Homebeech Limited

Homebeech

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Homebeech is a nursing home registered to provide accommodation, personal care and nursing care for up to 62 people. They catered for a wide range of needs including care for older people, people living with dementia, and adults with physical disabilities, all of whom required nursing care. At the time of our inspection there were 57 people living at the home. Within the home there were three areas arranged by people's needs. The main part of the home supported older people with nursing needs while Daffodil supported younger adults and Beechside provided support to people living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health and safety were assessed prior to admission and were regularly reviewed. We found however that there was not always sufficient detail to tell staff what action should be taken when risk is identified, particularly in relation to malnutrition risk. Risk assessments stated that the aim was to reduce the risk of weight loss and dietician contact details were in place, but there was no information on when staff should take action in response to body mass index (BMI) data or weight loss. There was a risk that people may not receive appropriate support to mitigate the risk of weight loss and malnutrition.

People had mixed responses when asked about the caring manner of staff. One person told us, "There's a percentage of staff that don't speak". From our observations staff did not always respond in a caring way towards people.

People told us they did not feel there were enough activities, commenting "There's nothing to do", and "That's something we could do with more of". While people's social needs were assessed there was a lack of activities or opportunities for people to be occupied in a meaningful way and in line with their interests.

Staff were aware of their responsibilities in relation to keeping people safe. Staff felt that reported signs of suspected abuse would be taken seriously and knew who to contact externally should they feel their concerns had not been dealt with appropriately.

People told us staff responded to them when they needed help and were not left waiting. For example one person said, "I've never had to wait. The staff are very good. If they are busy with other jobs they say, 'I will be five or ten minutes'.
Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work.

Staff had undertaken appropriate training to ensure that they had to skills and competencies to meet people's needs. There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting.

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.

People's rights were upheld as the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) had been adhered to.

People's hydration needs were met. Fluid charts were used to ensure that people received enough to drink. People received enough to eat and drink. People spoke positively of the food and the choice they were offered.

Relatives told us they felt staff made them feel welcome and made time to speak with them about any changes to their relative's health or the care they received. A relative told us, "They always say hello and give a smile".

People received care that was responsive to their needs and included information on their life history. People's care plans were reviewed monthly or more often if needed to ensure that they reflected people's current level of need.

The provider had a quality monitoring system in place, which had been effective in actioning areas for improvement.

We found a number of breaches 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 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

Risk assessments were in place but people may not be protected from harm as their care records did not always contain sufficient guidance on how to mitigate identified risk in relation to malnutrition.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's hydration and nutrition needs were met however staff appeared task orientated and had limited interaction with people during mealtimes.

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed.

Staff had received training as required to ensure that they were able to meet people's needs effectively.

People were supported to maintain good health and had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring

People were not always treated with kindness or their needs responded to quickly.

People's relatives were able to visit without being unnecessarily restricted

Is the service responsive?

Requires Improvement

The service was not always responsive

There were not enough meaningful activities for people and people did not always receive the support they needed to take part in activities.

People received care which was personalised and responsive to their needs.

Complaints were recorded and dealt with promptly.

Is the service well-led?

Good

The service was well led.

Quality assurance process were in place which identified and actioned concerns.

Staff and relatives told us the registered manager was approachable and they felt able to discuss any concerns with them.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Two inspectors and a specialist advisor undertook the inspection. A specialist advisor provides specialist clinical advice to the inspection team.

Before the inspection, we checked the information that we held about the home and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We reviewed safeguarding information that we had received from the West Sussex County Council Safeguarding Team. We also reviewed feedback from healthcare and social care professionals. We used all this information to decide which areas to focus on during the inspection.

Some people living at the service were unable to tell us about their experiences; therefore we observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the area manager, the registered manager, eight members of staff, three visiting relatives, twelve people who lived at the home and two health care professionals. We also examined a selection of records. These included eight care records, four staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints, quality assurance audits and other records relating to the management of the service.

The service was last inspected 31 July 2015 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

Before our visit the registered manager had notified us of an incident which resulted in a person being admitted to hospital. The home notified the safeguarding team and an investigation was carried out. In response to the incident staff had received additional training around the management of diabetes and people's care plans had been updated to reflect changes in their diabetes management practice. We reviewed people's care plans and saw that they had been updated to reflect the recommendations made by health care professionals following the incident. Following our inspection we spoke with health care professionals who raised concerns about nursing staff keeping up to date with best practice guidance. We identified concerns with guidance available on how to mitigate the risk of malnutrition. We spoke with the registered manager and while people at risk of malnutrition had been identified they did not seem clear on when it would be appropriate to contact the doctor or dietician. This lack of clear guidance for staff could lead to people receiving inconsistent or unsafe care.

Risks to people's health and safety were assessed prior to admission and were regularly reviewed. We found however that there was not always sufficient detail to tell staff what action should be taken when risk is identified. Some people were at risk of malnutrition and we saw that they had food monitoring charts in place. The registered manager told us, "If we have concerns we set up a four day food chart to monitor their intake. The GP is also notified, who will make a referral to the dietician." We reviewed the risk assessments for two people who were PEG fed and saw that they had a low body mass index (BMI) score indicating that they were under weight for their height. Percutaneous endoscopic gastrostomy (PEG) feeding is used to feed people who have problems swallowing. The BMI score for a normal weight range should fall between 18.5 and 24.9. One person had a BMI of 16 had continued to lose a small amount of weight. We saw that they were weighed weekly and a BMI score was recorded for each person. No contact had been made with health professionals regarding the low BMI scores and continued weight loss. While risk assessments stated that the aim was to reduce the risk of weight loss and dietician contact details were in place there was no information on when staff should take action or what BMI score would indicate that the health care professionals should be contacted. There was a risk that people may not receive appropriate support to mitigate the risk of weight loss and malnutrition. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they would speak to the registered manager if they had concerns about safety. One person told us, "I have never been abused here, nor I have I ever seen anybody else being abused." People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, financial and verbal. Staff were aware of their responsibilities in relation to keeping people safe. Staff felt that reported signs of suspected abuse would be taken seriously and knew who to contact externally should they feel their concerns had not been dealt with appropriately. Staff said they felt comfortable referring any concerns they had to the registered manager if needed. The registered manager was able to explain the process which would be followed if a concern was raised.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. People told us they were responded to and not left waiting. They told us, "I've never had to wait. The staff are very good. If they

are busy with other jobs they say, 'I will be five or ten minutes'" and "If I ring the bell they will come straight away." Staffing levels were assessed by the registered manager and varied with the changing needs of people living at the home. We observed that people were not left waiting for assistance and people were responded to in a timely way. A member of staff told us "This is sufficient when everything goes smoothly. The manager arranges cover for staff who are on sick leave or on holiday. We don't often use agency staff; they are used to cover sickness. The manager will also organise additional cover if required, for example if there are hospital appointments and a member of staff needs to accompany them. We also get additional cover if we are providing end of life care". We reviewed the rota and the numbers of staff on duty matched the numbers recorded on the rota. On the day of our inspection there were 16 care staff in the morning and 14 care staff in the afternoon/evening. Two trained nurses were on duty throughout the day. At night there were eight care staff with one trained nurse. There was also catering and domestic staff on duty. Domestic and laundry staff were on duty during the day and also night, while catering staff were on duty from 7am to 7pm each day. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff files contained evidence to show, where necessary, staff were registered with appropriate professional bodies such as the Nursing and Midwifery Council and pin numbers were noted in staff files. The Nursing and Midwifery Council regulate nursing staff and ensure professional standards; once they are registered they receive a pin number.
Disclosure and Barring Service checks (DBS) had been requested and were present in all checked records. DBS checks allow the provider to check whether staff are suitable to work in a care setting.

Nursing staff were responsible for managing people's medicines and people received their medicines when needed. One person commented, "I get my medicines at the right times. I'm not on any pain killers at the moment but they are available if I need them". Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed people receiving their medicines on the first day of our inspection and saw that the staff who administered medicines did this safely. Staff locked the medicines trolley when it was left unattended and signed medicines administration records (MAR) once people had taken their medicines to confirm that people had received their medicine as prescribed. Staff confirmed that they were confident and understood the importance of this role. Medicines were locked away as appropriate and where refrigeration was required, temperatures had been logged and fell within guidelines that ensured effectiveness of the medicines was maintained. The registered manager regularly completed an observation of staff to ensure they were competent in the administration of medicines. We spoke with staff who told us that they received annual medicines management training, the training records we reviewed confirmed this.

Good

Is the service effective?

Our findings

People told us "The staff know what they are doing" and "I believe the staff know what they are doing. I can tell they do because of the way they react to me. They do understand my needs, but I don't know if they have had any training." Staff had undertaken appropriate training to ensure that they had to skills and competencies to meet people's needs. We reviewed the provider's training records and saw that staff had completed infection control, health and safety, moving and handling people and dementia awareness training. Staff had also received additional training to ensure that they were able to meet the needs of people they care for. We saw that staff had received training in areas such as diabetes and PEG feeding. Following the outcome of a safeguarding investigation which identified concerns with the management of diabetes, nursing staff had taken part in diabetes training provided my diabetes specialist nurse from a local health service. The learning from this training had been used by nursing staff when planning care for people and we saw that this was reflected in people's care records. There was a consistent staff team within the Beechside unit who provided support to people with dementia. We saw that staff working within Beechside received additional dementia awareness training and also dementia mapping training. Dementia mapping is an approach which focuses on providing person centred care and is used to improve the quality of life of people with dementia. There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting. Staff confirmed that they received supervision every two months and annual appraisals. Staff told us they discussed individual people and how best to support them and any other issues relating to their role. Additional training required was also discussed as part of the supervison and appraisal process, this allowed staff to carry out their role effectively.

New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff. Staff had completed the provider's induction checklist which involved familiarisation with the layout of the building, policies and procedures and the call bell system. The registered manager told us that all new staff now completed the Care Certificate. The Care Certificate is a set of standards which staff complete to ensure that they are competent in the caring role.

Consent to care and treatment was sought in line with legislation and guidance. 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 make 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that applications had been made for 10 people living at the home and 4 had been authorised by the local authority while the remained

were awaiting a decision. Capacity assessments had been completed appropriately for people and were in their care records. When people's application had been authorised we saw that the registered manager had recorded the date that the application expired to ensure that any subsequent application is made in a timely way and that people are not deprived of their liberty unlawfully. People were able to make day to day choices and decisions, but where decisions needed to be taken relating to finance or health, for example, and then a best interest decision would be made, involving care professionals and relatives to make a decision on the person's behalf in their best interest. Where possible, the person would also be included in this decision-making.

People's hydration needs were met. Fluid charts were used to monitor that people received enough to drink. For those who were at risk of dehydration, a target daily intake volume was set. Staff had totalled the drinks they consumed during the day to check that people had enough fluid to meet their needs. We observed people's water jugs in bedrooms being filled up, a choice of water and squash drinks were available in the lounge and people were offered tea and coffee throughout the day.
Dietary needs and nutritional requirements had been assessed and recorded. Weight charts were seen and had been completed appropriately on a monthly or weekly basis if needed to monitor changes. The Malnutrition Universal Screening Tool (MUST) tool was used to promote best practice and identified if a person was malnourished or at risk of becoming malnourished. However we identified concerns about the guidance available for staff on when advice should be taken from health care professionals in response to malnutrition risk and we have explored this is further detail in the safe domain.

People spoke positively of the food and told us that there were choices available which took into consideration their preferences; they told us, "The mealtimes are all right although they can be very busy. I don't like salad very much, so the staff don't give it to me. There is a choice of meals provided. We have to choose what we want for our dinner the night before." We were also told "I don't get any food I don't like. If I wanted something special, like a salad, the staff would get it for me. The food is adequate." Another person told us, "I get enough to eat. They bring a list round with choices and ask you what you want, scampi, pies, cabbage, veg. I don't have to wait too long between meals, I am never hungry. You can ask for biscuits if you want. "

We observed a lunchtime meal and saw that people had a choice of where they ate their meal. Some chose to eat in the dining room and others in the lounge or in their bedroom. We saw that people were supported to have enough to eat, drink and maintain a balanced diet. People's meals looked hot and appetising. However on the first day of our inspection we saw that one person in the dining room waited for over 45 minutes for their food while everyone else enjoyed their meal and we have explored this further in the caring domain. During the lunchtime meal staff focused on ensuring that people in the dining area and bedrooms received their meal; however there was limited interaction between staff and people. We saw one person who was having difficulty removing their protective apron and was not able to get the attention of staff. The person became increasingly frustrated before pulling the apron off them. Staff were task focused and consideration did not appear to be given to ensuring the people enjoyed the lunchtime experience. However where people needed assistance with eating we saw that this was done at an appropriate pace. Staff sat beside the person and spoke with them to make sure that food was at the correct temperature and that this was a pleasant experience. They spoke with the person about their day and asked the person when they would like more food and what part of their meal they would like to try next. When they were supporting the person with their ice cream they asked "would you like to start with vanilla or strawberry?"

People told us that they were able to see a doctor if they needed to see one. They would speak with a member of staff and this would be arranged. We were told, "If I need to see my GP I would ask the staff to

arrange it. I would get a private consultation – no problems." Another person said, "I would ring the bell and ask to see the nurse. I would ask them to see the doctor." Staff had regular contact with professionals when needed. When people received end of life care, staff ensured they had access to specialist advice from a local hospice. Chiropody was also a regular service that was provided. We spoke with a health care professional and they told us they were confident that staff or the registered manager would contact them if they needed advice or guidance. They told us, "They generally respond quickly, we speak regularly about any little issues." Another health care professional also told "we have a good working relationship with them".

Requires Improvement

Is the service caring?

Our findings

Staff did not always respond in a caring way towards people. We observed an interaction between staff and a person in the communal lounge area in which the staff member did not respond in a kind and caring way. We discussed this with the registered manager and the provider and action was taken to address this situation. People had a mixed response when asked about the caring manner of staff. One person told us "there's a percentage of staff that don't speak". On the first day of our inspection we saw one person sitting in the lounge area who wanted to go back to their bedroom which was upstairs. As staff walked passed they said "excuse me, excuse me, can you help me up the stairs?" The member of staff looked at the person but did not respond and walked passed without offering support. After waiting a short period of time the inspector had to intervene by informing a member of staff that this person would like to go to their room. On the first day of our inspection we saw that one person in the dining room waited for over 45 minutes for their food while everyone else enjoyed their meal. We discussed this with the registered manager who told us that this person needed support with their meals and staff were not available to support them. This did not show respect for this person as they were not able to enjoy their meal at the same time as everyone else. People's day to day decisions were not always respected. We observed the lunchtime meal on the second day of our inspection and saw a member of staff came to ask someone if they wanted some pudding. The person replied, "No thank you." The member of staff came back to the person with some pudding. The person told them "No, I don't want that!" but the member of staff decided to leave the bowl on the table in front of them anyways. The person's wishes and preferences had not be listened to or respected.
The above evidence demonstrates that people were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.
However people told us of examples where staff encouraged people to make choices in their daily life such as about what clothes they would like to wear and when they would like to get out of bed in the morning. One person told us "Staff do listen to me. I'm able to choose the clothes I like to wear. I have my own wardrobe." People we spoke with felt they were involved in decisions about the care they received and told us "The staff are very good. They have never refused me anything. They don't come along and tell me, 'You can't have that!'".

We also saw examples of staff taking time to speak to people. People smiled at the member of staff and appeared to enjoy these friendly interactions. On the second day of our inspection we saw that staff sat beside people in the lounge area and spent time speaking with them. People appeared to enjoy this interaction and conversations seemed warm and friendly.
Some people spoke positively of the caring manner of staff, they told us, "Living here is better than lovely, they really take care of you, I have been here 1 or 2 years now," and, "They are caring and kind to me". We spoke with a relative who told us, "It's all been good, they are lovely friendly staff". Health care professionals spoke positively of the caring manner of staff and told us "staff seem caring".

Staff knew which people needed equipment to support their independence and ensured this was in easy reach or provided when they needed it. Staff told us they encouraged people to remain as independent as possible with tasks such as cleaning their teeth and brushing their hair. At times we saw staff took time to make sure people understood what had been said and made eye contact when speaking with people.

We spent time observing care practices in the communal area of the home. We observed staff maintained people's privacy and that they knocked before entering people's bedrooms. Through both inspection days we saw and heard staff knocking before entering people's bedrooms. At times staff took time to speak to people as they supported them. A member of staff told us, "I respect each person as a human being. I would ensure that any personal care tasks were explained to them before we began. I would make sure the door to their bedroom, and the curtains, was closed first". Staff spoke with us about the importance of gaining consent from people before supporting with care, they told us, "I would ask the person concerned if it was okay to provide personal care, I would ask for their consent before I began. I would ask people even if they did not have capacity". Throughout our inspection we observed that people's hair
was brushed, that they were wearing glasses, hearing aids were in place and watches were set at the correct time.
People told us their family and friends were able to visit without restriction. For example one relative told us, "My sister is coming to visit me this afternoon. She lives in Bognor. She more or less visits when she wants. She comes to see me every week." Relatives told us they felt staff made them feel welcome and made time to speak with them about any changes to their relative's health or the care they received. A relative told us, "They always say hello and give a smile".

Requires Improvement

Is the service responsive?

Our findings

People were not consistently supported to follow their interests and take part in social activities. While people's social needs were assessed, there was a lack of activities or opportunities for people to be occupied in a meaningful way and in line with their interests. People told us they did not feel there were enough activities. For example one person said "There's nothing to do", and another said, "that's something we could do with more of". On both days of our inspection we saw that while staff were present in the communal areas there was limited interaction with people. On the first day of our inspection we did not observe people taking part in any activities. We spoke with the member of staff responsible for planning and arranging activities for people. They worked four hours a day, five days a week, when they were not on duty it was the responsibility of care staff to meet people's needs. They told us there was no planned schedule of daily activities and they did not have enough time to focus on ensuring that a schedule of activities was available as they supported people with care tasks. There was a schedule for visits from external entertainers, once a fortnight armchair exercises were arranged and a musical entertainer also visited once a fortnight.

We reviewed people's activity records and saw that they contained limited information and it was unclear how people had spent their day. We reviewed the activity records for the 7 February 2016 and saw that no information on the activities people had taken part in had been recorded. The 8 February 2016 showed that support had been offered to people with eating and drinking and that eight people had taken part in music and movement. The records for 9 February showed that nine people had taken part in domino's and music and movement. There were people who were unable to take part in the activities in the lounge and spent their day in their bedroom. We spoke with someone who spent most of their time on their room. We asked them if staff made time to speak with them, the response was, "You must be joking?" They told us that they felt bored and spent most of their time watching television or listening to the radio. We did not observe any activities being offered to people who remained in their room due to choice or health needs.

The home provided support to older people with nursing needs and dementia and also to younger people with physical disabilities; however we did not see that consideration had been given to ensuring that activities were planned in line with people's likes or abilities. When group activities were arranged this was for all people in the home. We spoke with one younger person who told us that they joined in some of the group activities but that they were often aimed at older people. They told us that an external entertainer visited every 2 weeks and arranged a reminiscence quiz; however this person was unable to answer the questions as they were not from his era. On the second day of our inspection we saw a member of staff encouraged a small group of people to make cards. However the staff member did not stay with the group and we saw that after a short period of time two of the people in the group had fallen asleep. A lack of stimulating and meaningful activities for people living with dementia placed them at risk of isolation, withdrawal and low mood. This aspect of people's care had not been considered or delivered consistently. We spoke with the registered manager and they told us that they were in the process of recruiting an activities coordinator as they had identified this as an area which required improvement. On the second day of our inspection that registered manager told us that a member of the care staff had applied for this post and consideration was being given to this application.

The above evidence demonstrates a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care plans included information on people's key relationships, personality and preferences. They also contained information on people's social and physical needs. Care plans detailed health concerns such as pressure area care, moving and handling, assistance with person care and nutrition. Prior to admission an assessment of people's needs was completed which covered details of the person's physical and social needs. Where appropriate people had a Do Not Attempt Resuscitation (DNAR) order in place at the front of their care plan. A DNAR is a legal order which tells medical professionals not to perform cardiopulmonary resuscitation on a person in the event of cardiac arrest and is completed by a medical practitioner. People's care plans contained a section detailing communication with healthcare professionals such as the GP. Care plans contained information on people's life history which gave staff information about the person's life before they moved into the home. The registered manager told us they documented people's individual preferences and dislikes in the care plan. They spoke with us about the importance of staff being aware of people's preferences to ensure they delivered person centred care. We reviewed people's care records and saw that people's likes and preferences were recorded. One person's care records showed that the enjoyed coffee and detailed their favourite brand of coffee. Another person's care records detailed their preferences around their morning routine including when they liked to get out of bed and whether they preferred to have breakfast before receiving personal care. The care records contained information for staff on what days they preferred to have their bath or a shower.

People's care records were stored electronically and paperwork was also stored in the nurse's office. On the first day of our inspection the registered manager told us that they were in the process of ensuring that a copy of each person's care plan was in their bedroom and by the second day of the inspection this was in place. . They told us that this was to ensure that staff had easy access to people's records to ensure the care they received reflect their current level of need.

People's care plans were reviewed monthly or more often if needed to ensure that they reflected people's current level of need. The registered manager spoke with us about the process of reviewing the care plans and how they involved people and their relatives, they told us, and "I would print off the care plan and read through it with them and ask them what they thought. This is done each year. We also review them each month, by talking with each person to find out if any changes were needed."

Where people displayed behaviour which may be challenging they had care plans in place which detailed what behaviour may be displayed and how staff should respond to this to reduce the likelihood of the person becoming upset. The registered manager was the Dementia Champion with the home. A Dementia Champion is someone within the home who has knowledge of dementia and they focus on improving the care provided to people living with dementia. The registered manger met monthly with the area manager to discuss ways in which they could improve the care offered to people with this need.

People had pressure relieving mattresses in place to reduce the risk of pressure area injury and maintain their skin integrity. People's care plans contained information on the correct setting for the pressure relieving mattress. The registered manager told us that this was set based on people's weight and height and was reviewed when needed.

We observed a staff handover and saw that staff discussed individual residents, their specific needs and any changes to their health or medicines. Staff passed on information about people's nutritional needs and if they needed to be encouraged to eat or drink more. Daily records were kept in individual diaries for each person. These recorded what the person had to eat, what support had been offered and accepted. This also

recorded information about people's moods and behaviours, any concerns and what action had been taken by staff. This ensured the person's needs could be monitored for any changes.

Within the Beechside dementia unit we saw that one person had a board on their wall which had photographs and postcards from family members. Staff told us they sat with the person who decided what went on the board and this changed regularly if they wanted. We also saw one person who spent most of their day in bed and they had a noticeboard with family photographs and pet photos. This had been positioned to ensure that the person could easily see this.

People told us knew what to do if they were not satisfied with the service they received or if they wished to make a complaint. They told us, "I would speak to either the staff or the manager. I believe they would listen to me. I haven't needed to yet!". Someone else told us, "I would speak to one of the girls in charge. As far as I'm concerned everything is perfectly all right. When things come up they are put right for me. For example, I have lost my pyjamas and they are seeing to this for me". The area manager told us that they dealt with complaints rather than the registered manager as they felt they were able to provide a more objective view on any concerns. The area manager had maintained a record of any complaints made. This included details of the complaint including who was involved, the provider's investigation of the concerns raised, whether the complaint was upheld and what further action would be taken.

Residents' and relatives' meeting took place every three or four months although were not well attended. We spoke with the area manager who told us they were considering ways to improve attendance. At the April 2015 residents' and relatives' meeting only one resident attended. They discussed their views on activities and staffing .The person attending spoke positively of both staff and activities, stating they enjoyed the reminiscence sessions. The January 2016 was attended by one person and four relatives. Updates to repairs to the roof were discussed. The registered manager told us they have tried different days and times of the meetings to improve attendance and are now considering a weekend meeting. Dates of the residents' and relatives' meetings were posted throughout the home and relatives received an email notifying of the dates of meetings. The registered manager sent quarterly newsletters to relatives and professionals involved with the home to ensure that people were kept up to date on what was going on and any changes.

Good

Is the service well-led?

Our findings

The provider told us that they had recently introduced a quality assurance system to ensure that issues could be identified and responded to in a timely way. There was an audit schedule for aspects of care such as medicines, care plans and infection control which were completed by the registered manager and also the provider. The audit schedule also included staffing levels as well as recruitment and supervision. The area manager completed a dignity in care audit which checked on the environment and included observations at mealtimes. The purpose of this audit was to ensure that people's dignity was upheld and not compromised by the home. The February 2015 dignity in care audit was mainly positive however it identified an issue with the attitude of one staff member during the mealtime observation. The registered manager discussed this with the individual staff member and also the staff team. We reviewed the audit of activities completed in January 2016 by the quality assurance manager and saw that they noted there was no planned activities on the day of their visit. They noted that they had spoken with the member of staff responsible for activities; however we could not see that any further action had been taken.

We saw examples of when action had been taken in response to quality assurance checks. A monthly quality assurance report was completed by the registered manager and sent to the provider. This report detailed any concerns within the home including concerns about staffing, infection control, checks on environment, safeguarding. The January 2016 identified an issue with the management of clinical waste. The registered manager ordered additional clinical waste bins and we saw that these were in place on the day of our inspection.

Specific incidents were recorded collectively such as falls, changing body weight and pressure areas, so any trends could be identified and appropriate action taken. Environmental risk assessments were also carried out and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. The registered manager told us that they carried out observations of people's lunchtime meal and also with the communal areas.

Regular staff meetings took place which meant that staff had the opportunity to communicate their views about the policies and procedures in the home as well as to discuss arrangements for meeting people's needs. We reviewed the minutes of recent staff meetings and saw that at the September 2015 nursing staff meeting they told the registered manager that they felt they needed an additional registered nurse at nights as they were finding it difficult to provide care and also update people's date records. We saw that the additional member of staff was agreed by the provider. Staff told us the registered manger was approachable and they would feel comfortable discussing any concerns with them. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously in order to improve the standard of care.

People told us the home was well led and they had regular contact with the registered manager. One person told us, "It is run very well". We spoke with a person's relative who said they had met the manager and they felt that they were approachable. Healthcare professionals told us the registered manager was approachable and open to hearing their views, they told us, "She's really open, if she's got concerns she will

ask us for a plan for that person". We reviewed a selection of thank you cards which the home had received. Some of the comments included, "You were all so kind and caring, The best! And the food was first class," and, "Thank you so much for all the care and attention you gave to my mother during the final days 11 months of her life".

The registered manager was supported by senior management and told us they had regular contact with the area manager. The area manager told us, "There isn't a week that goes by without contact, daily phone calls or visits. I try to get down at least twice a fortnight". The registered manager told us they felt comfortable addressing any issues with the provider and was open about challenges which they might face. The registered manager ensured that they had support within their role through regular contact with senior management, from managers of other services and by taking advice and guidance from other health care professionals in the local area.

The registered manager spoke with us about the vision and values of the home, they told us, "Our purpose is to provide a high standard of care and to be the best we can." They also told us, "I feel comfortable here and I enjoy the challenge of meeting the needs of so many different people." We spoke with staff about the values of the home and they told us, "I like to come in to work because I believe we are making a difference to people's lives." The area manager also spoke with us about their views on the aims of the home and told us "our aim is to provide a fulfilling life for our residents, maintain their independence and achieve their wishes". They also spoke about the importance of involving people's family: "we acknowledge that caring for relatives is difficult, we support relatives at a difficult time, it's equally important to look after relatives".

The provider sent annual surveys to family and health care professionals. There was no response from health care professionals to the most recent survey in July 2015. The area manager felt that the poor response from professionals may be because the registered manager had regular contact with them and feedback was given when they visited. Relatives were also asked for feedback in July 2015 and the home received two responses. The survey asked for feedback on the overall impression of the home, quality of food and views on management. The comments received were positive. For example, one read, "Good quality of care from staff. Home like environment," and, "really happy with the home". Due to the poor response the area manager told us they were considering sending another mid-year survey in an attempt to gain further feedback from relatives and professionals.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that the care and treatment of service users had met their needs and reflected their preferences. Regulation 9 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not ensured that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that risks to people were mitigated. Regulation 12(2)(b)