Bupa Care Homes (CFChomes) Limited

Beacon Edge Care Home

Inspection report

Beacon Edge
Penrith
Cumbria
CA11 8BN

Tel: 01768866885

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21 November 2016
22 November 2016
13 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 21, 22 November and 13 December 2016. The inspection was unannounced.

At our last inspection of Beacon Edge Care Home, the service was compliant with the Regulations in force at that time. However, we did make some recommendations for improvements in relation to staffing levels and the safe management of medicines (particularly creams/ointments).

During our inspection in November 2016, we found that the recommendations for improvements had not been actioned by the provider.

Beacon Edge Care Home provides care and support (with nursing) for up to 33 people who live with dementia. Accommodation is provided in single bedrooms all on the ground floor of the home. There are communal lounge and dining areas. The home is located in the town of Penrith and is set in its own grounds with ample parking.

The service should have a registered manager in post. At the time of our inspection the service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff available to meet the needs of people who used this service and sometimes people had to wait for help. We observed some good interactions and friendly banter between staff, visitors and people who used the service. Staff did not consistently use this approach and this was particularly noticeable when they were supporting people with eating and drinking or where people had limited verbal communication skills.

Care plans and risk assessments had not been developed to meet the individual needs of people who used this service. Staff did not always know what had been written in care plans and daily notes. We observed that much of the support provided by staff was 'task orientated' rather than centred on people's individual preferences. We have made a recommendation that the service finds out more about training for staff, based on current best practice, in relation to supporting the specialist needs of people living with dementia.

We observed some social activities taking place at the home during our inspection. These were limited to communal areas, meaning that people being looked after in bed were placed at risk of social isolation. Beacon Edge Care Home provided care for people living with dementia, but there was little evidence to show that activities and the environment took this condition into account. We have made a recommendation that the service finds out more about the environmental design of the premises in relation to the specialist needs of people with dementia.

The people we spoke to during our inspection thought that the frontline staff were caring, pleasant and helpful. Visitors told us that staff kept them up to date with any concerns there might be regarding their relatives. We did not see any signs of people feeling uncomfortable around staff.

Medicines were poorly managed and people were placed at risk of not receiving their medicines as prescribed.

People who used the service had not always been supported appropriately with eating and drinking. Special dietary requirements were poorly managed. However, we noted that when concerns had been identified advice had been obtained from the dietician or speech and language therapist.
There were gaps in the staff training programme and in the ways in which they received supervision and support, including the monitoring of their work practices. We have made a recommendation that the service considers current advice, guidance and legislation in relation to the safe recruitment and performance management of staff, including the provider's own policies and procedures in relation to disciplinary measures. We have also made a recommendation that the service finds out more about training for staff, based on current best practice, in relation to supporting people at the end of their life.

The service did not have an effective system in place to help monitor and improve the quality and safety of the service. The systems that were in place had not been used appropriately. There had been no senior management oversight to help ensure effective quality monitoring and improvements were carried out. We have made a recommendation that the service seeks advice and guidance about the management of and learning from complaints.

The registered provider had reported accidents and incidents to us as required. However, we found that there were other matters that had not been reported such as the closure of the kitchen for refurbishment.

We found breaches of regulation in relation to person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, good governance and staffing. We will report on any action we take once this is completed.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing levels and skills mix were not regularly reviewed to make sure the service could respond to people's changing needs.

There was poor management of accidents and incidents which placed people who used this service at risk from harm and injury.

Medicines were poorly managed and people who used this service did not always receive their medicines as their doctor had prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the skills and knowledge to effectively support some of the people who used the service.

Staff at the home showed a lack of understanding and inconsistent application of the requirements of the Mental Capacity Act 2005. People who lived at Beacon Edge Care Home were placed at risk of inappropriate restraint and of receiving care and treatment that they had not consented to.

The monitoring and management of people's nutritional needs were poor. Mealtimes were not sufficiently supported by staff who had the right skills and time to make sure people had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service told us that they thought the staff were very caring, pleasant and helpful. We observed some good interactions between staff and the people they supported but they were not always consistently applied.

Communication between staff and people with complex needs was poor. This meant that the needs of people who used the

service were not always understood.

People were supported with personal care needs in a discreet way but they did not always receive support to help protect their dignity.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not focused on upon individual preferences, choices, needs and abilities.

People received inconsistent care because staff focused on tasks rather than supporting people with their individual needs and preferences.

Activities were limited to taking place in communal areas and had not taken into account people's personal interests.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager. There had been inconsistent managerial arrangements in place. This had impacted on the ability of the service to operate safely and smoothly.

Staff were not adequately supported to understand their job role and what was expected of them.

Quality assurance systems were poorly maintained and operated. There was little senior management oversight to help promote the drive for improvements.

Beacon Edge Care 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 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.

The inspection took place on 21, 22 November and 13 December 2016 and was unannounced.

The inspection was undertaken by two adult social care inspectors, a pharmacist inspector 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.

Prior to the inspection we looked at the information we held about the service for example notifications, comments from relatives of people who used the service and from health and social care professionals.

Before the inspection the interim manager, at that time, completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 13 people who lived at the home and ten of their relatives, friends or visitors. We spoke with three of the registered nurses, three care staff, the activities co-ordinator and receptionist. We also spent time talking to the interim manager, at the time of our inspection, and the regional support manager. We spoke via telephone with the area training manager in order to obtain some clarity regarding aspects of staff training. We spoke to health and social care professionals order to get their views of the service.

We spent time in communal areas of the home observing staff working and supporting some of the people who used the service.

We looked in detail at the care records of five people who lived at the home. We looked in detail at the medicines; medication administration records (MARs) and other records of 17 people who lived at Beacon Edge Care Home.

We reviewed two staff recruitment records and looked at the staff training and supervision records. We also looked at some of the records regarding the running of the home, such as quality audits, action plans, meeting minutes and the 'Residents Report 2015' (a resident satisfaction survey carried out by the provider).

Inadequate

Is the service safe?

Our findings

Most of the people who used this service, that we were able to speak to, told us that they "felt happy" with the service.

Most of the people who used this service were living with dementia and verbal communication was not always possible. We did not observe any signs of people feeling uncomfortable around staff.

We looked at the way in which the registered provider kept people safe from the risks of harm, injury or abuse. The records we held about the service showed that there were a significant number of people reported as suffering skin injuries and 'unexplained' bruising. The local authority's safeguarding team knew about the injuries and were also monitoring the frequency of the reports.

The sample of care records we looked at contained risk assessments in relation to supporting people with their mobility, supporting people at risk from falls and supporting people who may at times become distressed or use inappropriate behaviours.

There was insufficient information recorded and little evidence of guidance for staff to follow to help ensure they worked safely and that the people they supported were safe.

When people had suffered a fall, we found that risk assessments and equipment in use had not been routinely reviewed and updated to help reduce the risks of that person falling again.

During our inspection of the service we noticed that call bells were constantly ringing. We observed that some staff did not react to the call bells. We looked at the records relating to call bells and the response time. We found that there were times when people did not receive a prompt response from staff. We asked two members of staff about responding to call bells. We were told that many people had sensor mats in their bedrooms that activated when people stepped from their beds. This type of equipment was usually used by people identified at risk of falling.

On one occasion we noted that a call bell was ringing for over 10 minutes. Staff told us; "They have a sensor mat in their room and could be sat on it." We commented that the person could have fallen and been lying on the floor, but staff still did not respond promptly to the call bell. We checked the response records for this person and found that that they frequently activated their sensor mat and that the response from staff was not always promptly provided. This indicated that sensor mats may not have been the most appropriate method of keeping people safe. We spoke to the interim manager and regional support manager about this during our inspection. However, action was not taken and three days later this person was found on the floor by staff and suffered bruising to their hands.

Another person who used this service was being looked after in bed following a fall, which had resulted in an injury. Their room was in a remote area of the home and they did not have access to their call bell at all. The expert by experience heard this person calling for help and had to go and find a member of staff. When we

asked staff about this situation they told us that they "checked" this person every one or two hours.

We reviewed the records of another person who lived at Beacon Edge Care Home. There were four instances recorded where this person had fallen from their bed. When we asked staff about how they kept this person safe, they told us that this person had not experienced any falls whilst they had been at the home.

These were breaches of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who lived at the home were not protected against the risks of harm or injury because the registered provider had not done everything reasonably practicable to mitigate the risks.

We looked at how medicines were managed for 17 of the 31 people living in the home. We found that medicines were not handled safely and that medication was not obtained safely.

We found that five people missed doses of some of their prescribed medicines for up to four days because there was no stock available in the home. Missing doses of medicines places people's health at risk of harm.

We observed that people were not given their medicines safely and that the medicines round took a long time to complete. We noted that the time people were given their medicines had not been recorded, which meant that people were at risk of being given medication without safe therapeutic gaps between doses.

Medicines must be given to people as prescribed. However we saw that people missed as much as half their prescribed doses of medicines because they were asleep or because they refused their medicines. This meant that medicines were not being given as prescribed and appropriate actions were not being taken to ensure people's health was protected.

Some people needed to be given their medicines covertly, by hiding their medication in food or drink. However we saw that nurses did not give one person their medicines in this way and as a result they were not given doses of their medicines for eight days over a 20 day period. They were also not given their antibiotics for eight days over a 10 day period. As a result their heath was placed at risk.

We saw that for some people the information recorded to guide staff when administering medicines which were prescribed to be given "when required" was missing. The information about how and where to apply creams was not available to guide care staff for the application of some creams.

Most medication which needed to be given before food had been given at the correct time. However, we saw that two people had been prescribed medicines to be given in this way but were given their tablets with their breakfast. This meant that those medicines may not have been effective.

Records about medicines did not demonstrate that medicines were given safely as prescribed. When a choice of dose was prescribed, nurses failed to record the exact dose they had given. Nurses did not keep a clear record of the use of medication that was administered by the district nurses, which meant they could not account for the use of some very strong medication. We saw the records about the use of food thickeners and topical creams were poor and did not provide evidence that creams had been applied properly or that thickeners had been used in all drinks.

Most medicines and creams had been stored safely. However during the inspection we saw the lock on the controlled drug cupboard was missing and this meant that controlled drugs were not stored legally.

These were breaches of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not ensure that nurses and carers followed the systems in place to manage medicines safely.

There was a policy and procedure in place with regards to safeguarding vulnerable adults. We checked with staff and reviewed their training records and found that they had been provided with training about safeguarding and abuse of vulnerable adults. Social care professionals told us that they had visited the home recently to provide a question and answer session for staff to help reinforce their knowledge of the local safeguarding and reporting processes.

We were unable to review a safeguarding investigation that had been carried out by the provider because the documents could not be accounted for.

We reviewed the records of three people who could at times display inappropriate behaviours and were at risk of causing harm or vulnerable to being harmed. We saw that advice and support had been obtained from the community mental health team and occupational therapists. However, none of the advice provided had been included in people's safety care plans or risk assessments. This meant that they and other people who used this service were sometimes placed at risk of abuse, harm or injury.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not properly protected from the risks of harm or abuse because the systems and processes in place were not effectively operated.

One of the visitors to the home told us; "It's not always like this (staffing levels). Many times they are very short of staff even just having two nurses and two carers to cover everyone." Another visitor commented; "At times people are waiting a long while, needing to go to the toilet because of staff shortages."

The staff we spoke to also raised concerns with us about the staffing levels at the home. The records we held about the service showed that we had been notified at the beginning of November that the service had operated a shift with reduced staffing levels that had affected the safe running of the service.

We looked at the staff rota and this confirmed what we had been told by visitors to the home and by staff working at Beacon Edge Care Home. We found that there were times when there were not enough staff on duty or appropriately deployed in order to meet the needs of the people who lived at the home. We found that people's care and support needs had not been accurately assessed. We discussed this with the interim manager and the regional support manager at the time of our inspection. If people's care and support needs are not accurately assessed, staffing levels cannot be appropriately calculated.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have their care and support needs met in a timely manner because there were insufficient numbers of staff deployed at the home.

We reviewed the records of two members of staff who had recently been recruited to the service. We found that the recruitment processes and checks had mostly been carried out safely but there were gaps in checking the employment history of people who had previously worked in health or social care.

We were aware that two members of staff had recently been subjected to disciplinary action. We asked the interim manager and the regional support manager if we could review the investigation records and

outcomes. These documents could not be accounted for.

We recommended that the service considers current advice, guidance and legislation in relation to the safe recruitment and performance management of staff, including the provider's own policies and procedures in relation to disciplinary measures.

Inadequate

Is the service effective?

Our findings

The people we spoke to during our inspection of the service told us that the staff were "very good" and that the nurses "stepped up to the mark."

Prior to our inspection we received comments and reports from health and social care professionals regarding poor moving and handling practices that they had observed whilst at the home. Some of the information we held about the service was indicative of accidents occurring during moving and handling procedures.

The interim manager provided us with information about staff training that had taken place and about the staff training that was planned. We also spoke to the area training manager about the training plan. We particularly spoke about training for staff working with people who may, at times display behaviours that could be challenging. We were concerned about the lack of this type of training and discussed with the training manager whether this could be linked to the number of notifications of injuries we had received.

We looked at the information about staff training. We found that most staff had completed training in relation to safeguarding people from abuse, moving and handling people, Mental Capacity Act awareness and safe use of bed rails. However, we also found that half of the staff had not recently completed fire drill training. The training matrix we were given recorded this training as 'overdue'. Additionally, we found that there were three nurses, with the responsibility of administering medicines who were also 'overdue' with this type of training.

We spoke to two of the care staff about the training they had received. They confirmed that they had been trained in safe moving and handling techniques by the internal BUPA trainer. They could tell us about their safeguarding training and that they attended staff meetings. They told us that they had not received any training to help them safely manage people who may, at times display behaviours that challenged.

We spoke to two of the registered nurses who were on duty at the time of our inspection. They told us about the processes and training in place to help them keep up to date and re-validate their professional qualification. They told us that BUPA had provided "a lot of resources" to help them with this process. They told us that there used to be specific staff meetings for nurses at the home but that these had "tailed off due to the lack of a manager."

We asked the interim manager and the regional support manager if we could review the staff supervision records. We found that five out of 35 staff had received supervision in 2016. The minutes of a recent staff meeting recorded that staff had asked for supervision. The interim manager at that time had told staff that supervision meetings would be held quarterly in the future.

There was no information available at the home to show that staff were adequately supported with their work or that they regularly had their competence checked by an appropriately qualified person.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who lived at the home were placed at unnecessary risk of harm because staff had not received appropriate training.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The 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).

The regional support manager told us that there were seven people living at Beacon Edge Care Home who were subject to DoLS, although the information we had received from the provider prior to the inspection indicated that there were 12 people.

The sample of records we reviewed showed that there was an inconsistent approach to the application of the principles of the MCA and DoLS at the service. There was confusing information recorded about people's capacity to make decisions. The provider had a tool to help ensure staff acted in the assessed best interests of people who used the service but this had also been used inconsistently. All of the people living at this service had been subjected to some level of continuous supervision and control, combined with lack of freedom to leave the home as they wished. These matters indicated a deprivation of liberty but applications had not been not applied for in every case.

Providers are required to notify CQC of the outcome of any applications for DoLS authorisation. When we checked the records we held about the service we found that we had not always been notified.

This was a breach of Regulation 13 (5) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of being unlawfully deprived of their rights and liberty because the provider did not consistently follow the principles of the MCA 2005.

We observed people sitting in the dining room or one of the communal lounges. Many people were still in bed. We observed the service of breakfast. There was a choice of breakfast foods but little evidence to confirm people were supported appropriately to make that choice where necessary.

We saw one member of staff working in the dining room feeding people their breakfast (porridge). This was observed to be very task orientated. There were no social interactions between staff member and service user, not even a chat, before the staff member moved on to the next person who needed assistance to eat and drink. Staff told us that they had 12 people that needed support with eating and drinking.

We observed another person sleeping in a chair in the lounge. A bowl of cornflakes, a plate of toast and a cup of tea had been placed in front of them. There were no staff about at this time as they were busy with medications, assisting people in the dining room or helping people to get out of bed. This resulted in the cereal becoming soggy and the tea and toast going cold and none of this being consumed by the person.

We asked a member of staff about the support needs of this person. We were told that this person "grazed" throughout the day but we did not see any evidence of appropriate foods being offered or encouragement given to eat and drink.

We observed another person who was mobile the whole day. We did not see this person eating or drinking during our visit to the service. We reviewed their nutritional support plan. An assessment in their care plan noted that they "ate on the go" but we did not observe this. At one point this person entered the dining room, but was not offered any food even though there were three staff present. Their nutritional care plan recorded that they needed to be guided into the dining room, encouraged to sit down and eat a fortified diet. There were no suggestions or explanations of what this might mean and we did not observe this to happen.

We noticed that all meals served at the home were crammed into a short space during the day. We saw the last breakfast served at 11:45, lunch was served at 13:00, afternoon tea and cake at 15:00 and tea at 16:30. With the exception of breakfast, food and fluids were observed to be provided at set times. We not see other regular access to fluids or nutritious snacks being made available.

We spoke to the recently appointed chef. We asked about special diets and the information they had been given about people's nutritional needs. The chef provided us with a list of people's nutritional needs. Some of the people on the list no longer lived at Beacon Edge Care Home and we judged this list to be out of date. The chef told us that there was another list but that it had "disappeared" and they couldn't find it.

The chef told us that they didn't get told what people liked and didn't like. When asked about fortifying diets and nutritious snacks the chef referred only to adding powdered milk and cream to foods and confirmed that the "nightbite" snacks were crisps, fruit, sandwiches and yogurt.

The chef described the special diets that needed to be prepared; "Three diabetics, five liquidised and five soft diets." The chef was aware of one person not being able to "eat anything orange or yellow coloured." We looked at the nutritional records of this person and found scant information about their allergies to orange juice, tomatoes and baked beans. We also noted from their food diary that they had been given spaghetti hoops to eat even though their allergy to tomatoes was recorded. This person had also been recorded as not liking milk but had been given milky drinks.

Some people had been prescribed thickeners to make sure they could have drinks without choking. We found that staff who prepared and served drinks did not have any written guidance as to how to thicken people's drinks to the correct thickness. Care staff had to rely on their memories to remember how to thicken each person's drinks. The information recorded for one person gave conflicting information as to how thick their drinks should be. This meant that their drinks may be thickened incorrectly. This was unsafe practice.

We observed that tins of thickeners had been left on the top of an unattended medicines trolley and on an unattended tea trolley in the dining room. In February 2015 a patient safely alert was issued regarding the need to keep thickening powder out of people's reach to avoid accidental asphyxiation if it was inadvertently swallowed. By failing to follow the advice in the safety alert people were placed at risk of harm.

On the first day of our inspection BUPA's admiral nurse carried out an observation of the lunchtime dining experience. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support. The outcome was poor and the service received a low score (48%). The admiral nurse identified concerns with staff interactions, choices, hand-washing, noise and that the photographic menu did not

accurately display what was on offer. These were similar observations to those we had made as part of the inspection.

We reviewed the records of people identified as being at risk of poor nutrition. The nutritional records of people who required close monitoring had not been completed with sufficient detail. It was impossible to tell exactly how much someone had eaten or drank. When people had been asleep at meal times, there was no indication that they had been offered or taken food when they had woken. There was no indication of alternatives being offered and taken when food had been refused.

This was a breach of Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of receiving inadequate support with their nutritional and hydration needs because the provider did not follow a robust food and drink strategy that met the individual nutritional needs of people who used the service.

During our inspection of Beacon Edge Care Home, we looked around the home. We found that the home had not been well maintained. There was an unpleasant odour in the entrance hall and the general décor needed attention.

The home provided care for older people living with dementia. However, during our inspection we found little evidence to support a "dementia friendly" environment.

There were few appropriate aids to assist people with orientation and enable them to maintain some level of independence. Memory boxes had been placed outside the rooms of people who used this service but not all of them were in use.

The bedrooms within the home had limited space and some of them did not have windows to allow natural light in or a have a view.

We recommended that the service considers appropriate advice and guidance. This should be from a reputable source, and based on current best practice with regards to the environmental design at the home and the specialist needs of people with dementia.

Requires Improvement

Is the service caring?

Our findings

The people we spoke to during our inspection of the service told us that they thought the staff were "very caring" "pleasant" and "helpful."

One of the people who used this service told us; "I am very happy here and well looked after, better than my previous place." Another person commented; "They (staff) are all good round here."

However, another person had not experienced such positive support. They told us; "Sometimes they tell me to wait a minute, hang on and I don't want to hang on when I need to go to toilet."

Visitors to the home said; "The staff are very good, I think they are well trained, they all love their jobs, are very caring, pleasant and helpful." Another added; "It has been grand my relative has settled in quite well, the staff are lovely. They (relative) will hopefully be getting some physio to help them walk with their Zimmer frame. They (staff) are very good here, from what we see."

During our inspection we observed some good interactions between staff and the people that used the service. There was some friendly banter and joking. Staff spoke to people respectfully and we saw care being delivered in a dignified manner with staff mindful of respecting people's privacy. Personal care tasks were carried out discreetly and with sensitivity.

However, we noticed that people did not always experience dignified care. We saw people left in clothing or bed linen that had been soiled with food or drink. Some people appeared unkempt. Hair was not brushed and many people wore shoes or slippers without socks or stockings.

People were left slumped in chairs in an undignified way in communal areas rather than being supported to their rooms for a sleep in private. Cold and soggy food was left on tables in front of them.

Some people in their own rooms could not access their call bell in order to summon help from staff and those that did were not responded to in a timely manner.

Staff did not have the skills to support people or communicate with people who became challenging or demonstrated inappropriate behaviours. They could not protect people's dignity in these situations.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to supporting the specialist needs of people living with dementia.

Staff at Beacon Edge Care Home had not received any training specifically designed for them to support people coming to the end of their lives. We also saw that there was no information available to guide staff and help them decide when to commence the administration of medication (anticipatory drugs), used when people were very poorly. If this information is missing medicines may not be given effectively or consistently and people's health could be at risk or people may be in unnecessary discomfort.

Some concern had been raised by health and social care professionals with regards to the competency of registered nurses at the home, because they were unable to manage syringe drivers and end of life medicines. One member of staff at the home told us that they did not feel "confident or competent" to use this type of equipment. We received an action plan from the provider in October 2016. This specialist training and end of life training was said to be "in the pipeline" but no target date for this to be achieved had been provided. On the day of our inspection the regional support manager told us the training had been sourced from a Hospice, but again no date fixed.

At the time of our inspection community nurses were being called on to monitor and manage medicines administered in this way, when they were required.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to supporting people at the end of their life.

Inadequate

Is the service responsive?

Our findings

One visitor to the service told us; "Our relative lives here. The staff are great, we have no complaints whatsoever. If we have any queries we can get them sorted straight away and if there are any incidents the staff will ring us."

Another said; "No hesitation staff do a good job, any concerns, and we have precious few, things get done. The staff are good and the new chef in the kitchen steps up to the mark. We feel we are encouraged to get involved especially when there are some events on like Halloween."

We looked at customer satisfaction reviews on the provider's website. In the most recent review a relative commented; "There are few life-enriching features here. Chairs are crammed together in living rooms, or there is a corridor to sit in with little natural light." This reflected our observations during our inspection.

We reviewed a sample of people's care records and observed staff providing care and support in communal areas during our inspection of this service.

We found that care plans had not been developed in a person centred way. Assessments of people's support needs had not been accurately recorded or reviewed as their needs changed.

Most of the people who lived at Beacon Edge Care Home had limited verbal communication skills. We did not see that alternative communication methods had been used to encourage people to be involved in the development of their care plans. We saw that relatives had been involved in the development of some care plans, particularly in relation to lifestyles, life history, likes and dislikes. However, when we spoke to some of the visitors to the home about their participation in care planning they were vague about this part of the care process. One visitor told us; "The staff are quite friendly and do not mind being approached and asked for information when we need to."

We could see from care records that where particular issues had arisen, for example inappropriate behaviours, staff at the home had contacted the community mental health team for help and advice. We noted that advice and strategies had been provided by the community psychiatric nurse but we could not find any evidence of this advice being integrated into people's personal support plans. Furthermore, we did not observe staff implementing any of the advice or guidance. One person's care plan that we looked at suggested simple adjustments to their immediate environment but nothing had been changed. There were no stimulating or self-distraction aids provided for this person, despite them sitting less than a metre away from a cupboard containing such items.

The community mental health team had provided advice for another person we reviewed but again their advice had not been incorporated into their care plan or the support being delivered to them. This person's personal interests and choices had been recorded and included dancing, watching TV and going out. The mental health team had suggested this person was encouraged to spend time out of their room. On the days of our visit this person remained in their room and in their bed, with no encouragement from staff to do

otherwise.

People who used the service, particularly those looked after in bed, were placed at risk of social isolation. This was because activities were limited to taking place in communal areas and did not take into account people's personal interests. Staff relied on the input of the activities co-ordinator and did not see social and leisure stimulation as part of their role. We discussed this with the regional support manager during our inspection.

The staff on the front line providing care told us that they had not read the care plans of the people they were supporting. When we asked them about people's personal interests and even events that had happened whilst they were living at Beacon Edge Care Home the staff were unaware. This was particularly noticeable where people could at times present with challenging or inappropriate behaviours. Staff did not have the skills or knowledge to support people living with dementia.

The expert by experience spoke to the activity co-ordinator during the inspection. We observed the activities co-ordinator trying to engage some of the people sitting in the lounge area to participate in gentle exercise and a simple quiz. Whilst waiting for lunch people were encouraged to join in a brief sing-along, again with the people sitting in the lounge.

During the afternoon a church service took place in the lounge. We observed that the response from people participating was variable and not everyone at the home was offered the opportunity to join the service if they wished. There did not seem to be any opportunities for people to have a "quiet word" or a one to one with the Vicar or his helpers, especially those people who stayed in their own rooms for most of the time.

This was a breach of Regulation 9, Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not receive care and support that had been specifically personalised to meet their needs and reflect their personal preferences.

The provider had a complaints procedure in place. Leaflets outlining the process, including timescales for response from the provider, were available in the home. The information was not available in a format that met the needs of most people who used this service.

The provider told us that they had received four complaints in the last 12 months. We checked the information we held about the service and found that we had received the same number of concerns raised with us in the last six months. All of the concerns raised were around staff training (particularly around moving and handling), staffing levels and meal choices. The provider had not given any details of what they had learned from the complaints or what they had changed to ensure improvements had been made.

We could not be confident that complaints had been dealt with appropriately and robustly because records had either been lost or not completed with sufficient details.

However, we did not have any concerns or complaints raised with us, by anyone, during our inspection of the service.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Inadequate

Is the service well-led?

Our findings

During our inspection we were told by relatives that the staff at the home contacted them if there was anything of concern, illness or a problem and that they kept them informed. However, one of the people spoken to said; "Management don't appear to be keeping us relatives up to date with changes but the everyday staff are good, approachable and understanding of our needs and know what going on."

Two relatives were very pleased with the responses they had received from the regional support manager and described them as "very supportive to staff and relatives."

The staff spoken to by the expert by experience, were open about the poor staff morale but did say that after the "horrible times" things were settling down and staff were working together as a team. They said that Beacon Edge Care Home was now a "nicer place to work."

We received concerns from local health and social care professionals about the inconsistent management team in the home.

Beacon Edge Care Home had not had a registered manager since July 2016. Since that time the service had been managed by four different managers with oversight from a registered manager from another BUPA care home. The provider told us that a permanent manager had been recruited and was due to take up the post in January 2017, with a view to applying for registration with CQC.

The way the service had been managed meant that risks had not been identified and appropriate strategies had not been developed and implemented to help make sure the service operated safely and smoothly.

Beacon Edge Care Home publicised in their information leaflet, that they took "great care to focus on the person" and that their "person-centred approach emphasises respect, dignity and quality of life."

During this inspection of the service we looked at the way in which registered provider ensured medicines were managed safely. Although one of the interim managers had completed audits (checks) of the medicines and records, these had failed to highlight any of the concerns and discrepancies that we found.

We looked at the way in which the registered provider ensured the health, safety and welfare of people who lived and worked at Beacon Edge Care Home were protected. Care plans and risk assessments were either not up to date and/or did not accurately reflect people's personal preferences or expectations. There was no evidence to support that these types of records had been audited to help ensure they reflected the current needs and requirements of people who used this service.

Some of the staff that we spoke to told us that they did not read care plans and relied on the daily shift handovers to keep them up to date with information about the people they were supporting.

This meant that people who lived at the home were placed at risk of receiving unsafe and inappropriate care

and support.

When we checked the information we held about the service we found that the provider had reported a significant number of injuries, such as falls, skin tears and "unexplained bruising" to people who used this service. The registered provider had not used the information gathered to monitor falls and accidents or take appropriate actions to help mitigate any further risk of harm or injury to people who used this service.

We looked at the ways in which people had been consulted on the quality of the service and how people were able to voice their opinions. Interim managers at the home had held two relative's meetings. One in July 2016 and more recently in October 2016. Management arrangements and staffing levels had been discussed at both meetings.

The regional support manager told us that satisfaction surveys were currently being distributed in readiness for the annual quality survey. However, we were provided with the 'Residents Report' from the last survey in December 2015. Areas of strengths for the home had been identified as the staff and contentment with living at the home. Areas for improvements included quality of care received and staff availability when needed, both of which were areas of concern identified by our inspection of the service. This meant that the registered provider had not taken appropriate action to make improvements to the service.

We also noted that a staff meeting had been held and the minutes of these were available. However, there was no evidence to support that staff were supervised or that their practice was monitored on a regular basis.

We were shown examples of quality audits that had taken place at the home recently. The regional support manager showed us the BUPA 'Operational Essentials Plan'. This gave an overview of all the checks and audits that should have been completed on either a daily, weekly, monthly or quarterly basis.

However, the plan had not been followed. Audits had either not been completed or had been inaccurately completed. The auditing process had had not been checked and scrutinised by senior managers. This meant that there were serious gaps in the governance systems and robust action plans had not been developed to help drive improvements.

Records relating to the care and treatment of people who used this service were not fit for purpose. Information about people's care and support needs was not up to date. Confidential information was not always stored securely and did not meet the requirements of the Data Protection Act 1998. Some of the records we asked to see could not be accounted for.

These were breaches of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems and processes in place to monitor and assess the quality and safety of the service. This meant that the provider had no way of checking that they were keeping people safe or meeting the requirements of the regulations.

We checked the information we held about the service. We found that the registered provider had notified us, as required, about incidents affecting the wellbeing of people who used the service. However, when we reviewed our information against the records in the home, we found that the registered provider had not always notified us about the outcome of DoLS applications or of events that affect the running of the service. We noted from the resident meeting minutes that the kitchen had been closed for refurbishment and meals had been sourced from one of the other BUPA homes in the area. The registered provider had failed to tell us how these arrangements would be managed safely in order to reduce any risks to the health, safety and

welfare of people who used the service. We are dealing with this matter outside the inspection process.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used this service did not receive care and support that had been specifically personalised to meet their needs and reflect their personal preferences.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who lived at the home were not protected against the risks of harm or injury because the registered provider had not done everything reasonably practicable to mitigate the risks. The provider had not ensured that nurses and carers followed the systems in place to manage medicines safely.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used this service were not properly protected from the risks of harm or abuse because the systems and processes in place were not effectively operated, including those related to the principles of the MCA 2005.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who used this service were placed at risk of receiving inadequate support with their nutritional and hydration needs. The provider did not follow a robust food and drink strategy that met the individual nutritional needs of people who used the service.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to monitor and assess the quality and safety of the service. This meant that the provider had no way of checking that they were keeping people safe or meeting the requirements of the regulations.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who used this service did not have their care and support needs met in a timely manner because there were insufficient numbers of staff deployed at the home. They were also placed at unnecessary risk of harm because staff had not received appropriate training.

The enforcement action we took:

Through our enforcement procedures we varied the providers registration which resulted in the removal of this location.