SHC Clemsfold Group Limited

# Beechcroft Care Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| 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

This comprehensive inspection took place on 12 September 2016. The inspection was unannounced.

Beechcroft Care Centre is nursing home that provides accommodation, nursing and personal care to 30 young adults with learning and physical disabilities. Accommodation is provided in three houses called Beechcroft Care Centre, Chestnut Lodge and Hazel Lodge, which are all on one site.

There were 28 people living on site at the time of our visit. People living at each house had their own bedroom and en-suite bathroom. There is a communal lounge and separate dining room on the ground floor of each building. This is where people can socialise and eat their meals if they wish. The houses offer the use of specialist baths, spa pool, physiotherapy, weekly GP visits, 24-hour nurse support, multi-sensory room, social and recreational activities programme and a swimming pool. Transport is available for people to access the community.

We previously carried out an unannounced comprehensive inspection of this service on 18, 19 and 20 January 2016. At that inspection, a number of breaches of legal requirements were found. As a result, the service was rated 'Requires Improvement'. We met with the provider to discuss our concerns and issued one Warning Notice, which required the provider to take immediate action in relation to the effective governance of the service.

Following our last inspection, the manager at that time left the service. The provider transferred a manager from another one of their services in April 2016 to manage Beechcroft Care Centre. The appointed manager was already registered with the Care Quality Commission in November 2014. The manager was familiar with the people living at the service and the staffing team due to their previous experience managing the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection, we confirmed that the registered manager and provider had taken sufficient action to address previous concerns and comply with required standards. As a result, the provider has complied with the Warning Notice and requirements we issued and had sustained improvements across all domains. Therefore the overall rating of the service has improved to 'good.'

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Staff worked closely with community health professionals and therapists to maximise people's well-being. People felt safe and had positive and caring relationships with the staff that supported them.

People were protected against avoidable harm and abuse. Good systems were in place for reporting accidents and incidents and the service was responsive to people's individual needs.

Staff enjoyed working at the service and felt well supported in their roles. They had access to a wide range of training, which equipped them to deliver their roles effectively. Staff completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. This ensured they had the appropriate knowledge and skills to support people effectively. Records showed that the training, which the provider had assessed as mandatory was up to date. Staff told us that they felt supported and received training to enable them to understand about the needs of the people they care for. People and their relatives felt the staff had the skills and knowledge to support people well.

There were sufficient numbers of staff on duty to keep people safe and to meet people's needs. We saw that staff recruited had the right values, and skills to work with people who used the service. Staff rotas showed that the staffing levels remained at the levels required to ensure all people's needs were met and helped to keep people safe.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely. Nurses had completed safe management of medicines training and had their competency assessed annually. The nurses were able to tell us about people's different medicines and why they were prescribed, together with any potential side effects.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The members of the management team and nurses we spoke with had a full and up to date understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. We found that appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations.

The service placed a strong emphasis on meeting people's emotional well-being through the provision of meaningful social activities and opportunities. People were offered a wide range of both group and individual activities, which met their needs and preferences. Visiting was unrestricted and people's relatives felt included in the care of their loved ones.

People were provided with a variety of meals and the menu catered for any specialist dietary needs or preferences. Mealtimes were often viewed as a social occasion, but equally any choice to dine alone was fully respected.

People were supported to maintain a healthy balanced diet through the provision of nutritious food and drink by staff who understood their dietary preferences. We observed communal mealtimes where people ate together. Where people had been identified to be at risk of choking, staff supported them discreetly to minimise such risks, while protecting them from harm and promoting their dignity.

We looked at care records and found good standards of person centred care planning. Care plans represented people's needs and preferences to enable staff to fully understand people's needs and wishes. The service was responsive to people's individual needs. The good level of person centred care meant that people could lead independent lifestyles, maintain relationships and be involved in the local community.

People's privacy and dignity were respected. Staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

People were involved as much as possible in planning their care. The manager and staff were flexible and responsive to people's individual preferences and ensured people were supported in accordance with their needs and abilities. People were encouraged to maintain their independence and to participate in activities that interested them. People who lived at the service were allocated key workers and we observed trusting friendships between people and staff members. A key worker is a named member of staff responsible for ensuring people's care needs were met.

The service had robust systems in place for monitoring the quality of care and support. The auditing systems showed that the manager was responsive to the needs of people who lived at the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People living at the home had detailed care plans, which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

People were protected from the risk of abuse, avoidable harm or discrimination because staff understood their roles and responsibilities in protecting them.

Staffing levels were sufficient to meet people's individual needs.

Staff had undergone thorough and relevant pre-employment checks to ensure their suitability to support people.

Medicines were managed safely and there were good processes in place to ensure people received the right medicines at the right time.

### Is the service effective?

Good

The service was effective.

Staff had received all essential training and had the necessary skills and experience to support people effectively. Regular supervision and team meetings took place.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People were provided with a choice of high quality meals, which met their personal preferences and supported them to maintain a balanced diet and adequate hydration.

People were supported to maintain good health.

The service had good working relationships with other professionals to ensure that people received the holistic care.

The adaptation and design of the home meant that people were able to move freely and access its facilities.

## Is the service caring?

Good

The service was caring.

People said kind and caring staff treated them with respect. Staff supported people to maintain regular contact with their families.

People were supported to be involved in all aspects of their care and in their care plans. They were treated with dignity and respect.

We saw people's privacy was respected. People and staff got on well together.

## Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information to staff on people's care needs and how they wished to be supported.

People were encouraged and supported by staff to pursue educational and recreational activities that were of interest to them.

Complaints were managed in line with the provider's policy.

## Is the service well-led?

Good

The service was well-led.

Systems for monitoring quality and auditing the service had improved and were being used to continually develop the service.

People and their relatives were asked for their views and feedback through a range of surveys and questionnaires.

The daily management of the service was effective and staff felt the management team were good role models for them.

The culture within the service was open and delivered a service that placed people at the centre of the care they received.

# Beechcroft Care Centre

**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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection checked that improvements to meet legal requirements, identified in one warning notice, had been made. This inspection also checked to see whether breaches of legal requirements made as a result of the last inspection on 18, 19 and 20 January 2016 had been met.

This inspection took place on 12 September 2016 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor was a registered nurse.

Prior to 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 any improvements they plan to make. Before the inspection, we sought information from representatives of the local authority. We checked the information we held about the service and the service provider, including statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection, we spoke with four people, two relatives, the registered manager, the deputy manager, the area manager, two registered nurses, five staff and two internally employed physiotherapists. 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 looked at the care records for nine people and the medicines administration records for all people being administered medication. We looked at three staff members' recruitment, supervisions and appraisals records. We reviewed the staff training plan and the staff duty rota for the past eight weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits, policies and procedures.

Following our visit, we spoke with one further relative and contacted professionals to ask for their views and experiences. These included a speech and language therapist (SALT), Psychologist and general practitioner (GP). They consented to share their views in this report.

Good

# Is the service safe?

## Our findings

At our previous inspection in January 2016, we found that the provider had failed to mitigate risks and provide safe care to people. There were also concerns over how staff were deployed. We issued two requirement notices to the provider in respect of these breaches, which required the provider to make immediate improvements.

At this inspection, we found that action had been taken and the provider had met both requirement notices. People told us that they felt safe. One person said, "I do feel safe." A relative told us "I visit weekly, [person] is safe. They are meeting [person's] needs."

We previously reported that some electrical equipment had not been tested since 2012. Portable Appliance Testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Although not all items require PAT testing annually, there was no evidence any items had been tested since 2012. On this visit, we were shown valid certification for all electrical items that required PAT testing. The registered manager and provider had ensured that equipment used in the service was safe, well maintained and complied with required safety checks.

At our previous inspection, we found that people were not protected from the risk of harm because the provider and registered manager failed to assess and mitigate risks to people. We previously reported that when people with reoccurring health conditions saw the GP, their care plans and risk assessments had not been updated to provide guidance to staff and help prevent reoccurring infections. At this visit, we were shown that following GP visits, care plans had been updated to reflect the outcomes of people's health care conditions. A GP for the service told us, "I do a ward round every week; they [staff] are always concerned about the health and wellbeing of patients. There is always a nurse, who is dedicated to the doctor when they attend. Handovers and the paperwork have improved – so that when we do attend we have a full history of the patient."

At this inspection, we found that improvements had been made to ensure people's safety and wellbeing and the care people received was safe. We previously reported that there were people who had a diagnosis of epilepsy who required an emergency medication to be administered. There was a care plan in place for the medication but it did not contain information about who should administer the medication and there was no evidence it had ever been re-evaluated. Training certificates for the care staff to administer the emergency medication were out of date. At this inspection, we found that these care plans had been reviewed and were up to date. Staff had refreshed their training to be able to administer the emergency medication. The registered manager carried out competency checks to ensure staff were able to safely administer this medication. We found that people who may need this emergency medicine were no longer at risk of not having this need met.

We previously reported that a number of people were assessed and prescribed as needing oxygen to help with their breathing. We found that masks were not labelled, neither were the oxygen bottles. Therefore, it was unclear what equipment was intended for which person. At this inspection, we found that masks and

oxygen bottles were clearly labelled. There was guidance in place on how the masks and oxygen bottles should be used and maintained. Good practice was being followed to ensure that people requiring oxygen had appropriate equipment given as instructed.

Before people moved to the service an assessment of need was completed. This looked at the person's care needs and any risks to their health, safety or welfare. Where risks were identified, these had been assessed and actions were in place to mitigate them. We observed people being transferred from a wheelchair to a chair safely and this was consistent with their mobility risk assessments. We observed good practice at lunchtime where people were identified as at risk of choking. Staff supported people to cut their food up and were being encouraged to eat smaller mouthfuls, which was consistent with people's risk assessments. We observed that staff practice promoted people's safety and was in line with their identified support needs. Care plans contained risk assessments in relation to personal care including moving and handling, choking, nutrition and hydration, falls and epilepsy. People's care plans noted what support they needed to keep safe. They provided information about support each person required in relation to safety awareness and completing activities such as having a bath and mobility. These risk assessments detailed the required staffing ratio at different times and for specific activities to ensure the safety of people, staff and others.

At the last inspection we identified that there were not sufficient numbers of suitably qualified staff deployed at all times to meet people's needs and keep them safe. At this inspection, we found that staffing levels deployed were now sufficient and that this had been sustained to ensure people's safety. Since our last inspection, the occupancy of the service had increased but there was also an increase in the number of staff deployed which was evident throughout the service. People told us that there were now enough staff to care for them properly. A relative told us, "There is enough staff, they keep [person] safe."

The rota reflected the staffing levels in place as described by the management team. In Beechcroft Care Centre, there were five staff on each shift from 8 am to 8 pm. In Chestnut Lodge, there was three staff on each shift from 8 am to 8 pm. In Hazel Lodge, there was four staff on shift from 8 am to 8 pm. In addition to this, there was a nurse on duty in each house from 8 am to 8 pm. The night shift was from 8 pm to 8 am there were one support staff and one nurse in each house. There was a 24 hour on call system for staff to use in case of an emergency or support. The registered manager told us, as part of their admission process before people moved into the service, a needs led assessment tool was used. This is to identify the correct level of staffing needed to safely and effectively meet people's needs. The registered manager was able to show examples of how this had been used. We found that staffing levels and the skill mix of staff deployed were now reflective of people's individual needs and therefore enabled people to receive personalised care. Staff told us that they now had time to support people appropriately. We saw that when people became disorientated or anxious, staff spent time reassuring them individually.

The registered manager and deputy manager worked in addition to support staff to provide on-going management support and oversight of the service. The rotas confirmed that they were on duty and were supernumerary to the planned staffing levels.

The service had policies and procedures regarding the safeguarding of people, which included details about the definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, racial, financial and verbal. Without exception, staff told us they would keep the person safe, observe the person, offer the person 1:1 support if required, talk to their manager and if needed report their concerns to the local authority safeguarding team

and/or the Care Quality Commission. Staff said they felt comfortable referring any concerns they had to the registered manager if needed. The deputy manager was able to explain the process, which would be followed if a concern were raised.

The recruitment and selection process ensured staff recruited had the right skills and experience to support the people who used the service. The staff files we looked at included relevant information, including evidence of Disclosure and Barring Service (DBS) checks and references. DBS checks helps employers make safer recruitment decisions and prevent unsuitable people from working with people at risk. Records showed checks were made that staff from overseas had the authority to work in the UK and that registered nurses were registered with their professional body, the Nursing and Midwifery Council (NMC). Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were cared for by sufficient numbers of staff whose suitability for their role had been assessed by the provider.

People's medicines were managed safely in accordance with current legislation and guidance. Medicines had been administered by staff who had completed appropriate training and had their competency assessed annually by the registered manager. Staff told us about people's different medicines and why they were prescribed, together with any potential side effects. People's preferred method of taking their medicines, and any risks associated with their medicines, had been documented. We checked all the medication administration records (MAR). They included a picture of each person, any known allergies and any special administration instructions. The MAR forms were appropriately completed and records confirmed that people received their medicines as prescribed. Where people took medicines 'As required' there was guidance for staff about their use. These are medicines, which people take only when needed. Medicines were stored safely and securely.

Personal emergency evacuation plans were in place in care records to inform staff of people's support needs in the event of an emergency evacuation of the building. Additionally, staff had information available of the action to take if an incident affected the safe running of the service. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events.

Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electrical safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment; such as emergency lighting, extinguishers, alarms, were tested regularly by the provider's maintenance engineer to ensure they were in good working order. The provider had contingency plans to ensure the service could continue in the event of power failure or adverse weather. These plans provided detailed guidance and useful contacts for staff to use in the event of an emergency.

Good

# Is the service effective?

## Our findings

At our previous inspection in January 2016, we found one breach of Regulation in this domain relating to the provider not ensuring staff were suitably trained and supported to carry out their duties. At this inspection, we found that sufficient action had been taken in these areas and the provider was now meeting the required standards.

Staff were formally supervised, appraised and confirmed to us that they were happy with the supervision and appraisal process. This ensured staff received regular support and guidance, and the opportunity to discuss any personal and professional development needs. All staff felt well supported in their roles and said they were able to approach the registered manager with issues at any time. Supervisions were undertaken regularly in line with the provider's policy and more frequently if required, such as when staff first commenced employment. Staff meetings were held regularly to ensure good communication of issues and learning between staff.

At the previous inspection, we found that staff did not have training or knowledge related to epilepsy and nurses were providing support and supervisions without having been trained in how to do so. At this inspection, we found that training and support for staff had been improved to ensure staff had the skills and knowledge to meet people's needs. This included training on epilepsy, staff supervision training and training for staff in dignity, independence and compassion. One person communicated with staff using Makaton. Makaton uses speech with signs (gestures) and symbols (pictures) to help people communicate. We did not observe that the registered manager had adequately prepared staff to communicate with a person with this communication need. Following our feedback to the manager, Makaton training was booked for October 2016 to address this shortfall. Since the inspection, the registered manager sent us evidence this had been completed.

New staff were required to complete the Care Certificate, a nationally recognised set of standards that health and social care workers adhere to in their daily work. This covers 15 standards of health and social care topics. Essential training had been completed by existing staff; in moving and handling, health and safety, infection prevention and control, safeguarding, medicines, food hygiene, first aid, equality and diversity, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff had completed qualifications in health and social care such as the National Vocational Qualification in Levels 2 and 3. There were opportunities for staff to undertake additional qualifications and for continual professional development. For example, staff had opportunities to do their nursing training. The training offered to staff enabled them to gain the skills and knowledge to effectively meet people's needs.

At the previous inspection, we identified an area of concern with the management of people's oral health. All of the care records sampled for oral care stated that people should be supported at least twice daily to brush their teeth but all records sampled showed that there were gaps and on many occasions people were not being supported with their oral hygiene at this recommended frequency. This was an area requiring improvement. At this inspection, we found that each person had an oral health care plan, which clearly

guided staff what support each person needed. There were no gaps in the records sampled. This demonstrated that people received support in line with their assessed needs.

People told us that staff were good and supported them well. Everyone we spoke with praised the quality of the service. All of the relatives we spoke with told us the service maintained high levels of well trained staff, and that this was a contributory factor in how good the service was at ensuing people's needs were met. We observed examples of good staff interactions with people, which demonstrated kindness and respect. For example, a person receiving support with their meal, indicated they wanted their face stroked. The staff member supporting, said they were happy to do this and stroked their face. The staff member sat opposite the person and made sure they were eye to eye level. The person responded happily to this, until they moved their face to indicate they wanted the contact to stop. Another person, returning from a weekend away, was greeted by the staff on duty, a member of staff sat with the person, holding their hand and asking them about their time away.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our inspection, there was one person who was subject to a DoLS authorisation and this had been applied lawfully to protect the person's rights.

The registered manager and staff demonstrated an understanding of the MCA. The registered manager and nursing staff were able to describe to us how they involved people and their relatives in making decisions about their care and people confirmed staff discussed this with them. They confirmed applications for DoLS authorisations had been made to the supervisory body for some people living in the home and a decision from the local authority was pending. A copy was kept within the person's care records and staff were aware of these.

We observed that people were asked for their consent before care was provided. Staff were able to tell us what they would do if people refused care. Where people did not have capacity to make particular decisions relating to their care or treatment, the registered manager had acted in accordance with legal requirements. People's capacity had been assessed to determine whether they were able to participate in decision-making. Where this was not possible, best interest meetings had been held, involving relevant professionals and relatives to make a decision in the person's best interest on their behalf. Examples included a decision to use an audio monitor in a person's bedroom at night to monitor seizure activity.

People were offered a choice of food and drink and supported in line with their needs. We observed staff supported people to drink during the morning and offered one to one assistance at lunchtime. Information on people's needs and preferences were recorded in their care plans. On a daily basis, people were asked to choose from the menu, which was available pictorially, and their choice recorded and shared with the kitchen staff. If at the point of service, they changed their mind, alternative meals were available.

People were monitored and assessed to determine if they were at risk of malnutrition. Staff recorded people's weight on a monthly basis and made referrals for professional advice when concerns were identified. Where necessary, food and fluid charts were used to monitor people's intake. Eating and drinking guidelines were in place for some people, written by a Speech and Language Therapist. Staff were able to explain the support they provided, including on positioning and the use of aids such as plate guards, adapted cutlery or beakers. Some people were unable to eat and drink and received their nutrition via a gastrostomy tube directly into their stomach. The nurses were responsible for this and followed guidance from the dietician to ensure people's nutritional needs were met.

People had access to healthcare professionals. The home had two physiotherapists directly employed by the provider. They supported people with exercises, including passive movements, walking, using standing frames and accessing the hydrotherapy pool.

A GP told us, "The staff seem very ready to contact doctors about changes in the health of patients between our weekly visits". Relatives told us that they were kept informed if there were any changes or concerns in their relative's health.

The home was purpose built by the provider. Each room was equipped with an overhead tracking hoist. There were assisted, height adjustable baths, hydrotherapy pools and a sensory room, each equipped with overhead tracking hoists. People had personalised their bedrooms according to their taste. During our visit, people were outside enjoying the garden, which was accessible, including a pathway to allow those in wheelchairs to enjoy the grounds. The adaptation and design of the home meant that people were able to move freely and access its facilities.

Good

# Is the service caring?

## Our findings

At our previous inspection in January 2016, we identified one breach of Regulation in this domain. This was because people were not always treated with dignity and respect. At this inspection, we found that action had been taken and the provider was now meeting the required standards.

We observed that people had positive relationships with the staff that supported them. We noticed that staff spent time engaging with people in a meaningful way that was not purely task-led. For example, before one person returned from a stay with their relative, staff chatted with them to see how they had enjoyed their weekend away. They waited for the person to sign and indicate their response. We overheard one staff member say to the person, "Do you want to join [person] to watch a movie?" and cuddled them before they were moved into a position where they could see the TV. The person responded clearly indicating they were happy and excited to see the other person. In return, the person smiled happily and was very relaxed. One person was sitting in a chair with a jumper on. A staff member attended to them to check they were not too hot. The staff member then asked the person if they would like to listen to some music or watch the television. The staff member gave reassurance to the person and the person appeared pleased with this and chose to listen to music.

People consistently praised the caring attitude of staff. One person told us, "I do feel cared for. Staff are kind." A relative told us, "I do think there are some amazing staff. They really know [person], they're really quite loving with [person]". A GP told us, "The staff are caring, very much so."

Staff responded to people quickly and respected their wishes. We heard one person comment that they could not see the movie properly; staff immediately offered to reposition the person. On another occasion, we saw a person become upset. A member of staff comforted the person by reassuring them and rubbing the person's shoulder. The person thanked the staff and held their hand. The staff member remained with the person until they were completely calm. Staff knew people's needs and people responded to staff interactions and when staff spoke to them. Staff talked to people and made eye contact with them when they supported them with their medicines.

Most people who lived at the service were unable to communicate verbally. People's care plans included information on how they indicated a choice. For example, we read, 'I am non-verbal but can communicate using my gestures and body language. I'm also able to answer simple questions answerable by a 'yes'(eyes looking up) and 'no' (eyes looking down or shake my head)'. Another care plan indicated that if the person frowned, this may mean something is wrong and for staff to consider boredom, pain and discomfort.

The nurse told us, that a member of care staff supported a person to attend a local NHS service that provides specialist assessment and support with communication aids. The person was supported to use this service every week to work on their communication. She said they try to work with them on this in 15-minute blocks, as the person is very reticent to use it. Another person was supported to attend a computer class offered by a charitable organisation. The person's care plan stated, 'I have now learned more ways to express myself like composing emails for my family and the staff'.

People had a copy of the communication bill of rights in their care plan. This included rights such as, 'to express feelings' 'to be offered choices' 'to reject' 'to aids' 'to services and resources'. People had a 'How to communicate with me' care plan, an example of what we read was, 'Talk to me, give me options, speak clearly, use humour'.

We observed that staff communicated with some people using gestures. One staff member said, "There is a computer in Beechcroft Care Centre, which can be operated by click switches and [person] has used this. [Person] looks up for yes and down for no. You can tell from their facial expressions and there are definite noises for pleasure and displeasure. Just through yes/no you can get quite a long way". The staff member also told us, "[person] doesn't always want to do it (the communication system). We had one conversation using the grid system on the computer, he told me exactly what he wanted to do and how to help him". Another person used a 'Tellus board', which is a device that aids people to clearly communicate their thoughts and feelings with text or symbols. The person's care plan stated that they needed support from staff to switch it on. The care plan included, '[person] has a Tellus communication board but needs encouragement to use it.' Records stated, 'I activate Tellus by a switch on my head rest. Once switched on and connected I am able to use this independently. I have not been keen to use it lately. Please encourage me to use it regularly.'

Staff demonstrated skill in understanding people's wishes and offered choices accordingly; people were enabled to initiate communication.

People's privacy was respected. We observed that staff respected people's private space and they routinely knocked on people's bedroom doors and sought permission before entering. We saw that personal care was provided discreetly and in a way that upheld people's dignity.

Staff had spent time getting to know people, their histories and their interests. Staff demonstrated an understanding that supporting people effectively was about providing care that was personal to them.

People's rooms were personalised to reflect their tastes, preferences and interests. Photographs of families and activities were displayed in the service to remind people of events and others important to them. This ensured that relationships were maintained to promote people's wellbeing. Staff were aware of items of particular importance to people, which were available when people wanted them.

Relatives told us the staff worked closely with families and representatives and kept them fully involved in the person's care as required. We were told relatives and visitors were welcomed to the service and there were no restrictions on times or length of visits.

Good

# Is the service responsive?

## Our findings

At our previous inspection in January 2016, we found one breach of Regulation in this domain relating to people not always receiving support in a person centred way. At this inspection, we found that steps had been taken and the provider was now meeting the required standards.

At the last inspection, we found that people's care plans included inaccurate or incomplete information and that staff failed to follow people's plans of care to ensure their needs were met. At this inspection, we found that people's care was effectively planned and they received support in a way that was responsive to their changing needs.

Without exception, staff demonstrated thorough knowledge of people's needs. Each person had a current assessment of their needs and their preferences were documented. People told us staff responded to their requests and met their needs. People we spoke with did not know what a care plan was but did tell us that the staff spoke to them about what they liked, disliked and how they wanted to be supported. A GP told us staff understood people's needs and were responsive to changing needs. They said staff made referrals at appropriate times and always acted upon advice they were given.

Staff knew people well and understood how they liked to be supported. Each person had a named nurse and a keyworker. When a person moved to the home, they and their relatives were asked for information about their experiences and interests. Staff added to this as they got to know people better. People's choices and preferences were documented in their care plans and the daily records showed that these were taken into account when people received care. Relatives spoke positively about the support provided. One said, "All the staff are all so friendly, you can talk to them about anything. If you want a moan they'll listen and the issues get sorted". The relative gave an example of this; the person was finding the shower trolley painful so the registered manager arranged for the person to use a shower chair instead. The person told us, "They always ask me if I can do it and do I need help. Some days I can feed myself, some days I cannot. If I need help there is somebody there".

Where risks had been identified such as epilepsy, wounds or behaviour that could be described as challenging, monitoring was in place. This helped ensure appropriate action was taken to support people and to respond to changes in their needs. When staff noted a person's loss of weight, the nurses had made a referral to the Dietician for an assessment. A meeting was held and as a result, new strategies were put into place, the person's care plan and risk assessment was reviewed and updated to reflect the recommended action by the Dietician. During our visit, we observed staff took prompt action to relieve people's distress or discomfort, such as by supporting them to adjust their seating position, or positioning them so they could communicate with friends.

Each home had a sensory and spa room which people had access to. There was also a hydrotherapy pool on site, which people also accessed on a weekly basis. This supported people with physiotherapy needs and management of physical health conditions. People confirmed they felt listened to. They told us of activities that had taken place because of their feedback in resident meetings such as visiting a local farm, visiting a

cat sanctuary, going to Brighton and to the Bluebell steam railway. The feedback from people who had accessed these activities was positive and minutes from meetings demonstrated, they would like to do more of those activities. During the course of our visit, we observed people participating in a range of activities such as jigsaw puzzles, a person using an iPad with staff assistance to play games, card making with hand over hand support and the sensory room was in use.

Two people told us, they had plenty of activities, including going to Church, Karaoke, Hydrotherapy and Music Therapy. Their records documented that these activities had been taking place and stated they appeared to be enjoying them. Another person told us there was enough to do and they were ordering in a Chinese takeaway that evening. They told us, "That's why I had sandwiches at lunch because I'm having a takeaway later." Another person said they had been out to the shops a couple of times and to the pub down the road a few weeks back. They said, "They make time for all of us even if they're really busy".

People and relatives were encouraged to share their thoughts and ideas with staff. Most relatives felt they had good communication with the home. One relative told us, "I feel supported and any problems I can go straight to the manager." A suggestions box was available in reception, which provided an opportunity for those who preferred to make comments or raise concerns anonymously. The provider sent feedback questionnaires to relatives and responded to any comments that were made, where appropriate offering a meeting for further discussion.

There was a complaints procedure in place and on display in the communal areas. People knew who to speak with if they had any concerns or complaints. People confirmed they could talk to staff and felt listened too. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. There had been a number of complaints recorded in 2016, which the registered manager had investigated. The provider responded to complaints effectively and in line with their complaints procedure. We were able to see examples of written responses from the area manager addressing each complaint that had been made.

Good

# Is the service well-led?

## Our findings

At our previous inspection in January 2016, we found that the provider was in breach of two Regulations in this domain including that the statement of purpose did not reflect all of the aims and objectives of the services being provided. The service lacked effective monitoring to ensure the quality and safety of the service. We issued one warning notice and one requirement notice to the provider in respect of these breaches, which required the provider to make immediate improvements. At this inspection, we found that action had been taken and the provider had met the requirements of the warning notice and requirement.

Following our concerns raised at the last inspection about clear governance and leadership, the provider had instigated additional management oversight at Beechcroft Care Centre. They supplied us with updates that highlighted their progress against an official action plan of required improvements. A new manager was appointed in April 2016, who has registered with the Commission. The manager was familiar with the people living at the service and the staffing team due to their previous experience managing the service. A new management structure for the service was implemented which included the support of two deputy managers to provide support, supervision and guidance to staff. It was evident that the new management structure had led to real improvements in the leadership and culture of Beechcroft Care Centre.

Since our last inspection, the service had experienced a period of considerable change. It was evident that the new registered manager had effected improvements to the leadership of the service. The areas requiring improvement identified at our last inspection had all been addressed.

The feedback we received from people, relatives and staff reflected that the new management team had been effective in taking forward the level of change required in the service and in particular securing a more open and positive culture.

Staff praised the registered manager and deputy manager and said they felt motivated and empowered by them. Staff members told us, "The culture is supportive". Another staff member said, "[manager] was a big relief to everybody – communication is a lot better, there has been a concerted effort to make things work. If I go to [manager] and say, I'm not happy, she responds to it straight away. She'll have a meeting or deal with it directly, I can talk to her." Another staff member told us, "If I think something is wrong they don't see it as an aggravation, they take it as a positive. I think things are turning around".

Two relatives told us that they had confidence in the new management of the service and believed that the service was now going in the right direction. A relative told us, "I am very involved, I do get to give the manager my views. I do feel listened to. The manager is good. She has made the staff to be confident." Another relative told us, they were concerned last year, due to the lack of communication. The relative went on to say that, there still can be a tendency of this but felt reassured they could raise this with the manager and action would be taken. We were told, "I've got more confidence now [manager] is back".

A GP told us, "Their previous manager has returned, who has been doing a very good job, dealing with staffing very well."

The positive team spirit amongst staff was evident and staff were now working positively as a team. Staff told us that they now looked forward to coming to work and it was clear that staff enthusiasm had improved the morale of people who lived at Beechcroft Care Centre. One staff member told us, "I'm really proud of the staff; they're all really conscientious, they want to do the right thing and are here for the right reasons".

People were benefiting from a more open culture. Reflective practice was being used to encourage staff to think about their own conduct and constructively challenge their colleagues. Minutes of team meetings reflected healthy discussions between the registered manager and staff in reflecting on practice and improving practice. For example, where gaps had been identified in records, staff supported other staff to make improvements. Staff reported that they had felt empowered and supported by this process and in turn had learned a lot about how to improve the way they cared for people.

Communication of information across the service had improved. The registered manager and deputy manager attended meetings together to ensure the effective handover of information and delegation of tasks. We saw that this had improved quality of care for people. For example, where people had been identified as having health issues, information was better communicated and documented in people's records. Staff told us that nurses and staff had better oversight of each shift and that work was allocated to support staff, which helped ensure that things were not missed.

The management team had reintroduced the provider's existing systems to monitor the quality of the services provided. This included six monthly monitoring audits and quarterly good governance audits. In addition to provider level monitoring of the service against a specific action plan, the registered manager conducted monthly audits checking care plans, monitoring records, medication records and analysing all the audits conducted. We found that actions from these audits had led to redecoration of a hallway in Chestnut Lodge and reviews of multiple people's care plans.

People told us that they felt better engaged and that their views were now being listened to. In the past people had not always seen changes made as a result of their feedback. The management team had responded to this by chairing monthly meetings for people to attend. People and their relatives were asked for ideas on what entertainment could be arranged. The minutes sampled demonstrated an exchange of ideas. After reaching, a joint decision the registered manager booked activities that had been agreed.

Satisfaction surveys were being used as a way of canvassing the views of people, visitors and professionals. All results from these surveys were positive.

Staff logged all accidents and incidents, which were reviewed daily by the registered manager. This helped to ensure the provider identified trends and managed actions to reduce the risk of repeated incidents. Systems and processes supported reviews and monitoring of action taken to ensure identified and required.

Records accurately reflected people's needs and were up to date. Other records relating to the management of the service such as audit records and health and safety maintenance records were accurate and up-to date. People's and staff records were stored securely, protecting their confidential information from unauthorised access but remained accessible to authorised staff. Processes were in place to protect staff and people's confidential information.