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

Summary of findings

Overall summary

This inspection took place on the 5,6 and 10 July 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 51 people living in the home, 23 of whom were in the residential unit and 28 on the nursing unit.

The last inspection took place on the 18 and 19 January 2017 when Beechcroft Nursing and Residential Home was found to require improvement in all domains.

There was a manager who had been in post full time since May 2017 who had applied to the Care Quality Commission to register as the manager of Beechcroft. 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 the home had been on an improvement plan and they had restricted placements to one a week. 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. An on-going action plan was in place.

At our previous inspection in January 2017 we found breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations in relation to dignity and respect, safe care and treatment and good governance. At this inspection we found that there had been improvements but there were still breaches in relation to safe care and treatment and good governance.

Whilst the people we spoke 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 fully embedded because of frequent changes in management and a lack of clinical leadership on the nursing unit.

On the nursing unit, medicines were not always administered correctly and the recording of medicines required improvement.

Measures to prevent and control the spread of infection had not been fully implemented.

Since the last inspection actions identified to improve the safety of the premises had been actioned.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The handling of complaints had also improved.

People that were able to talk to us said they were happy in the home and with the people that cared for them. The interactions we observed between people and staff were positive.

People told us that staff were kind and compassionate and the care they received was good. Comments included: "I'm very happy here, I'm well looked after"; "It's lovely here, they're all lovely"; "I am happy and content here, very comfortable"; "The compassion shown is excellent. The staff have really made an effort to get to know Mum and encourage her and it's fantastic to see her joining in activities".

The staff ensured people's privacy and dignity were respected. We saw that bedroom doors were always kept closed when people were being supported with personal care.

People remarked that the food was good and there was plenty of it. One person said, "I can't complain about the food, its fine".

People could choose how to spend their day and they took part in activities in the home and the community. The home employed an activity organiser who engaged people in activities in small groups and individually during the day. They also took people out in the local community.People received visitors throughout the day and visitors told us they could visit at any time.

People's needs were assessed and care plans were developed to identify what care and support people required.

People's health and well-being needs were well monitored. There were regular reviews of people's health and staff responded promptly to any concerns. People were referred to appropriate health and social care professionals when necessary to ensure they received treatment and support for their specific needs.

Staff received specific training to meet the needs of people and also received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff spoken with were confident that any allegations made would be fully investigated to ensure people were protected.

Some people who used the service did not have the ability to make decisions about some aspects of their care and support. Staff had an understanding of the 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 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 safe.

Medicines on the nursing unit were not always administered or recorded correctly.

Measures to prevent and control the spread of infection had not been fully implemented.

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.

There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met.

Staff received appropriate training to meet people's needs.

Consent was sought from people who used the service before providing care and treatment. Where a person lacked capacity to consent, staff acted in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were provided with care that was with kind and compassionate. We asked the people living at Beechcroft about the home and the staff members working there and received a number of positive comments about their caring attitudes.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive.

People were given choices throughout the day. People were given choice about activities, food and how they spent their day.

Recreational activities were provided that met people's needs and reflected their preferences. People were supported to go out into the community and see their families.

The service had clear systems and processes that were applied consistently for referring people to external health and care services for advice and treatment.

The provider had a complaints policy and processes in place to record any complaints received and to ensure that these were addressed.

Is the service well-led?

Requires Improvement

The service was not well led.

There had been numerous changes of home and regional managers in the last year.

At the time of the inspection there was an experienced manager in place who had applied to the Commission to register as manager of Beechcroft. Staff and people who used the service said they could raise any issues and discuss them openly with her.

There was no clinical leadership on the nursing unit.

The service had a quality assurance system in place which included seeking the views of people who used the service, but it was not fully embedded because of the frequent managerial changes.

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.

This inspection took place over 3 days on 5, 6 and 10 July and was unannounced on the first day. We carried out the inspection to follow up on requirements made at our previous inspection in January 2017.

This inspection was carried out jointly with commissioners from Halton Borough Council and Halton Clinical Commissioning Group (CCG).

The Care Quality Commission inspection team consisted of three adult social care inspectors and a pharmacist inspector.

Before the inspection, we checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit. We invited the local authority to provide us with any information they held about Beechcroft. They advised us that the service had been subject to an improvement plan, which we were able to view prior to our inspection.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We spoke with a total of seven people living there, seven visiting relatives and 13 members of staff including the registered manager, three agency nurses, seven care staff, the administrator and the cook. Some of the people living in the home found it difficult to tell us what they thought of the care in the home due to their

health conditions, so we carried out a Short Observational Framework for Inspection (SOFI), which involved observing staff interaction with people who used the service.

We looked around the home and grounds as well as checking records. We looked at the care plans of four people who used the service together with their food and fluid intake charts. We looked at other documents including policies and procedures; staffing rotas; risk assessments; complaints; staff files covering recruitment; training; maintenance records; health and safety checks; minutes of meetings and medication records.

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: "Yes,I feel safe" and "Certainly I am safe". A relative told us, "Mum is safe – no doubt".

At our last inspection in January 2017 we had concerns regarding the safe handling of medicines on both the residential and nursing units.

At this inspection we looked at the way medicines were handled by staff on the residential unit and found that there were no concerns about the safe handling of medicines.

We did have concerns regarding the safe handling of medicines on the nursing unit. There were no permanently employed nurses at the home on day duty.

We found that medicines were not always administered safely. On the day of our inspection visit the agency nurses did not finish giving morning medicines until 11:30am and the lunch time medicines round did not commence until 1.30pm. This meant that people did not always get their medicines on time. One person was given their medication for the control of their Parkinson's symptoms over 50 minutes late. Their records showed that this medication was recorded as being given up to one and a half hours late each morning and up to an hour late at other times of the day, which meant their health was at risk. We looked at records made about the times other "time critical" medicines were given and found they had not been given at the correct times. For example we saw that two people were prescribed very strong pain relief (morphine) every 12 hours, this medication was given up to one and a half hours late, which meant they may have experienced pain.

Arrangements had been made to give most medicines which need to be given at specific times with regard to food at the correct times. However agency nurses gave an antibiotic which must be given on an empty stomach with a medicine which needed to be given with food at meal times.

Stock checks of tablets and capsules were carried out on a regular basis and this meant that medicines could be accounted for and any errors such as missed doses were discovered quickly. However there were no such stock checks on liquid medicines. The records about liquids we found were not accurate. We found that nurses had signed that they had given more liquid medication than was in the home for one person.

One person was prescribed eye drops to be used three times daily. On two days it was signed as being used four times each day. We also noted there was no information as to which eye the drops should be used in. Staff cannot administer medicines safely if instructions are incomplete.

One person had a very clear protocol to guide staff to enable them to administer the correct laxative at the right time. We saw staff did not follow the steps of the protocol and they were given a stronger laxative than the protocol said they should be given at that time.

Some people were prescribed insulin and had their blood sugars monitored, however there was no information recorded for nurses to follow which showed each person's "safe range" for blood sugars. We also saw that although there was some information for staff regarding the application of creams, not all creams had sufficient information recorded to ensure they were applied properly.

Other records about medicines were not accurate. We saw that there were a number of gaps (missing signatures) on the records. We saw one agency nurse 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 poor practice because the person may refuse the medicine or the nurse may be interrupted before giving the medicine. We also saw that when people refused medicines no reason was recorded, which made it difficult for nurses to assess if the prescriber needed to be contacted. Some entries on the MARS were handwritten rather than printed by the pharmacy and we found in one instance that there were no directions recorded as to how to give the prescribed morphine which meant it may not be given safely.

We saw that the CCG's medicines management team (MMT) visit at the start of the year had highlighted that there was confusion about a person having their medication hidden in food . During this inspection we saw that this confusion was on going, the information recorded did not reflect how they were given medication. We also saw that another person was given most of their medication via a feeding tube but there was no information for staff to refer to to check what medicines could be given orally.

The manager had carried out an audit of the medicines a week prior to the inspection and had identified some of the above concerns. She had produced an action plan for the nurses to complete. However, one of the actions was that time critical medications were to be given within 15 minutes of the time prescribed, with immediate effect. This action had not been taken.

Following the inspection we were informed that the manager was working with the MMT to develop an action plan to make the required improvements in the management of medicines on the nursing unit.

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 on the nursing unit was unsafe.

At the weekend prior to the inspection some people who lived at the home had suffered a stomach upset. The local infection prevention and control nurse had been contacted and she had visited the home and provided advice on how to contain the spread of this infection. However, staff had not followed all the advice. For example, they were advised not to leave the home in their uniform but staff were seen in a local shop and at an external meeting in uniform. They were also advised to keep bedroom doors closed for people who had the infection, but on the first day of the inspection two were open.

On the second day of the inspection the pharmacist inspector noted that the clinic room on the residential unit where medicines were stored was dirty and had a layer of dust covering the surfaces in the room. On the nursing unit they found that the clinic room where medicines were stored was dirty, the floor was sticky and grimy and the medicines trolley had a layer of ingrained dirt round the top of the trolley. This was a risk of infection due to the unhygienic conditions. However, these had been cleaned by the third day of the inspection.

This is a breach of Regulation 12(1), including 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that insufficient measures were taken to control the spread of infection.

At our previous inspection we found that the premises were not entirely safe because not all actions identified as requiring attention at the five yearly electrical installation inspection and fire risk assessment had been carried out and the garden paths were slippy with moss. At this inspection we found that these matters had been addressed but the home was not completely secure. The gate at the far end of the home was open and because it was a hot day some people had their bedroom patio doors wide open instead of on the restrictor, which meant that anybody could access the home via these bedrooms. This was pointed out to the manager and the gate was locked. She reminded staff to make sure that it was kept locked apart from when there were deliveries or the bins were being emptied.

We looked at the personnel files for three new staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been made to ensure that staff were suitable to work with vulnerable adults.

Our observations during the inspection indicated that there were sufficient staff on duty throughout the home. People who used the service said that staff responded quickly when they rang their bell. The staffing rotas we looked at during the visit demonstrated that there were usually two nurses and six care staff members between 8am and 2pm on the nursing unit with one less care staff member between 2pm and 8 pm. On the residential unit there was 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.

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 whenever possible. On the first day of the inspection the two agency nurses had worked at the home regularly, for 6 months and two years respectively.

The service had a safeguarding procedure in place, 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 and confirmed that they had received training in protecting 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 managers. (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 or more frequently if needs changed. Staff had 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.

People living in the home had Personal Emergency Evacuation Plans [PEEPS] within their care plan and in a file kept at the front of the home. 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.

Good

Is the service effective?

Our findings

All the people living at the home that we spoke with felt that their needs were well met by staff who were caring and knew what they were doing.

People told us they enjoyed the meals provided. Comments included: "I can't complain about the food, its fine"; "They have to cater for large amounts of people. It's not like going to a restaurant and picking off a varied menu but the food is generally fine"; "I enjoyed my dinner very much".

We observed staff members supporting people in a patient, unhurried manner at mealtimes.

The cook showed us a file which contained important information about people's food likes and dislikes; special dietary needs; portion sizes; texture of meals; allergies; ethnic, religious or cultural preferences and adapted cutlery, crockery or cups required.

There was a flexible menu in place which provided a good variety of food to the people using the service. Special diets such as 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 and catering staff told us that snacks such as fruit, smoothies, cakes, biscuits and yogurts were available 24 hours a day. We were told that even though people made their food selections the previous evening changes could easily be accommodated. We saw a staff member taking a sandwich back to the cook because a person who used the service had changed their mind about what they wanted. A fresh sandwich of their choice was made straight away. We also saw that people were asked if they wanted any more.

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. In addition squash was available in the lounges for use by the people living in the home.

We saw 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.

Staff were knowledgeable about people's needs. For example one staff member told us, "X cannot have any kind of food with pastry on it so if there is steak pie on the menu the cook will make X a steak casserole, if that's what they want".

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.

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 four 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 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 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.

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 showed that approximately half the staff had not had a formal one to one supervision session with their line manager since 2016, although the manager said she spoke to most staff every day. At the previous inspection staff were not receiving a written record of supervision, but at this inspection we saw that those staff who had received formal one to one supervision did have a written record to refer to. (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.)

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.

Good

Is the service caring?

Our findings

At the previous inspection we found that people were not always treated with dignity and respect by a minority of the staff, but at this inspection we found that the manager had addressed this.

We asked the people living in Beechcroft about the home and the staff members working there. Comments included: "I'm very happy here. I'm treated with respect and well looked after"; "It's ok here, the staff are good on the whole, they maintain my dignity and look after me well enough"; "It's lovely here, they're all lovely"; "I am happy and content here, very comfortable".

We saw that family and other visitors could attend whenever they wished, some being present over mealtimes and some helping with meals in relative's rooms. One family member we spoke with said, "The compassion shown is excellent. The staff have really made an effort to get to know Mum and encourage her and it's fantastic to see her joining in activities".

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 having a laugh with the people who used the service. 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. There was a relaxed, sociable atmosphere and we saw staff joining in activities with people.

The décor, furnishings and fittings provided people with a homely and comfortable environment to live in. The bedrooms seen during the visit were personalised and comfortable with some containing items of furniture belonging to the person.

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. One person was receiving end of life care at the time of the inspection and their relative said they were being kept comfortable and were not in any distress.

Good

Is the service responsive?

Our findings

Staff in the home were responsive to people's needs. One relative told us about their loved one having a fall in the home which resulted in a fracture and how promptly staff had responded by summoning medical assistance, informing the relative, and making sure the person had a prescription for adequate pain relief.

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 told us, "I did complain to the manager about one member of staff and she sorted it out".

Complaints were recorded on a file along with the response to the complainant. We looked at the three complaints received since the last inspection. We saw that details of the investigations and any action taken were recorded.

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. All of the plans we looked at were being reviewed monthly so staff would know what changes, if any, needed to be made. However, one person's health had deteriorated in the previous week. The person was receiving appropriate care, but their care plan had not been updated to reflect the care now required.

The four care files we looked at 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.

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.

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 coordinator 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.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who had commenced working at Beechcroft full time in May 2017. She had worked in the home part time before then as a turnaround manager to assist the previous manager to improve the service. She was previously the registered manager of another home owned by the registered provider and had submitted an application to CQC to register as the manager of Beechcroft.

We asked people what they thought of the management of the home. One person who used the service said "The manager is very good, she comes when you ask to see her, she listens to you and tries her best to make you happy". One staff member said, "She does daily handovers, keeps all the staff updated about everything, is very supportive, and I can see the difference she's made already". Another said, "She has had a positive influence upon the staff and the home in general. She knows what she is doing and how to improve this home. I have every faith in her".

HC-One Limited had a corporate management system within its homes called "Cornerstone". It was a combination of practical tools and corporate documentation. The manager or the person in charge carried 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.

Another element of Cornerstone was the on-going monitoring of the home via the company's computerised monitoring system called Datix. Audits on care plans and medicines were required to be submitted monthly. Audits on infection control, falls and catering were required to be submitted quarterly. Health and Safety audits were required to be submitted six monthly. In addition 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.

At our last inspection we saw that not all audits were being carried out as required and, when they were, not all actions identified for improvement were being implemented. At this inspection the manager showed us the steps she was taking to make sure that the governance system was being followed, but said she had not had time yet to fully implement it.

The registered provider's own quality inspection team had carried out a full review of the service in April 2017 and produced a report saying that the home required improvement.

At the time of this inspection the area director had just left and a new one had been appointed (the fourth in the last year), together with a new regional director. The regional director had visited the service to carry out a further audit and had supplied the manager with an action plan.

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, such as 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. Two residents' and relatives' meetings had been held since the previous inspection. 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 June 2017. Results showed that overall 63% of residents who responded thought the home was good or excellent and 38% thought it was average. 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 currently being managed, but said that the frequent changes of home manager (three in the last year) were very unsettling.

The breaches identified in the safe section of the report regarding medicines and infection control related to the nursing unit, where there were only two permanent nurses working on the unit, both of whom were on night duty. There was no clinical leadership in the home to make sure that people were receiving appropriate nursing care, that records in relation to nursing care and treatment were up to date and that staff were receiving regular clinical supervision.

This is a breach of Regulation 17(1), including 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered and recorded correctly on the nursing unit and measures to prevent and control the spread of infection had not been fully implemented.

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 registered provider had a system for assessing and monitoring the quality of the service but this was not fully embedded because of frequent changes in management and a lack of clinical leadership on the nursing unit.