Leonard Cheshire Disability

Beechwood - Care Home with Nursing Physical Disabilities

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection of Beechwood took place over two days, 6 and 8 February 2017, both of which were unannounced. The previous inspection had taken place in July 2014 and the home was rated good overall with requiring improvement in the safe domain due to a lack of staff. During this inspection we looked to see if improvements had been made.

Beechwood provides accommodation and nursing care for up to 26 adults with a physical disability. It is located in a large house with an accessible garden. On the days we inspected there were 19 people in the home.

There was a registered manager in post who had been with the home since 2002 and they were available both days of the inspection. 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.

People said they felt safe and staff had an awareness of what may constitute a safeguarding concern. Concerns were reported appropriately.

There were still concerns with staffing levels as evidenced during the previous inspection. This meant people were not always able to have a shower or bath when they wished or participate in their preferred activity. Call bell data was not available to look at response times but we saw continued discussion in residents' meeting minutes and from what people told us that staff were continually busy. There was no evidence staffing was based on the needs or dependency levels of people using the service which meant people's experiences were sometimes poor.

Risk assessments were in place but did not always address the area of risk identified, such as entrapment or suitable equipment provision. One person had been noted as at risk of falls so had specialist mobility equipment but this had not been considered in relation to their personal care needs.

Medication was recorded and administered in line with requirements but there were minor issues with storage of creams.

The environment needed considerable updating and the home was due further re-decoration.
People's dining experience was varied with some liking the food but others saying the choices were poor. This was after the menus had been changed to accommodate people's preferences. Staff did support people to eat and drink but not always in the most sensitive manner, by standing next to them and not engaging with people.

Staff had not received regular supervision and there were significant gaps in training received. Some of this

was due to changes in Head Office but it meant staff had not received the current guidance for the day to day support of people in the home.

Knowledge of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards was poor as people were not accurately assessed in relation to their levels of capacity.

People spoke with us about the lack of choice in relation to care staff, especially in regards to gender and cited some examples of practice which lacked empathy.

Activities were organised for people on a group and individual basis but relied heavily in the input of volunteers as staff did not have time to spend with people. There was a range of activities and people we observed seemed to enjoy them.

Care records were person-centred and written in conjunction with people who helped determine how they wished to receive support.

Complaints were not handled well as low level concerns were not logged, and people told us they had not received acknowledgement or outcomes of concerns they had previously raised.

We found mixed views as to people's experience of living at Beechwood, some people liked it and others felt it was too institutionalised. There appeared to be a lack of overall quality scrutiny and improvements focused solely on the environment, rather than quality of care provision. Many of the issues raised returned to the same theme of 'lack of funding' and there appeared little attempt to consider alternatives.

We found breaches of Regulations 10, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not always sufficient to meet people's needs.

Risk assessments were in place but some were out of date and others had not addressed the identified risk.

People and their relatives told us they felt safe and concerns were reported appropriately.

Medicines were administered safely but there were minor issues with storage.

Is the service effective?

Requires Improvement

The service was not always effective.

People had mixed views regarding their dining experiences and we observed people were not always offered choice.

Staff had not received regular training or supervision.

There was little understanding of the requirements of the Mental Capacity Act 2005.

The environment was poor and in need of significant improvements to ensure equipment was working effectively.

People had access to health and social care professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people said staff were kind and caring in their approach but others told us their preferences for gender of carer and conduct of some care staff at mealtimes was not respectful.

End of life wishes were recorded and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service relied on volunteer input for its activity provision which meant there was a potential unpredictability for people.

Care records were person-centred and reflected people's needs.

Complaints were not handled appropriately as low level concerns were not recorded and more serious issues were not addressed in full.

Is the service well-led?

Requires Improvement

The service was not always well led.

The experience of people in the home was mixed – some enjoyed living there and others were frustrated.

There was a lack of overall scrutiny and follow up actions, with most inactivity being blamed on lack of funding.

People and staff had some voice but this needed to be developed further.

Beechwood - Care Home with Nursing Physical Disabilities

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 checked 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 6 and 8 February 2017 and was unannounced on both days. The inspection team consisted of two adult social care inspectors on the first day and one adult social care inspector and an expert by experience on the second. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert we used had knowledge of physical and learning disability service provision.

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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also looked at information we held about the service and checked with local commissioners about their experience of the service.

We spoke with seven people using the service and three of their relatives. We spoke with six staff including one care worker, one nurse, the care supervisor, a member of the domestic team, the activity co-ordinator and the registered manager.

We looked at five care records including risk assessments, seven staff records, supervision records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and

quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

One person told us "I feel safe here" and another said "I feel safe and secure here. I have had one or two things go missing but I have a safe now. My money is locked away in the office but I do manage it myself." A further person said "The majority of the time I feel safer than when I was in the community."

We asked staff about different types of abuse and one member of staff told us it could be "physical, verbal, sexual or financial." They explained how they would be concerned if a "person became withdrawn, or chose not to communicate, or if there was unexplained bruising" they would report such concerns. Staff were also aware of how to whistle-blow on poor practice and said this was encouraged. The registered manager discussed recent investigations they had conducted into some concerns which evidenced they understood their role and responsibilities. They also showed how learning had taken place from these concerns to minimise a repeat occurrence.

We asked people if they felt there were enough staff. One person said "If I need to go to the toilet, wherever I am in the building, I have to go to my room and press the buzzer and wait for someone to come and assist me. It is horrible, and embarrassing because by the time they get to me sometimes it is too late. Not nice, not nice at all". We could not establish why the person had to return to their own room as there were communal toilets available. They continued "They have to rely on the volunteers when they come in if they want to do anything different or something they need assistance with. Weekends are very, very boring with not many staff on. We have a small mini bus and a large mini bus but no one to drive them; they are just stuck there and have been for a long time."

The registered manager advised us eight staff were on duty in the morning and six in the afternoon when the home was full but as this was not currently the case, staffing levels had been reduced by the registered provider. Ratios were determined by numbers of people in the home rather than their level of need. On the first day of the inspection there were seven staff on duty in the morning; one nurse, one senior and five care staff and in the afternoon this had reduced to five, a reduction of two care staff. There was one nurse and two care staff on duty overnight, and weekends reflected weekday patterns. This lack of flexibility posed particular difficulties when people had appointments outside of the home and needed a staff member to accompany them.

One person told us they had done their own personal care recently as no staff were available to support them and baths also had to be scheduled to ensure all people had the opportunity to have one. A member of staff advised us "a bath could take up to an hour for someone due to the complexity of needs and this impacts on staff availability. People also get frustrated if their buzzers aren't answered immediately." Another person said "There are not enough staff here or overall funding. We used to have five or six regular staff, now we get agency staff that are not trained properly. I ask them outright I do". One relative told us "They have two accessible mini busses here you know, a small one and a large one, but no one is qualified to drive them. Even if they had, they do not have enough staff to take the busses out; they are not staffed enough for activities and outings."

One person said "It would be nice to have an en-suite bathroom. I only have a shower twice a week. I like to have one every day but there are not enough staff. I understand staff constraints but we are not paying peanuts to stay here".

One staff member told us the service used agency staff if staff called in sick which had happened on the first day of the inspection. The registered manager did not feel there were issues with sickness in the home. However, one staff member told us they had recently worked seven consecutive days, two of which were double shift. They stressed this was their choice but this is not good practice. The registered manager stressed how much the service relied on the input of volunteers to assist, especially in supporting people with activities. In December 2016 the registered manager said the service had benefited from 900 hours of voluntary input.

We noted the call bell rang for long periods of time on both days but the care supervisor assured us this was now monitored as a new system had recently been installed. The registered manager also stressed how much improved the new system was as staff could indicate they were on their way to attend someone, this alleviating potential anxiety. There was no evidence to demonstrate how this new system had improved response times. The experience of people and our observations about staff absences and cover demonstrate a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not staffed adequately to meet people's needs in a manner which promoted their dignity or wishes.

We checked staff recruitment files and found all necessary checks had been conducted prior to employment. References were requested and identity checks carried out including DBS (Disclosure and Barring Service) Checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Each person had their own medication cupboard in their rooms and medication administration record (MAR). This included their photograph and any known allergies, and instructions for staff where the method of administration was more complex. PRN (as required) medication was given according to the direction given by the GP and time of administration recorded to ensure safe intervals between doses. Controlled drugs were stored as required and we saw evidence of correct administration practice relating to pain control patches. No one had their medicines administered covertly. Covert medicines are administered when people are resistant to taking necessary medicines and a protocol is in place to ensure this is in their best interests for the medicine to be administered in this manner.

The care supervisor told us most people had the same GP and medicines were provided by an attached pharmacy. Most medicines were in blister packs and were delivered on a monthly basis. The care supervisor conducted sample audits of medicines on a monthly basis to check stock levels tallied with the amounts recorded and weekly checks to ensure signatures had not been missed on the MAR. They said if an error was discovered they would check with the person concerned, contact the GP and raise a safeguarding alert if staff error had been to blame.

All nursing and senior care staff received training in medication administration and competencies were checked annually by the care supervisor, whose own competency was checked by a fellow nurse. However, we did find some of these competency checks were overdue which had been identified on the medication audit for January 2017. This meant not all staff were able to demonstrate they were following current procedure.

We found the fridge in the nurses' office unlocked on more than one occasion and the office door open

which meant people could have accessed medication easily. We spoke with the care supervisor who said this was a rare occurrence and would ensure it did not happen again. We checked later and found it was unlocked again.
The medication room's temperature was not monitored which meant medication may not have been stored in line with requirements. However, the fridge temperature was checked daily and was within the required range. We did observe some of the creams in the fridge did not have the date of opening recorded on them which meant there was the risk of them being used past their expiry date. One opened cream had been prescribed in February 2016 and was still in the fridge. The care supervisor agreed to destroy this.

Topical medication charts in people's rooms were out of date and some had not been completed in accordance with the prescription directions. One person who had been prescribed Cavillon cream should have had this applied daily as a barrier cream but for January 2017 only seven applications were recorded. There was no indication whether the person had refused on the days it was not recorded so it was difficult to determine if the cream had been applied as directed. These incidents demonstrate a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were left accessible to people, not checked for expiry dates and not always applied in line with people's requirements.

People had personal emergency evacuation plans in place in the event of an incident such as a fire which detailed their specific needs around mobility and sensory support required. These had been reviewed regularly.

Risk assessments were in place for falls, bedrails and moving and handling. These contained photographic guidance for staff in relation to the use of which hoist and sling, and also personalised bed rails risk assessments. However, not all the information was current or complete. One person had a choking risk assessment which specified they must receive '2 scoops of thick and easy for every 200ml of fluid' based on advice from the Speech and Language Therapy Team but another assessment said they could take 'normal drinks from a feeding cup'. This meant there was a risk staff who did not know this person could administer fluids incorrectly and place the person at risk of choking.

We did not see any risk assessments in regards to the use of shower chairs which posed significant risks for more than one person in the home due to their high risk of falls. Another person's bed rails risk assessment identified there was a risk of entrapment between the rails and they had refused a bumper. However, when we looked at their bed there was a bumper in place. This meant the risk assessment was either incorrect or there had been no attempt to address the identified risk of the person's refusal and their wishes had been ignored. We observed one person on bed rest in the afternoon but saw there was no pressure sensor mat in the floor despite this being specified in their care plan. This was necessary to alert staff to any movement so they could respond promptly as the person was unable to use the call bell. These are further examples of a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not all equipment had been appropriately risk assessed and some risk assessments were not followed putting people at increased likelihood of harm.

We saw accidents and incidents were logged on a central system which recorded details of the event, the circumstances surrounding it and the likely cause, and the system directed the registered manager as to whether further investigation needed to occur following initial fact finding. It was possible to add records of witness statements and photographic evidence if this was needed. This information was then assessed by the Health and Safety Oversight Team at Leonard Cheshire head office. The registered manager advised us, depending on the nature of the concern, another home manager may be appointed to lead an investigation ensuring neutrality during the process. By recording each incident on the central database any trends could be identified and actions taken to minimise the risk of future harm.

We saw all equipment had been checked under the Lifting Operations and Lifting Equipment Regulations as required. Further in-house equipment checks were conducted monthly including sling checks which considered the condition of the fabric, the straps and new slings were ordered when needed. Detailed photographic guidance was available to support staff when checking which was also evident for mattress checks.

Records kept in the communal bathrooms did not indicate they were used very frequently. In one bathroom the last noted date for checking was 2 April 2016. We found another bath dirty which we were later told was out of action although there was no record any defects had been reported. In another, the side panel was off the bath and we were advised the maintenance team were due to fix it but were not in that day. The bathroom had not been decommissioned which posed a potential hazard to people. We saw a weighing chair in the corridor which had last been cleaned on 12 May 2016. There was no evidence it had been used since. We observed one person brought into the dining room in a wheelchair but we noted one footplate was missing which posed a high risk the person could get skin damage as they had their ankle against the metal frame.

In one toilet we noted the linoleum had holes in it and was peeling up behind the toilet. This posed an infection control risk. We saw staff had access to personal protective equipment as needed as this was available in all shared bathrooms. One person told us domestic staff finished at 2pm which meant any cleaning was limited after this time as it relied on care staff to do it. However, we did note the home had, in April 2016, achieved a rating of 90% for its infection control external assessment 2016-17.

Other health and safety checks such as gas, electric and legionella were all conducted as necessary and records stored on the central database which included the renewal dates for such checks. We saw these were all current.

Requires Improvement

Is the service effective?

Our findings

We asked people what they thought of the food and dining experience. We had a mixed response. One person said "The meals are OK for me – liquidised" and another told us "It's very good food here. We get a fair choice. Lunch is always cooked and tea is often a snack. We always have options."

However, other people said "Yes I enjoyed my meal but I didn't like the pudding, so I asked for some more dinner but was told there was none left." A further person said "We've worked really hard to change the menu. Tea time is abysmal. Soft diets have just been tinned ravioli or macaroni. It took ages to get the menu changed." The registered manager advised "We are in the process of changing the menu. It took a while for people to get involved but we now have a committee and meetings to discuss this." A relative was also concerned about the mealtimes saying "It is not good here at mealtimes. I come so I can assist [name] and I see what goes on. There are five residents here who need assistance at meal times, and only four staff on duty for the whole place. Staff have no time to interact, speak or chat with the residents."

We observed people being given a choice of where to sit and a choice of hot meal. This was then plated in the kitchen and brought to the person. On the first day there were 13 people in the dining room, four of whom were being supported to eat. A further staff member was providing meals from the hatch in the kitchen. One person was asked if they were ready and their agreement obtained before being offered a spoonful of food. The food was the correct consistency for this person. Another person had an adapted plate to enable them to eat independently and they were encouraged to start eating their meal. People were supported with cleaning themselves after eating and advised what the choices were for dessert if they were unable to verbalise their preference.

On the second day the experience was poorer as people did not have any drinks and no access to cups. At lunch time the activities were cleared and table cloths, serviettes, condiments and cutlery were placed for people. At one point during the meal five people needed assistance but there was only one member of staff present. This meant people had to wait and their food went cold as it was not covered. People did not have access to their drinks until after their meal. This was delivered from a hot drinks trolley.

People deemed at nutritional risk had food and fluid charts in place. However, these were not always completed in full and no target fluids were set for people so staff would have been unable to determine if a person had received their required amount. On the second day of the inspection we checked the charts at 1.30pm but there were no entries after 10am which meant records were not current. People were weighed monthly and this was recorded in their care records, and action taken if necessary where concerns were noted.

One person told us "I feel the staff know what they are doing and are confident, especially with equipment such as a hoist." However, another said "I sometimes feel I'm in a boarding school with a headteacher, but on the whole I would say the staff were good, not excellent but good, I keep hearing staff saying 'I've only this to do for my NVQ but they never put what they have learned in to practice."

Staff completed an induction which included a 'safety' focus and a 'people' focus, the latter of which included the importance of empowering people, gaining consent and data protection. The care supervisor advised, "All new staff complete the Care Certificate," which is a tool for all staff new to care to ensure they meet minimum standards. A new staff member told us "I completed training in health and safety, moving and handling, first aid. I was shown how to use the slings and hoist. Each staff tried the sling on and was lifted in the hoist so we understood how it felt." All new staff shadowed more experienced colleagues before working in pairs initially pending the completion of their initial probation review.

The supervision policy stated staff were to receive supervision every twelve weeks and responsibility for this was based on line management responsibilities. We asked the registered manager about the frequency of supervision and they said "It is not up to date as we are undergoing this consultation regarding changes to staff roles. I know people's appraisals are due." There was no overall supervision matrix to check staff had been receiving supervision when required so we checked a random sample of files. One file contained no supervision records at all despite the staff member having been in the service some time, and another file had just one supervision for 2016, which although detailed, was not followed up over six months later. This person was in a supervisory role themselves but pointed out they could not fulfil this part of their job due to having to cover for staff absence, however no solution was offered by their line manager. Records were signed by both employee and line manager.

We did see some evidence of competency-based appraisals which had considered the staff member's progress, strengths and set objectives for the coming year, also allowing them to give feedback on the organisation.

Staff told us about the change to training delivery which meant they had allocated one carer to oversee all the training needs of staff in Beechwood based on a training matrix sent from head office. Their role was to ensure all training was received in a timely manner. Moving and handling training was provided in-house and staff were provided with a moving and handling passport upon successful completion. Other training including health and safety, communication including behaviour and fire training was a mix of e-learning and face to face sessions. Staff also accessed training in how to support someone with behaviour which may challenge themselves or others. We looked at the training matrix and found there were some significant shortfalls in training attainment. Only 68% of staff had received training in managing choking risks, 42% in fire safety and only 22.5% had current moving and handling training. These numbers highlight serious issues regarding the competency of staff to perform their roles well and is a further breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not received appropriate supervision or training to perform their roles safely or confidently.

We saw evidence of consent being obtained from people in regards to medicines, service provision and data protection. Where people lacked capacity there was evidence of mental capacity assessments in regards to day to day decisions which included best interest meetings with the relevant parties. The home also requested the input of outside services where necessary such as the Care Home Liaison Team or an advocacy service. However, we also saw one undated capacity assessment in regards to medicines which indicated the person was unable to give consent. There was no evidence a best interest decision had been made which meant the home was not operating in line with the requirements of the MCA.

No one in the service had a current DoLS in place. We found a restriction had been agreed by the local authority but there was no evidence the registered manager had submitted a new application despite the person's capacity having decreased further. The registered manager advised there were six applications awaiting local authority authorisation as these were people who were not able to leave the home without staff assistance. They had told us previously only one or two people in the home had fluctuating capacity,

everyone else was able to make decisions. This meant the application of DoLS was not valid for these people. This demonstrated the registered manager did not understand the application of DoLS. Staff told us they never used any form of restraint apart from lap belts in wheelchairs which were to ensure people's safety.

One person told us they were receiving physiotherapy and occupational therapy input to ensure they could develop their independence. They explained their needs varied on an hourly basis but on days when they were struggling a protocol was written in their room for staff so they knew how to support them safely when mobilising. We saw in people's care records evidence of regular input from external health and social care professionals such as dieticians, chiropody and physiotherapy.

Positional charts were completed with most entries timed and the actual turn, e.g. left or right was noted to ensure staff provided appropriate pressure relief. The registered manager explained all staff knew to report any signs of redness immediately and said they had received positive comments from the tissue viability nurse regarding skin integrity at the home.

Handovers were conducted at the end of each shift and included a detailed sheet which was given to staff along with any specific nursing information, so all staff knew of any key concerns or events to be aware of.

Some rooms had signs on some doors saying "I like my door closed" or "I like my door open" but all the doors we passed whether occupied or not were open. One staff member said "Only one person locked their door when they left the home, everyone else liked their door open." We saw people's personal effects on tables in their rooms not locked away for safety. Although the environment looked clean we found pull light cords were dirty and had the ends missing, and other areas of the home looked tired. The care supervisor advised us the home was due re-decoration and we appreciated some of the scuff damage was due to wheelchairs knocking paintwork as people moved themselves around the home.

During the second day the optician was conducting sight tests for people who wished to have one. They utilised the front room which meant people could only access two other communal rooms, neither of which was particularly warm. One room contained computers and a large trestle table and had one comfortable chair which was hidden amongst some heavy furniture and the room did not look inviting. When we initially arrived we found two dirty cups on this table and the remote control had its back missing. Others chairs were office or dining room-style chairs, and the front room contained two low settees but no other furniture. Although this was to ensure people in wheelchairs could access this easily it was a huge space which was not welcoming as it was very dark. There was also a smoking room near the front door which meant the home smelt of smoke at periodic intervals.

Requires Improvement

Is the service caring?

Our findings

One person told us "The staff are good and understand my needs" and another person said "Staff are very good to me – they like to listen. However, they are always very rushed." A further person said "I always feel listened to. I would be happy to talk to anyone if I had any concerns."

One relative also spoke well of the staff saying "The staff appear to be very nice, the manager as well. They encourage [name] with their paintings. They paint every Friday but more often if they have the staff. On the whole this is a nice place and people seem to be treated with dignity and respect from what I've seen."

We heard one staff member talk to a person while they were supporting them with their lunch, mentioning their cough. The staff member appeared to know the person and had good interaction discussing the person's previous social life. During both days staff related to people well, clearly knowing them and their interests.

Other people mentioned their anxieties around the lack of choice of care staff, particularly in regards to gender. One person replied "There's no forward planning. My friend didn't want a male carer but was told there was no choice. I am not happy to have male carers when they are on their own." Another person told us "There is one carer who I don't feel comfortable with. Some staff say I have no choice because there is no one else. One of them said to me, 'You have a husband who has seen you naked and children what's up with you?' I would rather stay in bed all day."

Another person raised concerns around the conduct of care staff at mealtimes. "At meal times I don't like to see the carers assisting residents with their meals because they stand up and chat to one another and completely ignore the person they are assisting. They do the same when they are dressing people; they don't talk to them they just talk to one another as though that person does not exist. I have reported this to the manager and they speak to the staff but nothing changes." On the second day of the inspection we observed care staff standing next to people while supporting them to eat. This was unnecessary and perpetuated a lack of engagement between the person and staff member. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not respected whilst care was being delivered and their requests for the specific gender of carer was ignored.

One person said "I constantly have to self advocate and tell staff how to care for me. Lots have been fabulous. They encourage me to be independent. 95% of staff are caring." For those people who were not as confident, we saw the home advertised the local advocacy service ensuring people could seek support from an external source if they needed this.

The home had Do Not Attempt Cardiac Pulmonary Resuscitation forms in place for people who did not wish to be resuscitated in the event of a cardiac arrest. We also saw evidence of people's wishes in regards to their last years of life including funeral arrangements where this was known. The home had just been re-accredited for the Gold Standard Framework which supports people at the end of their life, avoiding unnecessary hospital admissions and ensures care is received in their preferred manner.

People's spiritual needs were recorded in their care plans but there was not always evidence these were being met as they would like them to be. The dining room contained a 'memory tree' from which people had attached photographs and other significant information about people who had died. This was a positive way of supporting people with bereavement.

Requires Improvement

Is the service responsive?

Our findings

One person told us "I manage to get in the garden when it's warmer weather." Another person said "We have proper entertainment once a year, but now the garden is finished we hope to use it more for things like barbeques and garden parties. Some residents were taken to the pantomime near Christmas but I didn't go because I don't like them. I like classical music, but I don't go anywhere to see it." This person told us they had provided their own easy chair to sit and listen to music downstairs during the evening as other people usually retired to their rooms after tea. They also said "I can come and go around the building as I like."

One relative said "The activities officer is very good and tries to adapt things to include everyone." They said their relation relied on volunteers to take them out. The home had an activities organiser who worked Tuesday - Friday, and a volunteer co-ordinator who worked Monday -Thursday. On the first day of the inspection the volunteer co-ordinator was on leave so there was little going on for people apart from individual activities such as colouring. One staff member said "There is usually a lot going on and people are out most days. People go to church but if they can't get out we make sure they have communion every week." We were also told at weekends it was more limited as staff were only able to escort one person outside the home due to lack of available staff to support.

On the second day there were more in-house activities. We observed people completing craft activities such as colouring and others were playing games with volunteers. Other people just sat and talked. The home was assisted by a team of eight students from the local college who attended as part of a community involvement project. We spoke with the students who described some of the activities they undertook with people such as baking, playing games, doing quizzes and dances. They also supported in one-to-one conversations and helping people with small jobs.

Activities records were not always completed. One person did not appear to have undertaken any activities since 13 February 2016. Another person told us "Sometimes activities are put on but no one comes. People here are really institutionalised. We have a driver for two days every other week to take people out. People used to go out on a one-to-one but this was stopped."

In the reception area there were some beautiful photographs on display which had been taken by people in the home over Christmas when a photographic competition had been arranged. We were also told about one person who had recently held their own art exhibition in conjunction with the Young Volunteers project. We also saw the newly accessible garden area at the front of the house and where activities were planned in the warmer months.

Prior to admission to the home people were visited at their previous residence and their needs discussed in depth which helped form their care plan. One staff member said "Following this visit we try and match up a suitable keyworker to be their main point of reference."

One person told us "I was involved in writing my own care plan. There are the odd occasions when staff don't follow my preferences but mostly they do, and they ask consent." Care records contained information

regarding people's care needs including communication, diet and nutrition, mobility, mental health and relationships. One record read "[Name] will turn their head away if not happy or doesn't want something to happen." Care records incorporated a one page profile with a photograph, people important to that individual and what people would like about them. We saw in one care record reference to a person's sense of humour. There was also reference to relevant information a staff member would need to know when supporting that person which reflected their particular routines and preferences. People's interests were also noted.

People's care plans were reviewed on a monthly basis in conjunction with themselves and their families if they wished. More formal reviews with the named nurse and keyworker took place every six months.

We found a selection of notes in people's own rooms which included daily bedroom checks, cleaning logs, weight monitoring, and room audits but found most of these were rarely completed. When we discussed this with the care supervisor they informed us this was because they were no longer necessary as records were stored centrally. However, it was evident some staff were completing them on an ad hoc basis. Daily records of significant care support were completed in more detail and included repositioning information, continence management and activities undertaken. Most of the notes were task-focused.

We asked people about the response to concerns or complaints. One person told us of an incident where they had been advised by a staff member they were not able to have a shower due to staff shortages. They had relayed this information to the registered manager who advised the person they had spoken to the staff member about this. However, the person was unaware of the outcome of this conversation and they did not find this satisfactory. They gave examples of other incidents which had been reported and to which they had not received an outcome.

We checked the complaints file which contained a brief outline of the issue and noted the last complaint logged was for June 2016. The registered manager told us "This was dealt with promptly and there were no outstanding issues. I feel it is important for the person to know it has been dealt with if it's our fault, to acknowledge it and send a written letter of apology." However, there was no evidence of this in the file and this was not people's experience.

One staff member said "Residents meetings are held regularly and people will raise any concerns then. The registered manager has a complaint file in their office." One relative we spoke with told us they had raised issues with the registered manager who had advised them the concerns would be shared with Head Office. However, the relative said they had never received any written acknowledgement and was given the 'standard response of not enough funding'. They said the registered manager had advised them to forward concerns to them directly as it 'would be quicker'. This is a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as complaints were not being acknowledged, investigated or remedied effectively.

Requires Improvement

Is the service well-led?

Our findings

We asked people how felt about living at Beechwood. One person said "I like living here. It's nice and quiet" and another told us "I'm very happy here. I don't think anything could be done any better." They also spoke highly of the senior care staff. One person said "The care supervisor is very supportive" and another told us "The manager does all they can and is very considerate to the residents. They have helped me through some hard times." A further person said "The manager is visible. All the residents will go to the manager if they have any problems." One relative also said "Yes, I think it is a nice place."

However, not everyone felt the same. One person said, "I feel as if I have to fight against becoming institutionalised. It is nice when new staff come for a short time, and then they learn the ways of the old staff very quickly." Another person told us "I don't think this place is well led. There is a lot of room for improvement, and it is never the staff's fault, it is always the residents' fault." More worryingly one person said, "I really want to stress that this is a good home and I don't dislike any of the staff - as long as I do as I am told." and then added "I'm only joking," as an afterthought. We did not feel they were joking based on our observations.

There was a registered manager in post who had been with the home since 2002 and they were available both days of the inspection. 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.

We found there was an odd culture in the home and not everyone appeared at ease. Some people appeared reluctant to tell us about their experiences. One person told us "Residents' meetings are held monthly but it is hard getting everyone together." Another person said "We have a residents meeting every two months but I don't always go; no one listens anyway." We looked at the minutes of these meetings and saw people had raised their views on a variety of issues including the environment, meals and staffing. However, it was not evident that issues had been followed up from minutes of subsequent meetings.

The registered manager told us they focused strongly on ensuring people were involved. They explained "The committee bring issues raised at their meetings with me and I determine what I can alter. I want to push power back to them so they can take control. They live here and I don't. They should have a big say in what goes on." This view was echoed by staff, one of whom said "We are pro-active and trying to do the best for residents. We try to empower them and achieve in life what they want to achieve."

People's frustrations were voiced in relation to activities and services. One person said "When the manager joins us for meals and a chat, I tell them these things and the answer is always the same; there is not enough funding." One relative told us "What we need here is a driver for the minibuses, a physio and a chiropodist. We know other Leonard Cheshire homes that have all these people employed there. All we get told is that it is down to funding."

We asked staff if they enjoyed working in the home. One staff member said "I just love this job. The managers are very supportive." Another staff member told us "The manager has a good relationship with staff and we have team meetings every two months. The time varies so all staff can attend." A further staff member said "The manager tells us stuff and we are able to share things in return." The registered manager reiterated this saying, "We discuss health and safety, infection control, safeguarding and any other changes to policy or procedures." They also told us "Staff start the meeting as I am trying to introduce a culture change where staff should not feel they have to ask, they should just do." We looked at minutes of the staff meetings and saw the focus was mostly information sharing to staff with prescriptive instructions for specific tasks. There was little evidence staff contributed to the discussions.

We asked the registered manager what they felt the home's values were and they said "to have happy, secure and contented people in the home who are treated with honesty, respect and acknowledged." They stressed the home had a dignity champion who was one of the people living in the home and whose role was to ensure all staff treated people with dignity and respect.

We discussed what the registered manager felt had been achieved in the past year and they told us of key environmental changes such as the garden and plans to move the nurses' office (although this was not started at the time of inspection). They also spoke of ideas to move the smoking room to develop a relaxation and therapy room but this had not happened at the time of inspection. Staff spoke with us about the constraints of the old building. The care supervisor said "We'd love to develop an independent living flat in the grounds. We'd love to have an outreach into the community."

We saw evidence of manager monthly walk rounds which considered the same information each month; i.e. environmental checks, medication audits carried out by the care supervisor and care plan audits. However, there was no detail about any actions taken as a result of these. The latest one completed on 30 November 2016 referred to the new call bell system but without any reference to its effectiveness and some training being cancelled at short notice, but again no evidence of any follow up.

The home had an annual quality audit conducted by the registered provider. The care supervisor said, "The registered manager's manager visits every six weeks and wanders around the home discussing any issues." We checked the manager audit file but found most of the audits were dated 2013 and 2014. We asked for evidence of these meetings and actions resulting from them but these were not provided.

We found a lack of governance in the home which is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was little evidence of monitoring and improvement of quality and safety due to the issues previously mentioned around risk assessments and people's experience of care in the home, which was mixed and in some cases, poor. Key issues such as the impact of low staffing levels had not been addressed by the registered provider and there was no evidence to show what considerations had been given to meeting people's needs effectively.

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 10 HSCA RA Regulations 2014 Dignity and respect People's wishes for gender of carer were not met and poor dining support was observed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always stored safely and there were gaps in topical medicine administration records. Risk assessments did not always address identified risks or reflect actual need, and in some cases were not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not acknowledged, investigated or remedied effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was little evidence of monitoring and improvement of quality and safety due to the issues previously mentioned around risk assessments and people's experience of care in the home. Key issues such as the impact of low staffing levels had not been addressed by the registered provider and there was no evidence

to show what considerations had been given to meeting people's needs effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not permit people to receive care in their preferred manner.