improvement to enhance existing arrangements. These were centred on better use by staff of their positive interaction training. Our observations of and discussions with staff showed that they understood people's needs, and provided care with kindness and compassion, but that they sometimes showed anticipation of people's choices rather than enabling them to make active choices for themselves. Staff were seen engaging with people through activities and when they were sitting quietly. However, they did not make the best use of the communication tools available to aid this, which would help to make people feel included and consulted in daily decisions and planning of their care.

Staff respected peoples choices but did not always explore the reasons for changes in chosen or preferred activities or habitual behaviours. Staff were mindful of the impact of aging on the people in the home and provided activities accordingly, although improvements were needed to make some of these meaningful.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staffing levels ensured that people received all the support they required at the times they needed from suitably trained staff.

Staff understood how to keep people safe and implemented the requirements of the MCA and DoLS.

New staff underwent a thorough recruitment process to ensure all appropriate checks had been undertaken before they commenced work and their competency was monitored.

Good

Is the service effective?
The service was not effective.

People were able to make choices about what food and drinks they liked but staff sometimes anticipated their choices for them.

There were appropriate arrangements in place for the induction, training supervision and appraisal of staff, but staff did not always put what they had learned into practice.

People were supported to access appropriate health, and medical support when issues arose.

Requires Improvement

Is the service caring?
The service was not caring.

Staff had a well-developed understanding of how people made their wishes known but the detail of peoples methods of communication was not fully recorded in communication passports. People were involved in making decisions about their care and treatment within their capabilities but this was not well documented.

Staff supported people in a caring, compassionate and respectful manner, and were mindful of people's dignity.

Staff demonstrated an awareness of advocacy services. Relatives were encouraged to visit and were consulted.

Requires Improvement

Is the service responsive?
The service was not responsive.

Requires Improvement

Summary of findings

Staff respected peoples choices but did not always explore the reasons for changes in chosen or preferred activities or habitual behaviours. Staff were mindful of the impact of aging on the people in the home and provided activities accordingly, although improvements were needed to make some of these meaningful

People's immediate care and treatment needs were addressed and kept under review, and they were provided with the equipment or adaptations they needed.

Care plans were personalised and kept updated to reflect changing care and treatment needs.

Is the service well-led?

Requires Improvement

The service was not well led

A suitably experienced and qualified manager was in post awaiting registration. Staff said they felt well supported and listened to by the new manager. Staff felt confident of using the whistleblowing procedure if needed.

There was a clear management structure and staff understood the lines of accountability and their roles.

Comprehensive quality assurance processes were in place that helped ensure people received a consistent service. However, improvements were needed to ensure peoples individual experiences of care delivery and staff practice were reflected within this.

Beechcare

Detailed findings

Background to this inspection

At our last inspection in June 2013 we had not identified any areas of concern and all standards assessed were met. 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 home, what the home does well and improvements they plan to make. Before our inspection we reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports, notifications (A notification is information about a significant event taking place in the service that they are required to inform us about) and complaints. This enabled us to ensure we were addressing potential areas of concern.

We contacted four relatives who all spoke positively about the care their relative received. We also contacted a selection of health and social care professionals who have contacts with the home and they have not responded with any concerns.

The inspection team comprised of an inspector and an expert by experience who had knowledge and understanding of people with learning disabilities and autistic spectrum disorders. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of home.

We observed and had contact with all the people at the home. To find out their experiences and observe how staff engaged with them, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at how people were supported during the day with individual activities and at lunch.

We also spoke with the covering manager, a locality manager from the organisation with responsibility for oversight of this home, and three members of care staff.

We also looked at a range of care and management records that included three peoples care files, four staff records in addition to records about how the home was managed including incident information and assessment and monitoring of service quality.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005(MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014.They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People living in the home had high support needs, they were unable to tell us about their experiences but we observed them to be relaxed and settled throughout the inspection.

There were three staff on duty as well as a manager who spent shift time working alongside staff supporting people. Staff told us they had time to spend with people and provide them with assistance as and when required. Staff said that they did not feel rushed and were aware of people's needs at all times. The manager ensured that staffing levels were kept under review and continued to meet people's needs Staff told us that staffing levels were satisfactory for the number and current dependency of people in the home; they told us that if staff were needed to accompany people on an activity, other staff were brought in to ensure the same level of staff support was provided to those remaining in the home.

We spoke with staff who told us that they had received training in safeguarding and this was updated regularly, and this was supported by training records viewed. In discussion staff understood their personal role and responsibility to report concerns or suspected abuse. Whilst staff told us that they would report any incidents to the covering manager or locality manager they also demonstrated awareness that they could also report incidents to other relevant agencies if they were unable to go through the organisations internal reporting systems.

Staff said they did not have anyone whose behaviour could be challenging to others and restraint was not used as a means to restrict people's freedom. We looked at people's records to ensure that minor restraints for lap belts on wheelchairs and bed rails for one person had been implemented as part of a risk assessment and safety process.

We were informed that no one at the home was currently subject to a Deprivation of Liberty safeguards (DoLs) authorisation, (this is part of the Mental Capacity Act 2005 and ensures people can be given the care they need in the least restrictive regimes and prevents decisions being made without consultation that deprive vulnerable people of their liberty). Staff demonstrated a good understanding of mental capacity and deprivation of liberty safeguards and had received updated training in these areas.

The manager and staff knew what action to take if someone was unable to make an important decision about their care, support or treatment for example, with health interventions. Relatives and/or relevant professionals were involved with decision making and relatives confirmed they were kept informed and consulted. These were informal discussions and not always recorded. One relative we spoke with said that they had no concerns about their relatives care, and could now give more time to being involved in discussions about their care needs.

A review of care files showed us that risk assessments tailored to the needs of individual people were in place; these supported each area of people's identified needs and risks associated to this. Measures had been introduced to reduce risk for people and to keep them safe. For example, supervising someone at risk of seizures whilst bathing to ensure they remained safe, whilst maintaining the need to protect their privacy and dignity.

We saw that risk assessments were kept under review and updated and amended where necessary. The provider had support from an external health and safety consultancy that supported the organisation with individual and generic risk assessments to ensure these covered identified areas of risk and appropriate measures had been put in place to reduce risks to people.

Staff told us that once trained their competencies and skills were monitored by the covering manager and senior staff through observational supervisions. We saw records of competency assessments for some areas of support, for example medicine management.

We looked at how staff were recruited to the home. The covering manager explained the process and that as the home manager they would be actively involved in the recruitment and selection process. The gathering of recruitment information to demonstrate the applicant's fitness was the responsibility of a centralised human resources department, but a pro-forma summary of the checks made and their outcomes was provided to the home prior to the person commencing work at the home. From discussion with the newer staff and the covering manager we were satisfied that a robust system was in place to ensure staff appointed had appropriate fitness checks undertaken.

Requires Improvement

Is the service effective?

Our findings

People were unable to verbally express their preferences. Staff were very familiar with what they liked to eat and drink, and how it needed to be presented for example, cut up, mashed or pureed. People could make known what they wanted to staff through their body language, the sounds they made or by taking staff to what they wanted. Staff said if people did not want something they would make this known.

From our observations of care we saw that staff sometimes anticipated people's choices rather than enabled them to make these for themselves. This was partly due to staff familiarity with people's preferences over a long period of time.

Communication tools, objects of reference and pictorial information were available to provide people with opportunities to make active choices for them but these were not used effectively. This meant that although people were eating and drinking the things they liked, they were not given the opportunities to make changes to this. For example we observed people were asked by staff if they would like a drink. We observed that drinks were provided but people were not actively given a choice between two types of drink, this decision was made for them based on their usual routines.

We saw that people's weights were routinely recorded. We noted that one person was seen to have a small weight loss every month, but their record showed they had attended the doctors recently with regard to concerns about their health.

We looked at how pressure care was managed for those assessed as at risk. We saw that appropriate equipment and procedures were in place for staff to check people's skin daily and apply cream. The people at risk had resided at the home for a number of years. One person's air mattress was incorrectly set and we were told that this is what it had been set at for some time. The procedures in place and the diligence of staff had ensured the person had not developed a pressure ulcer during this time. However, staff were unclear whose role it was to ensure the air mattress was set correctly. The covering manager agreed to clarify this with the community nurse, so as to ensure the person's pressure relief was not placed at risk.

The covering manager told us that the provider has an in house induction pack; a new member of the staff team told us that they were currently working through the induction process and we saw their induction workbook with some entries where the staff member had already completed some elements of the induction. They told us that they were booked to attend a four day organisation induction which was not scheduled until September, as these occurred only a few times every year.

We were told that at the end of the formal induction programme new staff received a personalised learning plan that they discussed with their manager. There was a learning champion at the home who worked with new staff to help them understand what they had learned through reading and on line training. Records showed evidence of individualised workbooks, learning plans and observations of shadowed care.

We looked at records of staff training and saw this was kept updated in all essential key areas of care, and that they were also provided with a range of specialised training identified as important for people's support. For example, epilepsy, diabetes, and dementia training. This meant staff were able to understand and monitor appropriately people's health needs and also had an awareness of how the aging process was affecting some of the people living in the home.

Staff told us that they felt well supported now by the covering manager. They said they were provided with regular one to one sessions with the manager or a senior where they could discuss their learning and development needs and any issues they might want to raise. Records showed these had become irregular but the covering manager was ensuring these were now happening.

We were told that staff usually received an annual appraisal of their performance, however due to the change of manager this has been delayed until later in the year. The locality manager felt this was essential to give the covering manager time to get to know staff through one to one meetings and through observations of their work practice, before making assessments of their overall performance.

We were informed that senior support staff were being helped to understand and take more of a lead role in support planning for people. They were attending workshops about person centred planning run by an external consultancy that specialises in this area. Key work

Requires Improvement

Is the service effective?

roles had also been more clearly defined to ensure staff fully understood this role and its responsibilities to ensure people received the care and support they needed, and that key work staff undertook to co-ordinate areas of this.

Records showed that a health action plan was in place for each person. This recorded what their individual health needs were, who was involved in maintaining their health and what support was needed to do so. A record of health contacts and appointments including speech and language, occupational therapist, physiotherapist and community nurses, showed that people were supported to access routine and specialist healthcare and that changes in their health care needs were reported promptly to relevant health professionals, with whom the home staff had good supportive relationships.

We saw that this was an aging group of people and that the home was anticipating future support needs and ensuring through training and adaptation of the building these could continue to be met.

Requires Improvement

Is the service caring?

Our findings

Staff told us about each person's individual method of communication, and demonstrated an understanding of their unique and diverse communication styles. Communication passports had been established to support staff and provided them with a basic understanding of each person's known communication methods. However these did not reflect the level of detail about people's communication methods that was demonstrated by staff, and could mean that if people were cared for by people who did not know them the full range of their communication may not be understood.

Communication aids such as objects of reference and using picture prompts were also available to staff but we did not see these tools being used effectively with people on the day to actively ensure people were encouraged to make choices and decisions however limited.

We observed staff supporting people in a caring, compassionate and respectful manner. We saw that they were mindful of people's dignity. Staff contacts with people were kind, calm and caring and staff gave clear information to people to which they were able to respond to positively.

Staff told us that care plans were mainly developed from their knowledge and observations of people's needs and preferences and information gained from relatives. Staff encouraged people to be involved as much as they were able to, but these contacts were not well documented.

People in the home had complex needs and were unable to verbally tell us about their experiences. Staff had been provided with Intensive Interaction training, which is a practical approach to interacting with people with learning disabilities. However, staff were not using this routinely. The interactions we did observe were kind, calm and caring and we observed staff giving people information in a clear manner, which they were able to respond to positively. Staff spoke respectfully and kindly about the people they supported, and that people were treated with dignity and had their privacy respected. We observed that when people made a decision as to what they wanted to do staff respected this.

Staff demonstrated an understanding of people's life histories, and understood their individual likes and dislikes. They had used this knowledge to assist people in choosing the colours of their bedrooms and some of the furnishings in their rooms. Staff helped people express themselves through the decoration and possessions they had in their room, and in the choices people made about clothes and appearance.

Staff demonstrated an awareness of advocacy services but no one had required the use of an independent advocate to help support them with an important decision. Relatives were encouraged to visit and maintain contact and some attended care reviews if they were able to. Those who were unable to attend were also consulted and kept informed regarding any issues and confirmed this when we spoke with them.

Requires Improvement

Is the service responsive?

Our findings

People were offered choices of activities and staff knew the kinds of activities people preferred. Changes in peoples responses to preferred routines or activities of choice were not explored. For example we asked about people using the garden. Staff told us that one person in particular who enjoyed using the garden no longer did so, they did not know the reason for this change. One staff member thought it could be due to increased sensitivity to light but this had not been looked into or measures implemented that could help alleviate this. Staff continued to offer the garden as an activity but accepted the persons' choice if they refused. Meaningful alternatives were not offered.

When asking staff about their support of another person, a staff member told us they let the person take the lead, and that they would show staff if they wanted something. We observed that this person had sat with nothing to do for long periods, although later in the day we saw staff bring in a specific activity that the person enjoyed and staff supported them with this. We spoke with staff about this person's self-stimulatory behaviour. A staff member told us that this was something the person did all the time. Staff were not aware if this behaviour had a function and there had been no review of this habitual behaviour.

There was a lack of meaningful activities for people to do when they were at home. But they had opportunities to participate in a range of activities outside of the home including attending a day centre, shopping trips locally and further afield, walks swimming, and reflexology and aromatherapy input. Staff selected activities based on their knowledge of people's interests and the types of activities they had shown interest in. Staff told us that if after one or two sessions of an activity the person showed little interest, then this was replaced with another until they found something they liked. A holiday was planned for later in the year for three people living in the home. We were told that other people who would not respond well to a different environment would be provided with special days out.

People's care plans were personalised, reviewed and updated regularly in response to their changing needs. Provider information sent to us prior to the inspection indicated that there was a drive to develop person centred working. The covering manager told us that a specialist external agency was working with the staff team to introduce relevant training for them and to adapt present systems and support to be more person led. Staff told us that people's relatives were invited to review meetings and were involved as much as they wanted to be, review records showed us that some relatives attended reviews or were consulted.

People were provided with a range of equipment to support their needs which were kept in good order. When peoples care needs increased the manager implemented plans to ensure needs could still be met. This included the adaptation of a bathroom so that people with increasing frailty could be provided with appropriate facilities to meet their personal care needs.

There was a complaints procedure in place. The covering manager told us that he was unaware of any complaints being received at any time and records confirmed this. Relatives we spoke with told us if they had any concerns they would feel confident about raising these with the staff or provider, any issues they had were usually minor and resolved through discussion with staff and did not escalate into complaints.

Requires Improvement

Is the service well-led?

Our findings

The registered manager post had become vacant recently following an absence of more than three months by the previous registered manager. A registered manager from another home nearby had been providing cover. We were informed that they would in future on a permanent basis take on the management of this home and had applied to the Care Quality Commission (CQC) to do so. We were satisfied those arrangements for the management and oversight of this home during this period were satisfactory, and that the provider was taking appropriate action to fill the registered manager position.

A comprehensive quality assurance system was in place to continually assess and monitor the quality of the service both physically and operationally and to take forward actions for improvement. Monthly checks by the locality manager and six monthly checks by a compliance and regulation team ensured shortfalls were highlighted for the covering manager and their completion was monitored. However, the assurance system had not picked up on some of the shortfalls the inspection highlighted; improvements were needed to ensure peoples individual experiences were an accurate reflection of the delivery of care and practice of staff.

Care staff told us that they liked working at the home. They said that they liked the relaxed atmosphere and they never felt rushed, this meant they were able to spend time with people. They said there was a low staff turnover because staff tended to stay.

Longer serving staff felt that the staff team had been through a difficult period with changes in manager but felt that the culture of the home had now improved. They welcomed the arrival of the covering manager who they found supportive. They said that they felt able to express their views and opinions at staff meetings and felt listened to and able to influence change. The covering manager had a regard and understanding for people and it was clear he was keen to establish a good relationship with them. He spoke with us about the need for change, “but we are not going to rush into anything. It only works if we in introduce things slowly and gradually, both for the residents and the staff.”

The management structure was provided to staff with clear lines of accountability and a description of what their roles and responsibilities were. We saw from records and discussions with staff that they were kept informed of important events within the home. During the inspection we saw that the staff operated as a team to ensure that people’s needs, including their choice of activities, were taken into consideration.

The management team were available for staff to contact at any time and there was also an opportunity to raise concerns via a 24 hour contact number. Staff were aware of this system and told us they felt confident of raising any concerns they had with the covering manager and locality manager.

We saw that resources were available for the upgrade and improvement of the home, and this meant that people lived in an environment that met their changing needs.

The home had a whistleblowing policy in place and when we spoke with staff they demonstrated a good understanding of how to use it, had done so recently and felt confident in doing so again if needed. Where investigations had been required, for example in response to whistleblowing alerts, the provider had completed a detailed investigation alongside external agencies. This included what actions had been taken to resolve the issues so that risks to people of future occurrences were minimised. Staff were aware of the changes in practice implemented as a result of investigations.