B & L Premier Care Limited

Beechdale House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Beechdale House Care Home on 12 July 2017. The inspection was unannounced. Beechdale House is situated in Nottingham City. The service is registered to provide accommodation and nursing for a maximum of 40 older people and people living with dementia. There were 25 people living at the service on the day of our inspection visit.

Beechdale House Care Home is required to 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 home is run. At the time of our inspection a registered manager was in post.

People and their relatives told us that they felt staff provided safe care and support. Staff were trained in adult safeguarding procedures and knew what to do if they considered someone was at risk of harm or if they needed to report concerns.

There were systems in place to identify risks and protect people from harm. Risk assessments were in place but not all had been reviewed at the frequency required. Accidents and incidents were recorded and reported by staff. The registered manager analysed these to ensure appropriate action had been taken to protect people, and to consider if there were any themes or patterns that required further action. Contingency plans were in place to support staff to provide a safe service in the event of an untoward incident affecting the service. Staff did not always use safe moving and handling practice when supporting people with transferring.

Whilst some concerns were made about staffing levels these were found to be sufficient on the day of our inspection visit. Safe recruitment procedures were in place and followed. Medicines were given to people on time and as prescribed. Some concerns were identified with liquid medicines and topical creams that were not labelled with their date of opening. When medicines were handwritten on the medicine administration records there were not always two staff signatures to indicate they were checked for accuracy of transcription.

People were supported effectively by staff that had received an induction, ongoing training and support. Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Some people had a DoLS authorisation in place or the registered manager had submitted application where appropriate. Staff had received appropriate training and understood the processes in place for ensuring decisions were made in people's best interests. People and or their representative where appropriate, had given consent to their care and treatment.

People received sufficient to eat and drink and their nutritional needs had been assessed and planned for. People were appropriately supported with their eating and drinking needs if required, choices were offered

and respected, and independence encouraged as fully as possible.

The service worked well with visiting healthcare professionals to ensure they provided effective care and support. When concerns were identified about people's healthcare needs, appropriate action was taken to support people's health and well-being.

Staff were kind and caring, they knew people well, and they supported people on the whole in a dignified and respectful way. Staff on the whole acknowledged and promoted people's privacy. People felt that staff were understanding of their needs and that they had developed positive relationships with them. Information about an independent advocacy service was available for people should this support have been required.

People and or their relatives where appropriate, were involved in the assessment and review of their needs. Care plans informed staff how to support people and were on the whole personalised to people's needs, routines and preferences. Activity staff provided a range of one to one and social activities and opportunities, to support people with any interest's hobbies and pastimes. People and staff knew how to raise concerns and these were dealt with appropriately.

People who used the service and relatives were given opportunities to share their experience of the service. Quality assurance systems were in place to regularly review the quality and safety of the service provided. Since our last inspection the service had made some improvements and there was a plan in place to continually drive forward improvements and to sustain those already made.

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 consistently safe.

Staff understood what action they needed to take to keep people safe. Staff had received appropriate safeguarding training.

Risks associated to people's needs including the environment were assessed. People's risk plans were not always reviewed at the required frequency. Staff did not always use safe moving and handling techniques when transferring people.

We found there were sufficient staff available on the day of our inspection visit. New staff completed detailed recruitment checks before they started work.

People received their prescribed medicines. However, some concerns were identified with the management of medicines and records completed.

Is the service effective?

Good

The service was effective.

People were supported by staff that received an appropriate induction and ongoing training and support.

People's rights were protected by the use of the Mental Capacity Act 2005 (MCA) when needed.

People received choices of what to eat and drink and menu options met people's individual needs and preferences.

People received support with any associated healthcare need they had and the service worked with healthcare professionals to support people appropriately.

Is the service caring?

Good

The service was caring.

People were cared for by staff who showed kindness and compassion in the way they supported them. Staff were knowledgeable about people's individual needs.

People had access to information about an independent advocacy service should they have required this support.

People's privacy and dignity on the whole was respected by staff and independence was promoted.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to the activities and opportunities available for people.

People and or their relatives were involved in assessments and reviews.

People received opportunities to share their views and there was a complaints procedure available should they wish to complain about the service.

Is the service well-led?

Good

The service was well-led.

Improvements had been made to all areas of the service but further improvements were required for new systems and processes to fully embed. There was a commitment by all staff to continually drive forward further improvements.

People received opportunities to share their experience about the service.
There were quality assurance processes in place for checking and auditing safety and the service provision.

The registration and regulatory requirements were understood and met by the provider and registered manager.

Beechdale House 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 July 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a registered nurse and an expert by experience. 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, 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. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service, and Healthwatch to obtain their views about the service provided.

On the days of the inspection visit we spoke with eight people who used the service and four visiting relatives for their feedback about the service provided. We also spoke with a visiting healthcare professional. Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the provider's representative, the administrator, the clinical lead, the

cook, a domestic, the activity coordinator, a senior care worker and two care workers. We looked at all or parts of the care records of eight people along with other records relevant to the running of the service. These included policies and procedures, records of staff training, the management of medicines and records of quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People were protected as far as possible by any potential risk of abuse. People told us they felt safe using the service and they were treated well by staff. One person said, "I'm safe enough, it's a good place." A relative said, "It's brilliant here. So safe. We don't go home worrying about [family member]."

Staff were aware of the signs of abuse and the action which should be taken if a concern was raised. One staff member said, "Some people are at higher risk than others such as wandering off or their behaviour may affect other people, so we make sure we know where people are for safety." The clinical lead said in the absence of the registered manager they would deal with any safeguarding issue including reporting it to the local authority safeguarding team responsible for investigating concerns allegations and concerns.

We found safeguarding information was available for people, visitors and staff about how to report any safeguarding concerns. We were aware that the registered manager had reported safeguarding concerns appropriately to the local authority safeguarding team and had worked together to investigate these. Staff disciplinary action had also been taken when concerns had been identified about any unsafe care practice by staff. Staff had received adult safeguarding training and were knowledgeable about the safeguarding policies and procedures that were available to support them.

At the last inspection we found improvements were required to show how accidents and incidents were monitored and analysed to reduce further risks. At this inspection we found improvements had been made. For example, the registered manager showed us a recording tool they used to monitor falls. This enabled the registered manager to identify any patterns and themes. Where concerns had been identified action had been taken such as a referral to the community falls team for assessment or other external healthcare professionals such as an occupational or physiotherapist.

People were not unduly restricted of their freedom and choice. For example, we saw a person who accessed the community independently. Another person also liked to have their independence and go into the local community; however they had a health condition that could be unstable putting them at risk. Measures had been put in place that respected the person's independence whilst ensuring their safety.

Individual risk assessments were undertaken to assess risks to people's health and safety, including the risk of developing pressure ulcers, risk of falls and nutritional risk. Most risk assessments were updated monthly. However, this was not consistent for the pressure ulcer risk assessment score where these had not been reviewed for two people whose care we reviewed. We discussed this with the registered manager who took immediate action to review these care plans.

One person with pressure ulcers whose records we reviewed did not have photographs of the wound or any objective assessment of the progress of the healing of the wound. However, the wounds were being re-dressed and the wounds were stated to be "stable" or "healing well." The clinical lead implemented a reassessment record immediately. The registered manager said photographs were used to monitor pressure ulcers and showed us photographs that proved this but were unable to show us photographs for the person

we reviewed.

We found equipment was available such as mobile hoists and other moving and handling equipment that had all been serviced and maintained. Where people required pressure relieving mattress or cushions these were found to be available and being used. Some people were at risk of falls and had sensor mats to alert staff when they were independently mobile. We found one person who required a sensor mat at all times for their safety did not have the mat plugged in to the call system or placed near them. We discussed this with the registered manager who addressed this immediately with the staff.

People who used the service and visiting relatives told us that staff supported them well with their mobility. One person said, "They hoist me into chairs and bed. It's not too bad; they're good girls (staff)."

We observed two occasions when people were assisted by staff inappropriately whilst transferring from a chair to wheelchair or back again. Staff were seen to hold people under their arm pits; this is known to be an unsafe move and not in safe moving and handling best practice guidance or training procedures. After one person had been transferred they complained of pain in their shoulder and staff provided a cushion behind their shoulder which appeared to settle the person. However, this might have been linked to inappropriate moving and handling. In addition one person told us how staff held them under their arm pits when supporting them to transfer. We discussed this with the registered manager who told us they would speak with staff.

Staff had information available of the action to take should there be an event that affected the safe running of the service. This included a business continuity plan and personal evacuation plans for people. Staff had received health and safety training and were aware of their responsibility to ensure the environment was kept safe at all times. There were audits and checks completed regularly of the environment and the registered manager completed a regular walk around and undertook spot checks of the service that included a visual check on safety.

Three people who used the service and two visiting relatives told us they had concerns about the staffing levels. One person said, "They've been short lately so get me washed and up later than usual, about 9am." Another person said, "No, there aren't enough on often. A few go off sick and they're short-handed so things take longer." A visiting relative said, "I think there's a lack of staff as they tell me they're always under stress. [Family member] doesn't have any time with them." Two visiting relatives were positive about the staffing levels and comments included, "There seem to be loads [staff] on when we come (late morning)." And, "From what I notice, they seem ok on staffing mostly."

Staff told us that they felt there were sufficient numbers of staff available and that whilst they were busy they had time to spend with people. Staff told us that they picked up any shortfalls with staffing due to sickness or holiday and an agency was used to cover any nursing staff hours.

The registered manager told us what the staffing levels were and the staff rota confirmed staffing levels provided on the day of our inspection visit. The registered manager told us how they regularly reviewed the staffing levels to ensure they were sufficient to meet people's needs. An example was given how the night staffing had been increased the night before our inspection visit due to a person being unwell. The staff rota confirmed what we were told.

We found on the day of our inspection visit there to be sufficient staff on duty. People who used the service and visiting relatives said that staff responded in a timely manner to calls for assistance. We found staff responded in an appropriate time and they had time to spend with people.

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included criminal records check and employment history.

People were positive that they received their prescribed medicines appropriately. One person said, "The lady (staff member) stays by me while I have my tablets." Whilst another person said, "I have paracetamol three times a day. Some (staff) wait with me, some don't and leave me with the pot and trust me. The new people (staff) don't leave them though." Relatives were confident with how medicines were administered. One visiting relative said, "I see them (staff) giving tablets out and it seems well managed."

Staff told us they attended medicines training prior to administering medicines and records supported this. Records confirmed that staff had received appropriate training and included observational competency assessments to ensure they were administering medicines safely.

We observed the administration of medicines and saw staff carried out the required checks and stayed with people while they took their medicines. However, on one occasion the keys were left in a medicines trolley when the staff administering medicines had left the room. This meant there was the risk of unauthorised access to medicines.

We found liquid medicines and topical creams were not labelled with their date of opening. This is required to ensure they are used within the recommended time from opening to maintain their efficacy. When medicines were handwritten on the MAR there were not always two staff signatures to indicate they were checked for accuracy of transcription.

Medicines were stored correctly for example, temperature checks of the room and the refrigerator used to store medicines confirmed these were within acceptable limits. We did a sample stock check of medicines and found these to be correct.

Medicines administration records (MARs) contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicine. MARs confirmed people had received their medicines as required.

When medicines were prescribed to be given only as required (prn) protocols were mostly in place to provide the additional information required to ensure they were given safely and consistently. The registered manager showed us they were reviewing all prn protocol and revising the format to ensure they were clear and provided the required information.

A person was receiving covert medicines and there was evidence of consultation with the person's GP and the pharmacist. Covert means the person was given their medicines within food without their knowledge.

Medicines audits were completed monthly and action plans were in place to address issues from the audits. We identified the audit did not contain a check of liquid medicines for date of opening and when we discussed this with the registered manager they immediately amended the audit to ensure this check was included in the future.

Good

Is the service effective?

Our findings

Staff were knowledgeable and skilled, they provided effective care and treatment. Relatives told us that they felt staff understood how to meet their family member's needs. One relative said, "They (staff) seems to cope with [family member] well enough." Another relative said, "They seem a good team."

Staff told us that improvements had been made with regard to the support they received. They said the registered manager had made improvements with communication systems used and had an open door approach where they were always available to the staff. One staff member said, "We're working much better as a team, better organised and we have good handover meetings, we're kept up to date about people's needs."

Staff told us they had received an induction when they commenced their employment and ongoing training and supervision meetings where they discussed their work and development needs. One staff member said, "The training is more than enough." Nurses were able to access clinical training and updates as required. The clinical lead provided clinical supervision to the rest of the nurses. They told us they could obtain advice from one of the community nurses and support from the registered manager.

The staff training plan and training certificates confirmed staff had received an induction and the required training to meet people's needs. This included training such as first aid, fire safety, dementia awareness, moving and handling and end of life care. As part of the provider's induction staff were required to complete the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to. This told us that staff received a detailed induction programme that promoted good practice and was supportive to staff. Systems were in place to ensure that staff remained up to date with their training and received regular meetings to discuss their work and performance.

People told us they were not always asked for their consent before care and treatment was provided. One person said, "They (staff) ask me first if it's wash time or need to change me." Another person said, "They might make out they ask but just come and get on with it. They think they're always right."

We observed staff asking people for their consent before being supported with personal care tasks but not all staff asked for consent before they supported people with putting on protective clothing at lunchtime.

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.

Where people lacked mental capacity to consent to specific decisions about their care and treatment, we saw examples where mental capacity assessments had been completed and best interest decisions made. These records included decisions in a number of areas such as people's medicines, finances and the use of

assisted technology to alert staff to where people were. These were on the whole completed correctly, one exception to this was the assessment and decision made for a person with regard to the pressure relieving mattress they used. Whilst staff were clear of what mattress the person was using and why, records did not reflect what we were told showing there were instances when people's records lacked detail. We discussed this with the registered manager who took immediate action to address this.

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 are called the DoLS. We checked whether the service was working within the principles of the MCA. Some people had authorisations in place that restricted them of their freedom and liberty, some of which had conditions the registered manager was required to meet. It was not clear from one person's care records if the required conditions had been fully met. We discussed this with the registered manager who agreed to follow this up immediately and to review MCA and DoLS information as a priority.

Staff were aware of the principles of the MCA and DoLS and training records confirmed they had received training in this area.

Some people were living with dementia and experienced periods of high anxiety that affected their mood and behaviour. Staff were knowledgeable about people's individual needs and we saw examples of how staff supported people to manage their anxiety and behaviour. This involved providing comfort and reassurance and for other's distraction techniques were used. Care records provided guidance for staff in how to support people during these times.

We saw some care records for people who had a decision not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Where people had lasting power of attorney that gave another person legal authority to make decisions on their behalf or if an advanced decision had been made, this information was recorded and staff informed. This meant that people's wishes were known and decisions planned for and staff had access to this information.

People were positive about the food choices available. One person said, "I like my meals and we have lovely puddings." Another person told us they had a particular diet and they were pleased with the meal choices they received. Relatives were confident their family member were given choices of meals and the support they required to ensure they had sufficient to eat and drink. People who used the service and visiting relatives told us there was a choice of drinks and these were plentiful, comments included, I get coffee and tea brought up. The staff buy me in lucozade and lemonade."

We observed the cook ask people during the morning individually what their food choices were for the lunchtime meal. The menu on display matched what meal choices people received and people received a choice of two main meals and puddings with alternatives if required.

We observed a staff member offering a choice of squash to people. Staff brought out plated meals for people carrying two plates at a time and not in table order, meaning some people waited longer than others at the same table. Meals were not explained as they were set down in front of people just a kindly, "There you are." Some people required assistance with eating and drinking and this support was provided appropriately. Food looked appetising and well presented, with generous portions. We observed hot drinks being served mid-morning and afternoon. Jugs of squash were provided in the lounge and at lunch.

The menu was on a four weekly cycle and we saw a good variety of meals were provided. The cook was very knowledgeable about the people using the service and their preferences and told us they tried to cater for

these. They said if anyone expressed a wish for a particular meal they would provide it. We saw examples of the service catering for individual dietary choices.

People's nutritional risks were assessed and eating and drinking care plans were in place. These included information about their food and drink preferences and any support and encouragement they needed to eat and drink. We saw a person was referred to a dietician when staff identified some concerns about their nutritional needs. Staff weighed people monthly to monitor their weight and more frequently if a concern was identified.

People were positive their healthcare needs were understood and met. One person said, "I've seen the optician about once a year here and get the chiropodist doing my feet. I do my own nails and the hairdresser does me a trim now and then. I go out to the dentist by taxi."

Feedback from a district nurse was positive; they said that staff were knowledgeable about people's healthcare needs. They added that people's health was monitored and any concerns were acted upon quickly and that staff followed any recommendations they made.

People had access to healthcare services; a GP was visiting on the day of our inspection visit and we saw records of GP reviews of people on a regular basis. Staff were alert to a person's deteriorating health and arranged for a GP visit. We saw some people had access to a physiotherapist and records confirmed input of a dietician and regular visits from a chiropodist.

Good

Is the service caring?

Our findings

Feedback about the staff approach to people showed that staff were kind and caring. One person told us, "Some (staff) are polite and nice, others can be less so." We received positive comments from four visiting relatives. Comments included, "I find them (staff) kind and caring with [family member]." And, "They are great with the people living here."

Feedback from external health and social care professionals was very complementary about the care shown by the management and staff team. One professional said, "In my extensive experience of care homes I could never imagine another that would have responded like the manager and provider. My patient is still with them, happy and settled. It is a credit to them and their staff that my patient has done so well." Another professional said, "The atmosphere has changed to a welcoming and caring environment. I cannot praise this home highly enough for the care and empathy they have shown to my citizens, and the fact that they not only go the extra mile, but they take on board any suggestions from professionals and deliver the highest quality of service."

We observed staff interactions with people who used the service and found staff to be caring, kind and sensitive towards people. We observed a person became unsettled and shouted out shortly after being assisted to a chair in the lounge. Staff talked to the person reassuringly and stayed with them until they had settled. We observed the cook acknowledged a person had a dislike of gravy, this person asked for mint sauce to accompany the pork instead of apple sauce. The cook was heard to reply, "Of course you can [name of person]. You can have whatever you like with pork," whilst holding the person's hand at the table and both sharing a laugh. We also observed the cook at lunchtime asking a person if they would like their meal (small portion requested), served on a small or normal plate today.

Another good example of staff having a caring approach was at lunchtime, a person was reluctant to eat; staff had concerns about this person's food intake. A method used to encourage the person to eat was staff showing the person a laminated card that the person could read; this was a note from their doctor asking them to eat their meal so that their medicine did not make them feel sick. This approach worked well and the person began to eat more of their meal.

People's diverse needs such as their religious, spiritual and identity was recorded and supported and we found staff were knowledgeable about what was important to people. One staff member said, "People's care plans are better detailed to support us and the staff handover meetings have improved so we are always updated about people's needs. We are really trying to provide person centred care."

We reviewed the care of a person nearing the end of their life and saw they had a care plan in place to document their wishes and the care they required. We saw anticipatory medicines were prescribed and staff were administering these as required.

People told us they or their relative was involved in discussions and decisions about the care and treatment they received. One person said, "My brother comes in for meetings with the manager."

A relative said, "I've seen the care plan quite often and we get review meetings with the manager."

The registered manager said that as care plans were being reviewed, people using the service and their relatives were invited to contribute and were asked to sign their agreement to them. We saw examples of what we were told. This showed people received opportunities to be involved in their care.

People told us that staff usually treated them with respect and knocked before entering bedrooms, and closed doors and curtains for privacy. One person said, "Most knock and wait for me to call come in. A few will just come in. They shut the curtains and door for my private dressing." A relative said, "They (staff) respect [family member] and the way they like to be treated. They would tell us if anyone was being horrible."

Staff told us how they respected people's dignity and we observed staff were discrete and sensitive when supporting people with personal care needs. We noted that staff used a dignity blanket when supporting people to transfer using the mobile hoist.

Staff told us how they tried to encourage people's independence as fully as possible. One staff member said, "We recognise how important it is for people to be in control as fully as possible and we promote independence as much as we can." People who used the service and visiting relatives were confident that independence was respected and encouraged. One person said, "They encourage me to help myself as I'm not helpless. I don't like being waited on." A relative said, "[Family member] is independent so they'll let them try with whatever and help if they're struggling with anything."

People had information about independent advocacy services should they have required this information. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. There was no person who used the service that was currently being supported by an advocate.

People told us their relatives were able to visit them whenever they wanted to. One person said, "My son works shifts so he comes to suit him." A relative said, "We're not tied to set (visiting) times at all." We saw relatives visiting people throughout the inspection visit. Staff told us people's relatives were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service. We found people's personal information was respected, for example it was managed and stored securely and appropriately.

Good

Is the service responsive?

Our findings

Before people moved to Beechdale House they received a visit from a member of the management team who completed an assessment of their needs. This information is important to ensure the service can meet people's individual needs and is a time to consider if additional resources or staff training is required. A range of care plans were in place to provide information about the assistance each person needed and their personal preferences in relation to their care.

People were positive that staff understood and respected their choices about their preferred routines. This included a choice of morning and night routines. One person said, "I have the choice to have a shower but prefer a bed bath every day." Another person said, "I make my own decisions about what I'm going to do all day." A relative said, "[Family member] always looks clean and nicely dressed." One person said that they wanted a staff member to assist them to return to their room but they had not been supported as requested. Some relatives raised concerns about nail care. We informed the registered manager of what we were told and they agreed to speak with the staff team.

People gave examples of how staff had a person centred approach; this included a choice of staff gender when providing personal care. One person said, "I decide what I want doing and ask them (staff) to do things my way." A relative said, "They (staff) know [family member] very well and what they like or doesn't like being done. They've reverted to their mother tongue with their dementia so they've (staff) got a little book of simple words and phrases to use if they need to. [Family member] knows English and can speak it if they chose to."

People told us they were happy with the environment and bedrooms provided. One person said, "I've got a lot of my own belongings in here so it's homely." A relative said, "It's a good place and the garden is lovely for them to be able to sit out."

We observed an example of good person-centred care when a person was transferred into a wheelchair to go to the toilet but indicated that they were thirsty. The staff member immediately fetched a cup of tea and assisted them to drink before moving them. However, we observed where support could have been better. For example, a person was transferred to their wheelchair and was then left from 10.55am until 3pm (including over lunch.) They were positioned in front of an armchair in the middle of the lounge area, unable to see the TV that was showing a film. At 3pm three staff woke the person and moved them to an armchair. They were then settled in place and a rug placed over them for comfort.

People were generally positive about the activities and outings provided, with the option being given on participation. People were able to make suggestions for activities at the monthly residents' meeting. One person said, "I knit a lot all day and make blankets. I may watch TV. I prefer not to go down and join in anything." Another person said, "I've been on a few trips to garden centres and the boat trip." A relative said, "[Family member] joins in anything. They love knitting and crosswords too. Likes the garden here and sitting out. They're on the list for future outings now. Their Methodist church friends come in and visit too."

We received some good feedback from an external professional about how staff provided person centred care. Comments included, "The manager thinks out of the box and recently asked me for support in finding one of my residents activities in the community. They purchased and ID bracelet with a microchip with the person's medical history. This person likes their independence but due to health needs they can be risk."

Since our last inspection visit an activity coordinator had been employed. A noticeboard in the hall showed posters for planned activities, events included outings to a market, the beach and for a boat trip. This also included details about the annual fete. Other regular activities included armchair yoga, bingo, crafts, games, darts, and bowls, sing songs, pamper sessions, hairdresser day, gardening and walks, plus a visiting singer. The co-ordinator told us that garden games and ice cream were popular. They told they were building up a stock of DVDs of older musicals and films to show on the lounge TV. In the afternoon we observed three staff and the activity co-ordinator spending time in the lounge providing one to one activities such as ball catching, and dominoes as well as informal chats.

Most care plans contained an appropriate level of detail however, in some cases some information was missing. For example a person had COPD (Chronic obstructive airways disease) and was known to the integrated respiratory service. We saw a card in their care records which provided telephone contact numbers and instructions to contact the service if an emergency assessment was required but this information was not in their care plan.

We found a record of re-positioning for a person with two pressure ulcers was not consistently completed. We spoke with the registered manager about this and they told us the person was able to re-position themselves during the day but required assistance at night. They agreed there was some ambiguity in the re-positioning records during the night and said they would speak to staff to ensure the records were completed more clearly.

The provider's complaints procedure was available for people. A relative said, "We've had the inevitable little things but they (staff) listened to us and put things right." We looked at the complaints log and saw two complaints had been recorded since our last inspection visit. These were found to have been responded to in a timely manner in accordance to the complaint policy and procedure. Staff were found to be aware of their role and responsibility in responding to concerns and complaints.

Good

Is the service well-led?

Our findings

People, visiting relatives, staff and external professionals all gave positive feedback about how the service had improved since our last inspection visit. People described there being a, "Relaxed and lovely atmosphere." Positive comments were received about the registered manager being visible and approachable. One person said, "She pops up now and then to see me. She's a nice girl." Another person said, "You see her around and she's nice to talk to." Comments from visiting relatives included, "The place has changed round completely in the last year or so." And, "She's (registered manager) brilliant, all the team are lovely."

Feedback from an external professional included, "Since the change in care home management at Beechdale House I have found the management team to be professional in all aspects of care for my citizens. The manager and clinical lead work together really well they have made a difference, and I am pleased that the home is currently undergoing a refurbishment."

All staff spoken with were very positive that the registered manager had brought about positive changes to the service. They described the leadership of the service to be very good, describing the registered manager as approachable, supportive and responsive. One staff member said, "There have been so many improvements, its better in so many ways. The owner, manager, nurse and staff are all committed to provide person centred care." Another staff member said, "I've seen changes here, good and bad over the various managers. It's a much better place now."

In April 2017 Healthwatch Nottingham completed an 'Enter and View' visit to the service. Enter and View is a power given to local Healthwatch through the Health and Social Care Act 2012. It enables authorised representatives of local Healthwatch to go into health and social care premises to see and hear for themselves how services are provided and to collect the views of service users at the point of service delivery. The outcome of this visit found, 'The experience of Beechdale House appears to be overwhelmingly a positive one for residents and in particular visitors, who consistently held the home and its staff in a high regard. It was encouraging to hear reports of recent improvements. The majority of staff were perceived to be doing their best and providing compassionate care, with their attentiveness and responsiveness to residents being a particular strength.'

Staff told us that the staff team had improved direction that had resulted in them being better organised, with improvements to communication. Staff were clear about their different roles and responsibilities. The registered manager told us and our observation of the service confirmed, there had been improvements to the premise and environment with some areas of the service being refurbished. A programme to continue these improvements was in place. On the day of our inspection visit carpet suppliers visited to measure and quote for new carpeting throughout the service.

People and visiting relatives could not recall being invited to give their feedback about the service. However, we saw records that confirmed as part of the provider's internal quality monitoring processes, people who used the service, relatives, staff and external professionals received opportunities to share their experience

of the service. On display for people were the survey findings for the last three years (including 2017). Information stated what people had said and what action the provider had taken in response. During 2017 action taken by the provider to improve the service included, refurbishment to the kitchen, dining room, reception and lounge areas, new furniture including, dining room chairs, settees, garden furniture, redecoration, the appointment of an activity coordinator, new menus and the introduction of weekly community trips.

The registered manager told us that they also arranged monthly meetings for people who used the service and relatives. However, they said attendance was poor. We looked at the meeting records for February 2017 where people did attend. We saw that meetings were used as an opportunity for information sharing such as news about improvements being made to the service and requests for feedback about any areas the service could be further improved upon.

Staff told us that there were regular staff meetings where the registered manager shared and updated staff about new developments, areas that required improvement and action required following any accidents or incident. Records confirmed what we were told and included the registered manager praising staff for their work. Staff told us how the registered manager listened and took action to respond to staff's feedback. For example, there had been a change to the staff's working pattern, whilst staff agreed to this trail period they raised concerns which the registered manager respected and agreed to change the staff rota at the request of staff.

The service had submitted notifications, to the Care Quality Commission, that they were required to do and had policies and procedures in place to manage quality care delivery and health and safety.

There was a system of audits and processes in place that continually checked on quality and safety. These were completed, daily, weekly and monthly. We found these had been completed in areas such as health and safety, medicines, accidents and care plans to ensure the service complied with legislative requirements and promoted best practice. The provider's representative also completed additional audits. This told us that the provider had procedures and systems in place that demonstrated the service was continually driving forward improvements to the service people received.

A recent medicines audit (9/5/2017) was completed by the local clinical commissioning group (CCG). This found a high level of compliance with the audit standards. We saw that some of the issues identified for action in the audit had been addressed although the issue of unlabelled liquid medicines and creams was an issue that we also found at this inspection. When we brought this to the attention of the registered manager they took immediate action to address this.

The registered manager told us how they had worked with East Midlands Academic Health Science Network. The service had contributed in a study in promoting health equality and best practice. This told us that the registered manager and provider showed a commitment in wanting to be involved research that they could learn and improve from.