SHC Clemsfold Group Limited

Beech Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on 31 July and 1 August 2017.

Beech Lodge is registered to provide accommodation and nursing care for up to 40 people. The home comprises of three separate building: Beech Lodge, Oak Lodge and Redwood House. At the time of this inspection Redwood House was being used as a day centre and did not form part of this inspection. This is because day centre services are not regulated by the Care Quality Commission. The home is purpose built and well-equipped. It caters for young adults with physical and learning disabilities or autism. At the time of our visit there were 18 people living in Beech Lodge and nine people living in Oak Lodge.

We previously carried out an unannounced comprehensive inspection of this service on 6 and 8 July 2015 where it was awarded an overall rating of 'Good' and rated as 'Good' in all domains apart from the 'Well Led' domain which was rated 'Requires Improvement' as there was no registered manager in post.

This inspection was planned due to a previous overall rating of 'Good' published for Beech Lodge in August 2015. However since that inspection, we had been made aware that following the identification of significant risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service had been the subject to safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a criminal investigation. Our inspection did not examine the incidents and safeguarding allegations which have formed part of a criminal investigation. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

During our inspection the manager was present. The manager had been in post since 6 March 2017 and had submitted an application to register with CQC. 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.

Everyone commented positively about the new manager and we found that they had implemented improvements at the home. These included a new interactive menu planning system that people could use to decide what they wanted to eat, further support and guidance for staff in order that they had the skills and knowledge to support people and more detailed care planning documentation.

The provider had quality monitoring processes in place and the manager had used these to drive improvements at the home. A range of quality and safety audits had been conducted and since the intervention of outside agencies processes had been amended to share learning from potential

safeguarding situations.

People were supported to raise concerns. Information was provided in different formats in order that it was accessible and helped people to know their rights. Individualised support plans were in place that provided information for staff on how to deliver people's care in the way they wanted it. Discussions with people and staff, and observations and examination of records confirmed that staff supported people in line with their wishes and the contents of their support plans.

An activity programme was in place that offered people a choice of events that they could participate in and enjoy. The home had its own minibus to transport people to community events. However, this was not always available when being used by people to attend medical appointments and as a result some people did not access the wider community as much as others. This is an area for development that was recognised by the manager. The adaptation and design of the home meant that people were able to move freely and access its facilities.

Positive, caring relationships had been developed with people. We observed people smiling when spending time with staff who always gave people time and attention. Staff supported people to maintain relationships with people who were important to them. Visitors were welcomed. People were supported to express their views and to be involved in decisions relating to their care. Staff were skilful in communicating with people and understanding their wishes. They also promoted people's privacy and dignity. Staff said that they received sufficient support and training to undertake their roles and responsibilities.

Risks to people were managed safely. Risk assessments and care plans were in place for areas that included risk of choking, pressure areas, behaviour, moving and handling and nutrition. Staff followed the contents of these documents in order to reduce risks to people's wellbeing and safety.

People who were able told us that they felt safe. Staff were able to identify the correct safeguarding procedures should they suspect abuse. Appropriate recruitment checks were undertaken before staff began work which offered further protection to people.

Sufficient numbers of staff were allocated to shifts and deployed in order to provide safe care and support. Throughout the inspection we saw that staff were available to provide care and support when needed.

People were supported to maintain good health and had access to a range of healthcare professionals and services. Medicines management was safe. Discussion with staff and examination of records confirmed that people were referred to health care professionals promptly when needed and that their advice was acted upon. People received effective support to enjoy their meals and their dietary needs were met.

The manager and staff demonstrated understanding of their responsibilities in relation to the MCA and DoLS. Throughout the inspection staff were seen seeking peoples consent. People's care plans included information on their specific communication needs that also reinforced people's rights to consent.

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.

Medicines management was safe.

Sufficient numbers of staff were deployed to effectively to meet people's needs.

Safeguarding procedures were in place that offered protection to people. The provider and manager responded positively to safeguarding concerns and took action to address these.

Risks were assessed and managed safely, with care plans and risk assessments providing information and guidance to staff.

Appropriate recruitment checks were undertaken before staff began work.

Checks on the environment and equipment were completed to ensure it was safe.

Is the service effective?

Good

The service was effective.

Staff received regular support and training to fulfil their roles and responsibilities.

Staff understood the requirements of mental capacity legislation and put this into practice.

People's special dietary needs were met. People had a choice of what they wanted to eat.

People had access to a range of healthcare professionals and services.

The building was suitably designed and had sufficient equipment to meet people's needs.

Is the service caring?

Good

The service was caring.

Positive, caring relationships had been developed between people and staff.

As much as they were able, people were involved in decisions relating to their care. Their preferences, likes and dislikes were recorded in their care plans and guided staff on how they wished to be supported.

People were treated with dignity and respect.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People received a responsive service that was based on their individual needs and preferences.

An activity programme was in place that offered people a choice of events that they could participate in and enjoy.

Care plans were person-centred and provided individualised information on how to care for and support people.

Complaints were managed and responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Quality monitoring systems were in place and used to drive improvements. The provider and manager reacted positively in response to risks and quality issues raised by outside agencies. However, the provider had not always identified issues without outside agencies interventions. Therefore improvements were needed to ensure their monitoring systems were consistent and effective to ensure continuous improvement.

People said the home was well led and that the new manager had made lots of improvements. Staff felt supported and said that the manager was approachable.

People and their relatives were asked for their views about the service.

Beech Lodge

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 31 July and 1 August 2017. The inspection was undertaken by one inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted, in part, by notification of five safeguarding allegations and quality concerns, including an incident in which a person using the service died. The death and safeguarding concerns are the subject of a police investigation and as a result this inspection did not examine the circumstances of specific incidents. However, the information shared with CQC about the incident and safeguarding allegations indicated potential concerns about the management of risk with specific health conditions and needs including skin integrity, safe manual handling and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes for people who were not able to take food and drink by mouth. Therefore we examined those risks in detail as part of this inspection.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about 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 used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people who lived at the home, two visitors, the manager, the area manager, four nurses, five care staff, a maintenance person, an activity person and the chef.

The majority of people who lived at the home could not tell us about their views of the service they received. In order to obtain their views 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. On the first day of inspection we spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon. We also observed a nurse giving people their medicines. On the second day of inspection we arrived at the home at 5am and observed the early morning routines of staff.

We reviewed a range of records about people's care and how the home was managed. These included six people's care records and medicine records. We also looked at staff training, support and employment records, audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Good

Is the service safe?

Our findings

Before the inspection the local authority had made us aware of quality and safety concerns relating to people's care. The service had been closely monitored and supported by the local authority commissioners because of these increased risks. The service had five quality and safeguarding concerns that were under investigation by the local authority safeguarding teams and the police, including one historical death. This did not mean people were not safe, but that there were active safeguarding investigations in progress to find out if people were at risk. In some of the cases it had been determined that no harm had occurred to the person or that the origin of the concerns was attributed to another care provider (i.e. during the person's stay in hospital). In other cases the extent of the provider's contribution to instances of injury or people's health deterioration was not yet known as they were still being actively investigated.

Medicines management was safe. We observed a nurse giving people their medicines. This was done safely. The nurse checked the instructions on people's Medicine Administration Record (MAR) charts corresponded with the medicine directions on labels before administering to people and signed the MAR only after people had taken their medicines. The medicines trolley was locked at all times when unattended. One person was prescribed oxygen and we saw that this was being managed safely. There was a protocol in place and the agency nurse on duty was able to explain the contents of this without referring to the record.

All medicines were clearly labelled and individual MAR charts that we sampled had been completed in full. In addition to MAR charts people had individual medicine profiles which included a photograph of the individual, details of what each medicine was for and guidelines for 'as and when required' medicines. There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. Regular checks of the temperature of the medicine fridge and medicine room were completed to ensure medicines were stored safely. Nurses confirmed that they had received medicines training but that this did not include an assessment of their competency. The manager agreed this was an area for development. Although the manager had not yet completed individual competency assessments for nurses who administered medicines he had conducted spot checks of medicines management that included observation of medicines rounds to ensure this was appropriate. For example, a spot check was conducted during March 2017 that identified 'excess of medications have been requested from the GP/Pharmacy.' This was discussed with nurses in a staff meeting and also reinforced in the nurse communication book.

Nurses that we spoke with understood safe medicine procedures. For example, a night nurse explained that they gave a person their medicines via PEG before the day nurse came on duty. They explained that they did this as the person was prescribed medicine for epilepsy which needed to be given at very specific times in order that it was effective and safe.

Sufficient numbers of staff were allocated to shifts and deployed in order to provide safe care and support. Visitors to the home told us that in their opinion staffing levels were safe. They went on to add, "There are times when I think, where are the staff? But I wouldn't change it, (name of person who lives at the home) always loves coming back when they have been to visit us. You have to be reasonable, it's not one to one,

and her care is good. We can see recruiting consistent staff isn't easy. There are a lot of agency staff, but they are the same ones. Everybody knows what (family member) wants and she can make herself understood to get what she wants." Staff also said that they were deployed in sufficient numbers to meet people's needs. One member of staff said staffing levels were "Good."

The manager told us that staffing levels were decided using the Northwick Park dependency tool but that as people who lived at the home often went to stay with family members staffing levels were fluid and adjusted accordingly. On the first day of inspection there were two nurses and five care staff on duty in Beech Lodge and one nurse and four care staff in Oak Lodge. In addition to this there were activity, housekeeping and physiotherapy staff. Three people who lived at the home were funded one to one care from 8am until 8pm and we observed that this was provided during our inspection. Discussions with staff and examination of records confirmed this was provided daily. At night, there were three care staff and one nurse on duty in Beech Lodge and one care staff and one nurse in Oak Lodge. We observed that people were assisted in line with their individual preferences. For example, on the first day of inspection three people were assisted with personal care and came out of their rooms between 10am and 11.15am. At 5.30am on the second day of inspection one person in each of the Lodges was being assisted with personal care. When we left at 7.10am three people had been supported with their personal care and everyone else was still in bed. Staff said and records confirmed this was in line with their preferred times of rising.

We discussed staff vacancies with the manager and what actions he had taken in order that these did not impact on the safety or quality of care people received. The manager told us that unless it was an emergency situation he booked agency or bank staff three weeks in advance in order to arrange for the same regular staff to cover shifts. He explained that this helped with continuity of care which he said was vital due to the complex needs of people who lived at the home. We spoke with an agency nurse and an agency care assistant who both confirmed they worked at the home on a regular basis, that they had received an induction and that they always worked with permanent staff. Both members of staff were able to explain people's individual needs without referring to records which reinforced the manager's comment regarding continuity of care.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. Confirmation was also in place that nurses were registered to practice with the National Midwifery Council. Profiles were also in place for agency staff that confirmed they also had the required checks completed on their suitability to care for people.

People who were able told us that they felt safe. One person said, "Safe? Oh yes." Visitors to the home said, "It's definitely safe; the key elements are right. If you ring up, you get an answer. We get good information about any medical issues and the home is proactive seeing a need and getting the right service. They have their own physios and the GP comes in, they are a part of the place."

Staff we spoke with told us they had received adult safeguarding training. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would have to escalate any concerns to management. If I witnessed something extremely risky I would have to intervene to keep the person safe." A second person said, "If I saw anything I would go to (manager) or higher if needed."

The manager demonstrated understanding of his responsibilities to protect people from abuse and to provide safe care. Since being in post they had prioritised improvements based on providing safe care. He had arranged for further training and supervision of staff and reviewed people's risk assessments and care plans to ensure potential risks were reduced where possible.

Risks to people were managed safely. For example, a person sustained an injury in July 2017 when using the spa. The person received first aid from the nurse on duty whilst waiting for paramedic's to arrive at the home when further medical intervention was provided. A wound care plan and risk assessments were implemented on the same day as the incident, advice sought from a tissue viability nurse and treatment provided. The manager also closed the spa and arranged for engineers to visit the home to ensure that it was safe for people to use. It was confirmed that the injury was as a result of the design of the spa and not due to ineffective maintenance. However, changes to the design of the spa were completed in order to reduce the risk of further injuries occurring.

People who were at risk from aspiration had assessments and care plans in place for staff to follow in order to manage known risks. For example, one person's records explained how they needed full assistance from staff, that foods must be liquidised and fluids thickened to a syrup consistency. This person also had allergies that were clearly recorded along with alternative products that should be used in order that choices were not unduly restricted. In addition to this, we observed that each person had a laminated placemat at the dining table. This had a picture of the person and written guidance about the support they needed to eat and drink safely. For example, one person's placemat had precise guidance on the adapted cutlery, where to place the spoon in their mouth, how to know when to remove it and positioning guidance. Staff on duty demonstrated that they knew people well when we spoke to them but still referred to the placemats when assisting people in order to provide safe care.

Another person's suction care plan included information about suction equipment, its location, how to use this and the need to take this with the person when accessing external activities. This person also had a Waterlow risk assessment and detailed care plan that included clear instructions and measures to maintain skin integrity. This included information about the using of a wheelchair and correct seating posture.

Risk assessments were detailed and included photos to add clarity, such as on how a person should be positioned in bed when eating to minimise the risk of choking or how to use postural aids to reduce pressure damage. Staff were able to describe the steps in place to mitigate known risks and explained how they supported people safely. These had been implemented by a physiotherapist employed by the provider.

Since being in post the manager had been reviewing people's risk assessments and care plans focusing on particular areas of potential risk to ensure documentation was sufficiently detailed in order that staff could provide safe care. This included risks associated with mobility and moving and handling as many people who lived at the home were at increased risk of injury due to medical and health conditions. For example, one person's assessments detailed how they has specific conditions that increased their risk of injury, the interventions required including physical assistance and therapy and the use of equipment to mobilise. Separate, detailed assessments were in place for physical support that was provided and equipment used to support the person all of which had been reviewed monthly since being implemented in January 2017. Photographs were also included in the assessments that showed explicitly how equipment should be used. Advice had been sought from the provider's physiotherapy assistant and manual handling trainer when the assessments were being completed to ensure the contents provided sufficient information to ensure safe care. The manager monitored that staff were following the contents of the assessments and care plans during the spot checks and formal observation checks that he completed. In addition to this, the manager

also completed separate audits of equipment used to assist people to move such as slings to ensure this was safe to use. During our inspection we observed staff assist the person to move safely and in line with the contents of the assessments.

We found that people who had a percutaneous endoscopic gastrostomy (PEG) in place received safe care. PEGs involve placement of a tube through the abdominal wall and into the stomach through which fluids, food and medicines can be infused. Staff were knowledgeable about the management of these; nursing staff had been trained in this area. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed them receiving. Information included the timings of feeds, positions people needed to be in when receiving food and fluids and bed elevation afterwards to reduce risk of choking, additional fluid requirements, tube sizes, rotation of PEG sites and suctioning machines. We also noted that records of feeds given via people's PEG matched the timings and quantities described as required in their care records.

For people who displayed behaviours that could be viewed as challenging we found that measures were in place to reduce risks to the individual and others who lived at the home. People had comprehensive assessments and care plans that detailed their self-injurious behaviour, the de-escalating techniques staff were to use and what could trigger the behaviours. In addition, some people received one to one care during the day in order that distraction techniques could be applied to reduce the behaviour and to minimise the risk of injury to the person and others. During the inspection we observed staff following the contents of people's assessments and care plans. For example, staff were seen giving one person paper which they tore into strips and empty plastic bottles which they held. It was apparent that the person enjoyed these objects from their body language.

Checks on the environment and equipment were completed to ensure it was safe. These included equipment used to help people to transfer, fire tests and small portable electrical items. An emergency contingency plan was in place that gave staff information of the action to take in emergency situations that included fire and floods. 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.

Good

Is the service effective?

Our findings

People expressed satisfaction with the care they received. One visitor to the home said, "It was important for her and us that she could be supported to develop her own life and this is right for her. She is well looked after, not isolated and still fully involved in family life."

Staff said that they received sufficient support and training to undertake their roles and responsibilities. This included an induction when first employed, three monthly one to one supervision sessions and group staff meetings. One member of staff said, "I had an induction and have done lots of training. I have done moving and handling, learning disability, safeguarding." A second member of staff said, "It's nice working here as it's a nice team. I think the company are great. They provide lots of training which is great. I have just finished my induction and did three days shadowing. I observed how to move and handle people correctly. They explained everything. I had four days training, it was very clear."

Since being in post the manager had ensured that all new staff had completed probation review meetings in order to assess and discuss their performance. He had also reviewed the training requirements of the staff team and arranged for training to be provided to staff. An abundance of information about training that staff had been booked to attend was on display on the staff noticeboard. The manager explained that by giving staff prior notice of training events ensured that they attended. A nurse told us, "Training? Oh there is loads! I have done my revalidation papers. I have a training schedule and have done venepuncture and PEG training."

Discussions with staff and examination of records confirmed that staff had received training in areas that included moving and handling, fire safety, infection control, the Mental Capacity Act, first aid and food hygiene. Nurses had completed medicines training, PEG management and wound care. Staff who worked at the home completed learning disability training as part of their induction. In addition to this the manager had introduced a 'What's new to the service' folder to offer further support and guidance to staff. This contained newsletters, training and learning events, information about new products such as continence aids and new documentation from the provider. Staff confirmed that they were encouraged to read this on a regular basis.

People played an active role in planning their meals and had enough to eat and drink throughout the day. People received effective support to enjoy their meals. One visitor to the home told us, "The food seems good. It's always hot, and tastes good, even when pureed."

At lunch time we observed that people received varying degrees of support to eat, including full assistance based on their individual needs and preferences. The meal time was well staffed and all direct assistance was given by staff who were fully focussed on the person they were helping. Staff sat level with people and we observed that support was provided in line with people's care plans. Staff were attentive to people's needs and when one person spilled a drink quickly responded to maintain their dignity. Some people could eat unaided but staff still maintained oversight in case they needed help. Adaptive plates and cutlery was provided that helped people to maintain independence where possible and alternative meals were quickly

offered for example, when a person indicated they were unhappy with the sweet provided.

Since being in post the manager and the chef had introduced an interactive electronic menu planning system. The system included illustrated pictures of food that people who lived at the home could choose by touching the screen. The system also included information about each person, their likes and dislikes and flagged up special occasions such as birthdays three days in advance. The system incorporated a feedback screen for each meal, with emoji pictures to show varying levels of like or dislike. Once people had eaten their meal staff entered how much the person ate. This information was then locked and had to be signed off as complete by the manager. The information within the new system was then used to inform menu planning, the managers quality assurance and could be used when reviewing people's needs.

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 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 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). Where people had been assessed as lacking capacity, applications for DoLS had been completed as needed. For some people, audio monitoring equipment was used of a night to alert staff if they had an epileptic seizure or self-injurious behaviour to ensure a swift response. MCA assessments and DoLS applications had been completed for people who had been assessed as unable to consent to the use of this equipment. The assessment process also included seeking the views of others involved in people's lives such as family members and social workers to ensure decisions were made in people's best interest. This was in line with the MCA Code of Practice.

The manager demonstrated understanding of his responsibilities in relation to the MCA and DoLS. Since being in post he had sought written confirmation from people who had Lasting Power of Attorney for health and welfare or financial matters issued by the Office of the Public Guardian to ensure people had the legal right to act on behalf of individuals. Staff confirmed that they had received MCA training and demonstrated understanding of consent to care. One member of staff said, "It means if a person doesn't have capacity to make a decision for themselves. Best interest decisions have to be made. Multi-disciplinary team meetings have to take place to discuss decisions."

Care records evidenced that when decisions needed to be made in a person's best interest efforts were made to seek the views of family members. Mental capacity assessments were in place and included the involvement of staff at the home, the manager and other health and social care professionals, as well as relatives where possible. As part of the assessment process non verbal forms of communication had been used in order to involve people. For example, one person's assessment confirmed that pictures and communications boards had been used in order to give the person information and to help assess if they could retain information.

People's care plans included information on their specific communication needs that also reinforced people's rights to consent. For example, one person's plan stated their specific facial expressions and physical responses to indicate their agreement or preferences. We spent time with this person and saw that the staff who supported them followed the contents of this plan. For example, when assisting the person at breakfast time they looked at the persons facial gestures.

Throughout the inspection staff were seen seeking people's consent. For example, a member of staff was seen confirming non verbal consent from a person regarding the choice of clothes they were to wear and the breakfast they wanted. Another member of staff used sign language with another person to obtain consent to assist them to the toilet and that the person agreed with this support. On another occasion another person indicated that they did not want to go out in the home's mini bus as they wanted to continue participating in a story group that was taking place. Staff responded positively and readily accepted the choice made by the person.

People were supported to maintain good health and had access to a range of healthcare professionals and services. One visitor said, "We get good information about any medical issues and the home is proactive seeing a need and getting the right service. They have their own physios and the GP comes in, they are a part of the place." A physiotherapy assistant and a physiotherapy technician employed by the provider worked at the home and supported people with exercises, including passive movements, walking, using standing frames and accessing the hydrotherapy pool located at a different service operated by the provider. People had hospital passports which provided hospital staff with important information about their health if they were admitted to hospital. They also had health action plans in place which supported them to stay healthy and described help they could get. Disability Distress Assessment Tool (DisDAT) had been completed for people which helped staff identify if the person might be in pain or discomfort and require medical attention. This tool was designed to help identify distress in people who have severe limited communication. Discussion with staff and examination of records confirmed that people were referred to health care professionals promptly when needed and that their advice was acted upon.

The adaptation and design of the home meant that people were able to move freely and access its facilities. The home was purpose built by the provider. Each room was equipped with an overhead tracking hoist. There were assisted, height adjustable baths, a hydrotherapy pool and a sensory room, each equipped with overhead tracking hoists. Gardens were accessible, including a pathway to allow those in wheelchairs to enjoy the grounds.

Good

Is the service caring?

Our findings

People said that staff were kind and caring. One person said, "They are lovely and very nice."

Positive, caring relationships had been developed with people. We saw frequent, positive engagement with people and staff. Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. The atmosphere was relaxed with lots of laughter and banter heard between staff and people. We observed people smiling when spending time with staff who always gave people time and attention. Staff knew what people could do for themselves and areas where support was needed. Staff appeared dedicated and committed. They knew each person's individual needs, traits and personalities. They were able to talk about these without referring to people's care records. They ensured one person had a multi textured sensory blanket to hand and we observed this gave the person pleasure and reassurance.

As at our last inspection, staff were skilful in communicating with people and understanding their wishes. Many of the people who lived at Beech Lodge had limited or no verbal communication. People's care plans included detailed assessments of their verbal and non-verbal communication. These were used to identify physical and verbal cues to understand when a person was happy or was starting to become distressed. The assessments described the action staff needed to take in order to support and reassure the person. Care plans also recorded people's likes and dislikes and information was provided to staff on people's preferences. Throughout our inspection staff were observed using non-verbal as well as verbal communication in order to interact positively with people. Staff were observed using touch, movement and voice to communicate with people. This resulted in smiles from people and sounds of contentment.

Staff promoted people's privacy and dignity. One visitor told us, "It is good; she is always clean and well dressed." Everyone we saw during our inspection presented as well dressed. People wore clean clothes that were individual to them in terms of fashion and preferred dress sense. Very good attention had been paid to hair and nail care. We observed one person who was receiving one to one care. When the person needed specific assistance with personal care the member of staff discreetly obtained the assistance of another member of staff who immediately brought a screen and placed this around the person in order that the care could be provided in private. We observed a second person wearing a short sleeved top and this reflected their preference as detailed in their care plan. This demonstrated that staff understood and acted on the person's preference with regard to clothing.

People were supported to express their views and to be involved in decisions relating to their care. There was evidence that staff at the home worked in partnership and liaison with people and relatives to ensure a seamless transition upon admission, and continued partnership working after admission. We observed that information was provided in pictorial and easy to read formats in order to support people to understand their rights. One person and a visitor showed us a communication folder that was in place which had been developed over the person's lifetime. This contained pictures of significant people in the person's life and also included Makaton symbols that the person understood. The person's visitor confirmed that the person and staff used this to aid communication. They also said that the person had a key worker who understood

the person's needs and assisted them to express their views. Monthly residents meetings took place where subjects were discussed that included activities and family events.

People's rooms reflected their individual preferences and backgrounds. One visitor told us, "Her room is always very nice. The place doesn't smell and has been redecorated. She was very involved in décor choices for her room and we can do what we like with it."

Staff supported people to maintain relationships with people who were important to them. One visitor told us, "She has been home with us for the weekend; we've just brought her back. We come every two weeks to take her out and she has some weekends at home. But she needs the company and stimulation here, this is her home." Another person was supported to have regular Skype calls with a family member who lived abroad. One visitor did mention that communication could be expanded. They said, "If there's any area for improvement it's communication. Feedback isn't great. We would like a diary as we don't really know what she does, she can't tell us. We do phone twice a week so she can hear us, she has the loudspeaker on, and the staff member assisting will tell us what she has been doing."

Good

Is the service responsive?

Our findings

People received a responsive service based on their individual needs and preferences. One person who had nutritional risks had been seen by a GP who referred them to a dietician at a local hospital. The person was prescribed supplements and the frequency of weight monitoring increased. Since then the provider had recruited their own dietician to offer support and advice to people. The provider's dietician had reviewed the person to ensure the support they received was still appropriate. As a result of the support provided the person's weight had increased. This demonstrated that the person had received responsive care that promoted their wellbeing.

Another person who received one to one care during the day to support with their complex behaviours had comprehensive care plans in place regarding the support they should be provided in response to certain situations. During our inspection we observed staff responded positively when the person displayed certain behaviours and followed the contents of the person's care plan. As a result the person became calm. We also noted that the person's records included documentary evidence of prompt referrals to relevant specialists and a GP when required and staff were able to explain when they should seek advice from external professionals to ensure personalised care was provided.

Individualised care plans were in place that provided information for staff on how to deliver people's care. Records included information about people's social backgrounds and relationships important to them. They also included people's individual characteristics, likes and dislikes, places and activities they valued. Discussions with people and staff, and observations and examination of records confirmed that staff supported people in line with their wishes and the contents of their individual plans.

Peoples care records and information in the home was provided in large print, with the use of photographs and pictures which helped people to understand and to communicate. This was in line with the Accessible Information Standard. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

Staff were kept up to date with any changes in people's needs. Changes were communicated effectively and in order that staff could respond to people's needs. Daily handovers occurred between each shift and a record of these was maintained for people to refer to if needed. One member of staff explained, "We have the handovers so we know what's going on." Communication books between shifts evidenced that staff acted on changes in people's needs as these occurred.

We observed that routines were flexible and based on people's individual needs and preferences. People who could move independently by self-propelling wheelchairs were seen doing so. There appeared to be established friendship pairings or small groups, whilst people also had opportunities to be on their own. One person was seen choosing to watch a DVD film on TV on their own in a sitting room and other people were seen participating in activities in different parts of the home. People were seen getting up and leaving

their rooms at different times of their choosing and staff confirmed that they assisted people based on their individual preferences. One member of staff said, "We assist people to get up when they want to. It depends on them. If they are fast asleep we leave them unless they have an early morning appointment but most times it really depends on them and what they want." Ancillary workers also understood the importance of respecting people's wishes. For example, the maintenance person came to inform staff that they needed to show everyone a new fire panel. They told staff, "Obviously put care needs first and let me know when it will be best for you to come, I'll fit with their needs."

An activity programme was in place that offered people a choice of events that they could participate in and enjoy. One visitor said, "They have regular entertainment, three or four times a week. (Named service user) likes the outreach on Tuesday especially. She used to go to the college and fortunately they were able to keep this going through outreach. The spa is a good facility. She loves it, also goes swimming at Rapkyns but it seems to depend on driver availability. They do 'holidays at home', which is three or four whole days out to places the person really likes. It's in place of actually going away, which is appropriate and works well."

Activity staff were allocated on shift who planned and coordinated events for people to participate in. One activity person told us, "We aim to give stimulation to everybody, every day. It's not easy asking what they like or want to do, so we have to give a lead and see how they respond. We do have a meeting every month but it's limited. Most people have family contact every week and we rely on families for ideas of what they think their relative will enjoy, or what they would like us to try with them."

Each person had an individual activity plan that was reviewed by the activity coordinator to ensure it reflected people's needs and preferences. It was clear from our discussion with the activity coordinator that they had good knowledge of people. Activities that people participated in were reviewed on a monthly basis with a report of findings compiled. This was then used to plan the following months activities based on the findings of the report to ensure these reflected any changes in needs or preferences.

One person invited us to view their activity plan which was on their bedroom wall. The person told us the plan was accurate and was very positive about activities and having plenty to do. They told us how they particularly liked using the spa and the one to one art therapy adding, "Even though I'm blind, I've got my imagination." The person's activity plan also included garden walks, massage with music, listening to music, group crafts and television. They said of the television, "I can't see it but I like listening to it." There were CDs in the person's room, which they confirmed they listened to when they wanted to.

Information about forthcoming activities was on display and this reflected the events that we observed taking place during our inspection. Regular 'outreach sessions' took place that were led by a tutor from a college that many people used to attend, to provide continuity of activities and learning opportunities they had there. Other activities included an external singer who visited and provided one to one sessions as well as performing with groups and a weekly disco with amplified music and lights that offered sensory stimulation. There was a rota for people to be involved gardening and to go swimming.

During the afternoon in Oak Lodge there was a story reading session where a staff member was reading a Roald Dahl book to four people. It was apparent that the member of staff was skilled and they made the activity an interactive and fun session. Afterwards the member of staff told us, "They always like that story but you have to involve them, ask questions, and I help other staff to learn from how I do it."

Systems were in place that supported people to raise concerns and complaints. One person told us, "They do ask if I'm happy or have any concerns." Information about how to make a complaint was on display. This was produced in pictorial and easy to read format in order that information was in an accessible format that

people could understand. For people who could not access written or pictorial procedures staff told us that they observed their interactions and body language and would report any concerns to the manager. Records confirmed that when issues were raised this were acted upon. For example, as a result of one person raising concerns about laundry the manager held supervisions with staff to reinforce their responsibilities and changes were made to the labelling of items.

Requires Improvement

Is the service well-led?

Our findings

We found that a number of improvements had been made at the home following safeguarding allegations that had been brought to the provider's attention. The provider had taken prompt action to implement specific actions following recommendations made from external agencies and professionals. However, we remain concerned that the improvements identified were due in large part to the interventions and recommendations made by external parties and not as a result of on-going, proactive quality monitoring by the provider. Therefore the provider had missed opportunities to address issues relating to quality and risk as a result of robust governance systems not being operated effectively. For example, they had not identified before external agencies interventions a lack of detail in suctioning care plans for a person with risks in this area. Also, that PEG regimes were not always robust.

As a result of the safeguarding situations the provider had sourced a safeguarding expert and a new system was being implemented to ensure appropriate action was taken when incidents and events occurred. Registered managers were provided with a presentation about the new monitoring system at the July 2017 meeting and advised that the new system would help ensure the provider had a systematic approach to ensure concerns were responded to and acted upon in full. During this meeting the nominated individual also discussed how lessons could be learnt and shared in relation to record keeping, following policies and procedures and training.

People's views were obtained in order to drive improvements at the home. Questionnaires were sent to people's representatives and action taken when comments on service delivery were made. For example, one person commented about activities and arrangements were made for these to take place. However, we found that further action was needed to ensure transport arrangements facilitated community access. We were informed that there was an aim for everyone to have at least one community activity each week but that this was currently being achieved once a month. Staff informed us this was due to transport being used to attend medical appointments which took priority.

People commented positively about the new manager and said that the home was well led. One person said, "I get on quite well with (the manager), he knows how to get things over to you. I could tell him if I had any worries, or I'd tell my psychiatrist." One visitor said, "Staff all know (family member's) needs. They are competent but you can sense when there is low morale. It has improved a lot since there has been a manager in place; there was a tense feel in the past." A second visitor confirmed that they had met the new manager and said there were no problems making contact with head office and getting a good response. They said they received and returned satisfaction questionnaires from the provider. However, they did express the view that communication could be expanded further.

The manager commenced employment as manager of the home on 6 March 2017. He told us that he had received lots of support from representatives of the provider which included the area manager and nominated individual in order to fulfil his role and responsibilities.

Staff said that they felt fully supported and that the manager was approachable. One member of staff said of

the manager, "He has made such a difference. He's down to earth, spends a lot of time with all of us and the service users. The placemats were his idea and they've been really helpful, especially for agency staff. They aren't spending time going through communication passports, the information is right there." A second member of staff said, "He is great. Always has his door open and always checks we are ok. The presence of the manager in the house is very good." A third member of staff said, "He is very good. So efficient with everything. He is making lots of improvements."

Records were in place that confirmed daily handovers, heads of department meetings, and observation checks (known as managing by walking around your care home) were completed by the manager. During the meetings subjects were discussed that included any staffing issues, complaints, nursing and clinical issues and visits from other professionals. In addition to these, since the manager had been in post regular nurse and staff meetings took place in order that information could be shared.

We asked the manager what his work priorities were. He explained, "Any safeguarding issues and all service user's needs. I am also trying to do my best to help staff as well. There is a backlog of paperwork; care plan updates and staff supervision. Training has been left as well so I've been calling the academy to provide training here and they have been coming in. I have given information out to staff about yearly mandatory training and additional information about nursing skills. I'm a nurse as well so have been able to support staff with clinical knowledge." Since being in post the manager had ensured monthly audits had been completed for slings and had completed a PEG tube audit. These demonstrated that the manager was aware of situations that had occurred at other services operated by the provider and was using learning from these to monitor and drive improvements at the home.

We asked the manager about the quality monitoring systems in place at the home. He explained that a range of audits took place. These included audits of medicines, accidents, incidents, safeguarding, pressure wounds, deaths, fractures, hospital admissions, coroners, complaints and health and safety. In addition to these, monthly audits by the area manager were completed and audits by an external auditor commissioned by the provider. We looked at the monthly audits completed by the area manager and found that the manager had taken action to address shortfalls promptly. This included ensuring staff had received supervision in line with the provider's policy and arranging refresher training for staff.

An audit of the service was completed on 26 January 2017 by an external auditor commissioned by the provider and a follow up audit also by the external auditor on 2 June 2017. The first audit identified five areas for improvement, four of which had been addressed in full at the second audit. For the remaining one area plans were in place to address this.

We looked at the monthly accident and incident audit for July 2017. This detailed two events. One related to a person's self-injurious behaviour and the second an injury when using the spa. The audit confirmed that for both incidents appropriate medical intervention was sought and other agencies including CQC and WSCC informed.

Since being in post the manager had worked in conjunction with the chef to devise and implement an interactive electric menu planning system. We were informed that it is the intention of the provider to roll this out to other services that it operates. This showed a commitment by the manager to drive improvements in the home and by the provider to share quality improvements.