HC-One Limited

Beechcroft Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 18 & 19 January 2017. The first day was unannounced.

Beechcroft Nursing and Residential Home is a single storey care home located in the Palacefields area of Runcorn close to local shops, pubs and the local church. The home provides accommodation for up to 67 people. It is divided into two units, a nursing unit and a residential unit. At the time of our inspection visit there were 55 people living in the home.

The last inspection took place on the 15 December 2014 and 2 February 2015 when Beechcroft Nursing and Residential Home was found to be meeting all the regulatory requirements looked at and which applied to this kind of home.

There was a registered manager who had been in post since April 2016. 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.

Before the inspection Halton Borough Council informed us that they had concerns about the service and that they had put the home on an improvement plan and suspended placements. This is the council's usual practice that is designed to ensure improvements are made. They shared their concerns with us and informed us that they had been monitoring the home and had noted some improvement. The Care Quality Commission were fully involved in this process and attended meetings held in relation to these matters.

As a result of these concerns the provider had set up a project plan to improve the service, which included appointing a project manager to oversee the process and a turnaround manager to work with and support the registered manager. An on-going action plan was in place that was regularly updated until the issues were addressed.

Whilst many of the people spoken with told us that they were well cared for and they were happy in the home, we found that people could be at risk because there had been a lack of effective quality assurance in the home. The registered provider had a system for assessing and monitoring the quality of the service but this was not being used effectively so problems were not always identified or addressed in a timely manner.

Some people's medicines that were time critical were not always administered on time and the recording of medicines required improvement.

Checks on safety of the premises had taken place but not all actions identified to improve the safety had been actioned.

Most staff were observed to be very caring and attentive to the people who lived in the home, but two staff

were heard to refer to people who required assistance with feeding as 'feeders', which is disrespectful.

People received visitors throughout the day and we saw they were welcomed and included. Visitors told us they could visit at any time.

We could see that staff ensured people's privacy. We saw that bedroom doors were always kept closed when people were being supported with personal care.

People told us that they enjoyed the food and could choose how to spend their day. The home employed an activity organiser who supported people to take part in activities either individually or in groups, which included going out to places of interest.

Staff received specific training to meet the needs of the people who lived at the home including safeguarding vulnerable people from abuse. All staff spoken with were confident that any allegations made would be fully investigated to ensure people who lived at the home were safe.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. There were systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

We identified breaches of the relevant regulations in respect of safe care and treatment, dignity and respect and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not completely safe.

The arrangements for managing medicines required further improvement.

Risk assessments were detailed but were not always reviewed and updated if necessary in a timely fashion after accidents occurred to ensure people were protected from the risk of harm.

Staff knew how to recognise and respond to abuse. We found that safeguarding procedures were robust and staff understood how to safeguard the people they supported. People staying at the service felt safe.

Is the service effective?

Requires Improvement

The service was not entirely effective.

A sufficient number of staff were employed to meet people's needs but they were not always deployed in the most effective manner between the two units, meaning that people on the nursing unit sometimes had to wait for staff to address their needs.

The service had a range of policies and procedures which identified good practice on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). These were followed but not all staff had a sound understanding of the implications of DoLS. Further training had been arranged.

People's nutrition and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not fully caring.

People living in and visiting Beechcroft commented on how kind and caring most of the staff were, but an inspector heard two members of staff make disrespectful comments about some people who used the service.

Staff had a good knowledge of the needs of the people they were supporting.

People were provided with a range of information about the home and the registered provider.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

The recording and investigation of complaints was not consistent.

We saw that on-going review of the care plans led to referrals to other healthcare services such as speech and language services in order to ensure people received the most appropriate care.

Is the service well-led?

Requires Improvement

The service was not well led.

The service had a quality assurance system in place but this was not being operated effectively, resulting in opportunities to learn and improve being missed.

There was a registered manager in place and the staff all said they could raise any issues and discuss them openly within the staff team and with the management.

Beechcroft Nursing and Residential Home

Detailed findings

Background to this inspection

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

We carried out an unannounced inspection on the 18 January 2017 and then undertook a second announced visit on 19 January. The first day of the inspection was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had used health and social care services. The second day was undertaken by two adult social care inspectors.

Before the inspection we checked the information that we held about the service and the service provider and looked at any notifications received. We also invited Healthwatch, the local authority and local clinical commissioning group to provide us with any information they held about Beechcroft.

During our inspection we saw how the people who lived in the home were provided with care. We spoke with a total of 15 people living there, 6 family members and visitors and approximately 12 staff members over the two days. The people living in the home and their family members were able to tell us what they thought about the home and the staff members working there.

We looked around the home as well as checking records. We observed staff interaction with people who used the service, looked at the arrangements for medicines and read care plans and other documents including policies and procedures and audit materials.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe and all of the people we spoke with said that they did feel safe in the home. Comments from the people using the service included: "I feel safe and well looked after, I have no concerns"; "I don't feel threatened or have any concerns about the staff"; "No I'm not frightened here"; "I feel safe no trouble"; "On the whole I do feel safe, yes I have never been hurt by the staff and they are very obliging". A relative told us, "I can tell by her facial expressions and mannerisms that she feels safe here they are very attentive and pleasant with her".

We asked people whether they received the medicines prescribed by their doctor. Comments included: "I do my medication myself but they are sometimes there to help if I need them"; "I do get my medication on time and when I need them"; "I'm on all sorts of pills and I am on a Nebuliser and Warfarin so I struggle sometimes but they are there to help and I get my medication on time"; "I get my medication 3 times a day and it's generally on time". A visiting relative said, "She gets her meds on time and they fill in the plan and the MAR chart and we check to see if everything is done". The local clinical commissioning group had informed us that they had recently had concerns about the management of medicines at Beechcroft and had given them an action plan. We found that the home had since made improvements to the way medicines were managed. The manager carried out a medicines audit each month and concerns found in December had been acted upon. However, further improvement was needed to protect people living in the home from the risks associated with medicines. Staff who handled medicines had received training. However, managers had not recently watched or talked to staff individually to check they handled medicines safely, although all staff who administered medicines were undertaking re-training in the management of medicines and plans were in place to check their competence in the near future. We saw one member of staff sign medication administration records (MARs) before (not after) people had taken their medicines. This practice is contrary to the home's policy and national guidelines and is considered unsafe because the person may refuse the medicine or the staff member may be interrupted before giving the medicine. We watched medicines being administered in all the areas within the home. We saw that the two agency nurses on duty administered medicines safely. We looked at 22 out of 53 medication administration records (MARs) belonging to people living in the home. Information about people's allergies and their preferences as to how they took their medicines were kept with each MAR. We didn't see any 'gaps' in the records of administration. The receipt of medicines was recorded and people's tablets were counted each time a dose was administered to check the administration record was correct. Some people's medicine charts were handwritten. This is sometimes necessary but it is good practice for the information to be checked and signed by a second member of staff to reduce the chance of a mistake. All the handwritten charts we saw were signed by two people. Carers signed a different chart when they applied a person's prescribed cream. Four charts we looked at showed that people were receiving the cream when needed during the day, as well as in the morning when they dressed and at bedtime. We looked at the records for three people who needed thickened fluids. Two records clearly stated how much the person's drinks should be thickened but the third did not. There is a risk of a person choking if their fluids are not thickened to the right consistency.
Some people were prescribed a medicine that must be given at exact times of day to be effective. We saw one person receive this medicine at the right time but another person was given their lunchtime dose 40

minutes late. Two people were prescribed eye drops but the MAR did not say which eye should be treated, or if the drops were for both eyes. Staff cannot administer medicines safely if instructions are incomplete. Eye drop containers were not dated the first time they were opened. This is good practice as any eye drops left after 28 days must be thrown away and not used to reduce the risk of an eye infection. A lot of people were prescribed one or more medicines to be taken only 'when required'. Some people had a written protocol telling staff how and when the medicine should be given but others did not. This meant that the medicine might not be used as the doctor intended. We saw one nurse apply a pain relieving gel prescribed for use 'when required' to a person's knee, at their request. The protocol stated that the gel was for the person's chest. If information in people's records is incorrect staff cannot administer medicines safely. Medicines (including oxygen) were stored securely and at the right temperatures. The temperatures of rooms where medicines were kept were recorded each day. Temperatures of medicine refrigerators were also monitored and recorded in the right way. Medicines that are controlled drugs (drugs subject to tighter legal controls because of the risk of misuse) were stored and handled in the way required by law. The stock balances of the five controlled drugs we checked were correct. However, three bottles of a controlled drug in liquid form had not been dated when the bottle was first opened. This medicine has a shelf life of three months once the bottle has been opened. Therefore, unless the medicine has been dispensed within the previous three months staff cannot tell if the medicine is safe to use.
This is a breach of Regulation 12(1), including 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that the management of medicines was not completely safe.

The home was clean and we saw that there was plenty of specialist equipment available to meet people's needs, including hoists airflow mattresses and cushions to reduce the likelihood of pressure ulcers. Equipment had been serviced at the required intervals. However, when we were reviewing maintenance records we discovered that a five yearly electrical installation inspection and fire risk assessment had been carried out in summer 2016 and not all required actions had been addressed. We also observed that the garden was unsafe because paths were uneven, had moss growing on them and were slippy.
This is a breach of Regulation 12(1), including 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that the premises were not entirely safe.

We looked at the personnel files for five staff members to check that effective recruitment procedures had been completed. In four of the files we found that the appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). (These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.) However, in one file we noted that there was no evidence of a satisfactory DBS. This person had transferred from another home owned by the registered provider and we were told the DBS would be on file there. We also noted that some checks were many years old. It is good practice to carry out checks every three years and ask staff at their annual appraisal to confirm whether they have received any cautions or convictions since they were employed. We saw that the home required potential employees to complete an application form from which their employment history could be checked and references had been taken up in order to help verify this. We noted that the application form did not ask whether the applicant had any criminal convictions. (People who work in social care must declare any convictions, spent or unspent.) Each file held a photograph of the employee as well as suitable proof of identity. A system was in place for checking that the registration of any nurses working in the home was maintained. (Registered nurses in any care setting cannot practice unless their registration is up to date.) Records of employment interviews were maintained, but were inconsistent in the use of the registered provider's scoring system so did not adequately demonstrate the decision process behind the offer of employment.
We recommend that the registered provider considers current best practice in recruitment.

Although our observations during the inspection indicated that there were sufficient staff on duty throughout the home, some of the staff members spoken with on the nursing unit during the inspection felt there weren't enough staff at times. Comments included; "I personally do not think there are enough staff. Sometimes there are only five care staff and we need a t least six. We never have time to just sit and chat with people, we rush from one task to the next", "We could do with more, we have a lot of high dependency residents". Most people who used the service said that staff responded quickly when they rang their bell, but others made the following comments; "There's plenty on today but sometimes there are only two in here (residential unit) and if they get called to the other end you can wait a bit", "Sometimes you have to wait for the buzzer, like last night, the sheet was wet but I had to wait for them to give out the pills and do the tea before I got a new cover"; "I think they are short staffed, if six are doing jobs there is no floater to see to people"; "They could do with more staff they are always busy and rushing about but they are very good". A visiting nurse specialist told us they often had difficulty finding a member of staff to talk to because they were always busy. The staffing rotas we looked at during the visit demonstrated that there were usually two nurses and six care staff members between 8am and 8pm on the nursing unit and a senior carer and three care staff members on the residential unit between 8am and 2pm, going down to a senior carer and two care staff members from 2pm to 8pm. At night there was one nurse and three care staff members on the nursing unit and one senior carer and two care staff members on the residential unit. The registered manager was not included in these numbers. In addition to the above there were separate ancillary staff including an, administrator, kitchen, cleaning and laundry staff plus the home's maintenance person. We observed that whilst the staff on the nursing unit were busy all the time there were periods when staff on the residential unit were not occupied, such as during mealtimes and activities. We discussed this with the registered manager and turnaround manager during feedback who said that they had instructed the staff on the residential unit to help out on the nursing unit during their quiet periods and this would be reinforced. The registered manager used a dependency tool to determine staffing levels in the home, but we noted some discrepancies in the dependency scoring carried out by senior staff. For example, one person on the nursing unit who required assistance with all activities of daily living was recorded as medium dependency, and another person on the residential unit who required minimal assistance was also recorded as medium dependency. The registered manager said she would review all the dependency charts. The service was using a lot of agency nurses because of vacancies and sickness. They tried to ensure continuity by asking that the agencies they used supply the same nurses wherever possible. They had recently recruited a new clinical lead nurse who was due to start in the near future and another nurse was due back from leave in February. This would leave a nurse vacancy of two nights per week, for which they were trying to recruit.

We saw that the service had a safeguarding procedure in place. This was designed to ensure that any concerns that arose were dealt with openly and people were protected from possible harm. The staff working in the home were aware of the relevant process to follow. They said they would report any concerns to the local authority and to the Care Quality Commission [CQC]. Staff members confirmed that they had received training in protecting vulnerable adults. Those we spoke with told us they understood the process they would follow if a safeguarding incident occurred and they were aware of their responsibilities when caring for vulnerable adults. Staff members were also familiar with the term 'whistle blowing' and each said that they would report any concerns regarding poor practice they had to senior staff. (Whistleblowing is an option if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right.) This indicated that staff were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to accurately record and report potential incidents of concern.

Risk assessments were in place which assessed the environmental risks in the home together with risks to individuals, such as falls, pressure damage to skin, choking, use of bed rails and moving and handling. The

risk assessments were reviewed monthly. However, the local authority had identified that some risk assessments had not been updated in a timely fashion when people's needs had changed, for example if they had become more unsteady on their feet and had a fall. We saw evidence that the staff had now been instructed to review and update the risk assessments and care plans within 24 hours of an incident occurring. Staff members were kept up to date with any changes during the handovers that took place at every staff change. This helped to ensure they were aware of issues and could provide safe care.

Most people living in the home had Personal Emergency Evacuation Plans [PEEPS] within their care plan, but some did not. PEEPS provided details of any special circumstances affecting the person, for example if they were a wheelchair user. There was an emergency contingency plan in place if the home had to be evacuated in an emergency, such as a fire.

There was an on call system in place in case of emergencies outside of office hours and at weekends. This meant that any issues that arose could be dealt with appropriately.

Requires Improvement

Is the service effective?

Our findings

All the people living at the home that we spoke with and their family members felt that their needs were well met by staff who were caring and knew what they were doing. Since admission, two people's health had improved and they had transferred from nursing care to residential care.

There was a flexible menu in place which provided a good variety of food to the people using the service. Special diets such as vegetarian, diabetic and pureed meals were provided if needed. There were two choices available each day at lunchtime and in the evening. There were also alternatives available to the set menu, for example, baked potatoes and sandwiches. We were told that even though people made their food selections the previous evening changes could easily be accommodated. In addition to this people could have various drinks throughout the day. We saw staff offer people drinks and that they were alert to individual people's preferences and choices in this respect. We saw that a record was kept of fluid intake and was maintained where necessary. In addition squash was available in the lounges for use by the people living in the home. However, we noted on the nursing unit that there were no cups available on both days. The catering staff told us that snacks such as fruit, smoothies, cakes, biscuits and yogurts were available 24 hours a day. People who used the service told us: "The food is good, there's a couple of choices and I sit in a group with a few friends"; "If I want a drink or a sandwich I just ask"; "Food is good and I get plenty, you can have fish or pork and the like"; "It's good because since I've been in here I've put a stone on in weight". A family member we spoke with also commented positively on the food being provided, "She gets plenty to eat and drink she has breakfast in bed and sometimes she will go to the dining room at lunchtime". However, we did receive a complaint from another family member that her relative had been missed out twice at teatime and a relative had to go to the dining room to request a meal. We observed staff members supporting people in a patient, unhurried manner during lunch. We saw on the nursing unit that people who were at risk of malnutrition or dehydration had charts in their rooms to record food and fluid intake to ensure they were getting enough. These charts contained instructions on the type of diet people required and whether they needed any thickener in their drinks because of swallowing difficulties. We saw that the staff monitored people's weights and used the Malnutrition Universal Screening Tool (MUST) to identify whether people were at nutritional risk. This was done to ensure that people were not losing weight inappropriately. This area was also monitored through the home's on-going auditing systems. When we spoke to the chef she told us that she fortified a lot of the food by, for example, adding powdered milk to mashed potatoes and porridge, to increase the calorie intake of those at risk of losing weight. This was not appropriate to add it to everyone's meals because there were some people living at Beechcroft who wanted to lose weight. A customer survey had been carried out last year and some of the comments made requested a better choice of snacks for people who were unable to eat cakes or biscuits because of swallowing difficulties. To address this the chef was introducing some soft desserts.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this

is in their best interests and legally authorised under the MCA. The authorisation 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 looked at six people's care plans and saw that staff tried, wherever possible, to obtain consent to care from the person themselves. Policies and procedures had been developed by the provider to provide guidance for staff on how to safeguard the care and welfare of the people using the service. These included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We saw that mental capacity assessments were undertaken if necessary and if applicable DoLS applications were completed. These were only completed if a person was deemed to be at risk and it was in their best interests to restrict an element of liberty. Applications were submitted to the local social services department who were responsible for arranging any best interests meetings or agreeing to any DoLS imposed and for ensuring they were kept under review. The home had a record of people with authorised DoLS in place and the expiry dates. We talked to staff to ascertain their understanding of who had a DoLS in place and what this meant, but some staff were unclear on the implications. The registered manager told us that the local authority were going to provide further training on this for staff and the local authority confirmed this.

We saw that the provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. Following this initial induction and when the person actually started to work they would shadow existing staff members and would not be allowed to work unsupervised for a period. (Shadowing is where a new staff member works alongside either a senior or experienced staff member until they are confident enough to work on their own.) We asked staff members about training and they all confirmed that they received regular training throughout the year, those we spoke with also said that their training was up to date. We subsequently checked the staff training records and saw that staff had undertaken a range of training relevant to their role. This included safeguarding, moving and handling, dementia awareness and end of life care. One staff member told us, "We seem to get all the training we need. In the last two weeks I've done infection control, pressure area care and nutrition e-learning and a moving and handling practical session. Training is pretty good". The provider used a computer e-learning package called Touchstone for some of the training and staff were expected to undertake this when required. We looked at this and saw most staff were up to date. Staff competency would then be assessed through the supervision system and through the auditing of records. The staff members we spoke with told us that they received on-going support and supervision. We checked the records which confirmed that supervision sessions for most staff had been held regularly, although staff told us they did not get a written record of this. Some supervision records were not in enough detail to demonstrate what had been discussed. The registered manager said that not all supervisors had had formal training in how to carry out supervision and this was in the service's action plan to be addressed. (Supervision is a regular meeting between an employee and their line manager to discuss any issues that may affect the staff member; this may include a discussion of the training undertaken, whether it had been effective and if the staff member had any on-going training needs.)

During our visit we saw that staff took time to ensure that they were fully engaged with each person and checked that they had understood before carrying out any tasks with them. Staff explained what they needed or intended to do and asked if that was alright rather than assuming consent. People who used the service told us, "Yes they always ask if it's alright to do things for me" and "They're always asking what I want".

We saw evidence that people's health care needs were addressed. People were referred to other health care professionals for assessment, advice and treatment as necessary. Visits from other health care professionals, such as GPs, speech and language therapists, dieticians, chiropodists and opticians were recorded so staff

members knew when these visits had taken place and what had been advised or prescribed.

The home provided adaptations for use by people who needed additional assistance. These included bath and toilet aids, hoists, grab rails and other aids to help maintain independence. There was appropriate signage to bathrooms and activity areas.

Requires Improvement

Is the service caring?

Our findings

We asked the people living in Beechcroft about the home and the staff members working there. Comments included: "I feel very happy here"; "They treat me okay, I found it a bit strange coming here at first but I'm used to it now"; "They are nice and polite and do their job"; "They are there if I need help"; "They are very amiable and I get on very well with them"; "They treat me with respect, some are more friendly than others"; "Most of them are alright but I have my favourites"; "Oh yes they are very good with me"; "Some are very nice"; "Never had to complain, the staff do their job and more besides, like I ran out of deodorant and one of the girls nipped to the shops and got it for me". Comments from the family members we spoke with included, "We are confident she is well looked after and we are not worried about her when we have to leave" and "They treat her lovely she thinks the world of them".

We saw that family and other visitors could attend whenever they wished, some being present over lunchtime and some helping with meals in relative's rooms.

The staff members we spoke with showed that they had a good understanding of the people they were supporting and they were able to meet their various needs. From our observations during the inspection we could see that the staff did know and understand the needs of the people using the service. We saw staff members responding to the people using the service with both care and affection, this included carers putting an arm round someone and giving them a hug or having a laugh with them. We observed that staff members responded to any call bells quickly and knocked on people's doors before entering. We saw that the relationships between the people living in the home and most of the staff supporting them were warm, friendly and respectful. However, when talking with one of the inspectors, two staff referred to people who required assistance with feeding as "feeders". This was within earshot of people who used the service and is disrespectful. One of these staff made a further derogatory remark about a person who used the service to the inspector. This was reported to the registered manager who said she would address this with the staff concerned. We also noted from complaints records that the manager had received three complaints the previous year about the attitude of certain members of staff.
This is a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that people were not always treated with dignity and respect.

The décor, furnishings and fittings provided people with a homely and comfortable environment to live in. Although some bedrooms were in need of refurbishment the bedrooms seen during the visit were personalised and comfortable with some containing items of furniture belonging to the person. There was on-going refurbishment of the home taking place at the time of the inspection.

The provider had developed a range of information, including a service user guide for the people living in the home. This gave people detailed information on such topics as key staff, the facilities and the services provided, safety, what to do in the event of a fire, communication and complaints, activities and the laundry. A copy of this was available at the entrance to the building.

We asked about spiritual needs and were told that the home had a very close relationship with both the

local church and school who frequently came into the home to partake in activities. We saw evidence of this in the photos displayed on the residents' notice board. We also saw in the care plans that people were consulted about their wishes for end of life and this was documented.

Requires Improvement

Is the service responsive?

Our findings

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed. People were made aware of the process to follow in the service user guide. When asked if they knew what to do if they had a complaint both the people using the service and visitors knew about the complaints procedure. One person said "I would go to the office but I've never had to complain". Another said " I made a complaint last year and I've had a letter of apology, it hasn't happened again". Complaints were recorded on a file along with the response to the complainant. We looked at the most recent complaints and noted that they had not been addressed within the registered provider's published timescales. We also noted that documentation of the complaint and response could be improved. For example, there was not always a record of the investigation or identified action to prevent a recurrence. One family member told us about a concern they had raised with the manager. This was not documented because the manager said the person had said they did not wish to make a formal complaint. It is good practice to document all concerns raised.

A pre-admission assessment to ascertain whether a person's needs could be met by the home was carried out prior to anybody moving into Beechcroft. We looked at the pre-admission paperwork that had been completed for people currently living in the home and could see that the assessments had been completed for the people whose files we looked at.

We looked at care plans to see what support people needed and how this was recorded. We saw that each plan was personalised and reflected the needs of the individual. We also saw that the plans were written in a style that would enable any staff member reading it to have a good idea of what help and assistance someone needed at a particular time. However, the care files were rather bulky and contained some old information, which could make it harder for staff to access the most up to date information. All of the plans we looked at were being reviewed at least monthly so staff would know what changes, if any, needed to be made. We also saw short term care plans created in response to a particular issue. The seven care files we looked at throughout the two units contained relevant information regarding background history to ensure the staff had the information they needed to respect the person's preferred wishes, likes and dislikes. For example, food the person enjoyed, preferred social activities and social contacts, people who mattered to them and dates that were important to them. We asked staff members about some people's choices, likes and dislikes within care plans and the staff we spoke with were knowledgeable about them. Those people who commented confirmed that they had choices with regard to daily living activities and that they could choose what to do, where to spend their time and who with. Comments included: "I can do what I want, get up and go to bed when I want"; "I can go out whenever I want for a walk or to the shops"; "Of course I go to bed when I want and meal times are okay"; "It's easy going, I can go to bed when I want and if I want a lie in they will give me breakfast in bed, they are really sweet".

We saw that G.Ps, district nurses, dieticians, occupational therapists, tissue viability nurses and speech and language therapists [SALT] were regular visitors to people in the home. If people needed specialist help, for example assistance with swallowing staff contacted the relevant health professionals who would then be able to offer advice and guidance. A care plan to meet this need would then be put into place. We spoke to a

visiting nurse specialist who said that staff always followed their instructions.

The home employed an activity co-ordinator. Their job was to help plan and organise social and other events for people, either on an individual basis in someone's bedroom if needed, or in groups. The co-ordinator worked for 30 hours a week. Activities organised included board games, bingo, crosswords and dominoes and a regular arts and crafts day. In addition entertainers visited the home and trips out were arranged two or three times a month. These included visits to the pub or trips to shopping and garden centres. Two people said, "We go on all sorts of trips to the coast and to the shops" and "We've been to Southport and out shopping". On the first day of our inspection we saw the activity co-ordinator chatting with people who used the service about upcoming events and the trip out they had had the day before. In the afternoon people took part in an exercise class.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had commenced working at Beechcroft in April 2016. We asked people what they thought of the management of the home and received the following comments: "Overall can't find any fault with it"; "The manager is lovely but I don't know her name, she comes round and says hello"; "Linda is the manager, I can always talk to her"; "Linda is excellent, she calls in to have a chat with me"; "Linda is the manager, she's quite good, she speaks to me everyday, I have a good moan to her"; "They are all very approachable".

HC-One Limited had a corporate management system within its homes called "Cornerstones". It was a combination of practical tools and corporate documentation. The manager or the person in charge should carry out daily walkarounds looking at care and life in the home, the meal service, infection control and obtaining feedback from people who use the service and visitors. The completion of these records provided an on-going account of life within the home that could be audited as part of the company's internal quality assurance system. However, this wasn't being done when the manager was off duty.

Another element of Cornerstones was the on-going monitoring of the home via the company's computerised monitoring system called Datix. Audits on care plans, medicines, any accidents or incidents, falls, hospital admissions, infection control and the kitchen were required to be submitted monthly. We did see that audits had been carried out, for example medicines, mealtimes and care plans but did identify a number of shortfalls where audits had not been carried out or submitted as required. For example, falls audits had not been completed monthly and in the latest audit four accidents that had occurred over two weeks prior had not been investigated. We also saw audits where actions for improvement had been identified but not implemented. For example, an infection control audit had been carried out in August 2016, but when another audit was completed in November not all actions had been implemented. The registered manager told us that she felt that she had had a poor induction to the system and it had taken her a long time to understand what was required. She said she had repeatedly asked for assistance and was pleased that a turnaround manager had been put in place to support her. She said she felt that now understood the system and would be able to implement it properly.

An assistant operations director visited the service and spoke to the people living there on a monthly basis. They also carried out checks of the audits completed in the home. We looked at the records of these visits and saw that actions identified for improvement were not always followed through at the next visit. We saw that there had been three assistant operations directors in post since the registered manager's appointment, which may have contributed to the lack of continuity and support for the manager.

In addition to the above there were also a number of maintenance checks being carried out weekly and monthly. These included water temperatures as well as safety checks on the fire alarm system and emergency lighting.

The registered manager told us that information about the safety and quality of service provided was gathered on a continuous and on-going basis via feedback from the people who used the service and their

representatives, including their relatives and friends, where appropriate. She said she 'walked the floor' regularly in order to check that the home was running smoothly and that people were being cared for properly. She also held a daily briefing session with senior staff that covered any issues for the day and any comments or feedback from the people using the service, any relatives and from staff members.

Residents' and relatives' meetings were held monthly, although some people who used the service told us they did not bother going because they were quite happy with the service. We saw that minutes were produced following the meeting so that people who did not attend were kept informed.

A residents' and relatives' survey had been carried out in July 2016. Results showed that overall 84% of residents and 90% of relatives were happy with the service provided. The findings of the survey were displayed on the noticeboard in reception together with actions that the service intended to take to address any issues raised. Not all had been implemented, for example comments had been made about the safety of the garden but this hadn't been addressed at the time of the inspection. People could also provide feedback through carehome.co.uk.

Staff members we spoke with had a good understanding of their roles and responsibilities. They were generally positive about how the home was being managed and the quality of care being provided. We asked them how they would report any issues they were concerned about and they told us that they would speak to the registered manager. They all said they felt they could raise any issues and discuss them openly with her. Staff meetings were held to enable managers and staff to share information and raise concerns. We saw minutes of meetings held in October and December 2016.

This is a breach of Regulation 17(1), including 17(2)(a) and(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, although there were systems in place for assessing and monitoring the service to improve quality and mitigate risk, these were not being operated effectively.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Two staff were heard to make a disrespectful remark about people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not always following the policies and procedures for the recording and administration of medicines and the registered provider had not fully ensured the safety of the premises and grounds.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The audit and governance system in place was not always being operated effectively.