Beechey House

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Inspection report

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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**

Overall summary

Beechey House is registered to accommodate and provide personal care for up to 16 people and caters to the needs of people living with dementia. At the time of our inspection there were 12 people living at the home.

There was a registered manager at the home. 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 and associated Regulations about how the service is run.

This was an unannounced inspection that was carried out over a three days by two inspectors.

At a previous inspection in November 2013 the provider was not meeting the requirements of the law in and we issued warning notices in respect of; people's consent, the care and welfare of people, meeting people's nutritional needs, safety and suitability of the premises and the monitoring of service quality. We met with the provider in January 2014 and discussed our concerns. At that time one of the providers was also the registered

Summary of findings

manager. They decided to focus on their role as a provider, and appoint a manager to run the service. A manager was registered with the Commission to run the home in June 2014.

We followed up on the service's non-compliance with a further inspection of the home on April 2014. At that time we found improvements had been made and the service provided to people was compliant concerning meeting people's nutritional needs, premises and monitoring the quality of service. We issued compliance actions in respect of consent to care and the care and welfare of people living at the home.

We received safeguarding concerns about the service in September 2014, which lead to us carrying out this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

At this inspection there were poor arrangements for the management and administration of medicines that put people at risk of harm. People did not always have medicines administered as prescribed by their GP.

People's legal rights were not fully protected because legal requirements of the Deprivation of Liberty Safeguards (DoLS) had not been followed through. People were therefore detained of their liberty without proper legal protection. The provider had not complied with the requirements of the Mental Capacity Act 2005 at this or our two previous inspections.

Records did not fully detail 'best interest' decisions and who had been consulted in making these decisions for people who lacked capacity.

The service was not responsive to meeting people's needs. Care plans were not up to date. For one person who was nearing the end of their life there was no plan setting out how to meet their end of life care needs. Staff therefore did not know how to consistently care for this person. Equipment was not always provided to meet people's needs.

People's nutritional needs were met. People who required support with eating and drinking were assisted appropriately by staff.

The staff team were trained in the protection of vulnerable adults and knew what constituted abuse and how to report concerns.

The home had a caring staff team who had worked at the home for many years. Staff received induction training and further training to ensure they were competent to care for the people living there. However staffing levels at the time of inspection were inadequate to meet people's needs.

The systems in place and the culture at the home did not ensure the service was well-led. Staff did not feel supported and the systems to monitor the quality of service were inadequate. The provider had not taken action to address shortfalls identified at previous inspections to ensure that people received appropriate care.

Summary of findings

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

People did not always receive their medicines as prescribed.

Staffing levels at the time of this inspection were not adequate to meet people's needs.

Risks were not always identified and managed to make sure people were kept safe.

Is the service effective?

Inadequate 

The service was not effective

Where people lacked capacity, there was inadequate information about who had been involved in making 'best interest' decisions about the care that they received. The provider had not complied with the requirements of the Mental Capacity Act 2005 at this or our two previous inspections. This meant people who lacked capacity may be at risk of receiving inappropriate care.

Staff were provided with appropriate training and supervision to help them carry out their roles.

People were supported to access health care professionals when they were unwell.

Is the service caring?

Requires Improvement 

Staff were caring and knew the needs of the people living at the home. However, low staffing levels meant that people's needs were not always met.

Staff respected people's privacy and dignity.

Is the service responsive?

Inadequate 

The service was not responsive

Staff were unable to respond to people who needed support.

The provider had not responded to people's changing needs.

Is the service well-led?

Inadequate 

The home was not well led.

The systems to monitor the quality of service provided to people were inadequate.

The approach of management was not always supportive of staff.

The provider had not taken action to address shortfalls identified at previous inspections to ensure that people received appropriate care.

Beechey House

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 was 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 on 14, 15 and 17 October 2014 and was unannounced. Two inspectors carried out the inspection over all three days. We met and spoke with everyone living at the home as well as the registered manager, one of the registered providers, five members of staff and three visiting relatives. Because people were diagnosed with dementia, they were not able tell us about their experience of life in the home. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at people's care and support records, people's care monitoring records, all 12 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records, training records and quality assurance records.

Before our inspection, we reviewed the notifications we had been sent from the service since we carried out our last inspection. A notification is information about important events which the service is required to send us by law. We also liaised with the local social services department and received feedback from district nurses about the service provided to people at Beechey House.

The provider 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. This information was used as part of our planning, and provided us with evidence of how they managed the service.

Inadequate

Is the service safe?

Our findings

People did not always have medicines administered that were prescribed to them. For example, one person had been prescribed oral pain relief to be given four times a day. This was being treated as an 'as required' medicine and so staff were not administering this medication as often as had been prescribed by the person's doctor to relieve their pain.

One person had been seen by the doctor the night before our inspection and diagnosed as having pneumonia. Antibiotics had been prescribed and these were delivered to the home on the morning of the inspection. The antibiotics were not administered in the morning or at lunchtime that day until we brought this to the attention of the registered manager. This meant the person experienced a delay in receiving their medication.

Another person prescribed antibiotics, their record stated that the course had been completed but we found some of their antibiotics still available in the medication cabinet. A further person prescribed a medicine that should be given once a week had this medication administered a day late. These people had not received their medicines as prescribed to meet their needs.

There were some medicines that had been administered on the day of our inspection but had not been signed as administered on the person's record. We also found other medicines left in blister packs but records had been signed that the medicines had been given. Medication administration records (MARs) did not provide an accurate record of the medicine given to these people.

The lock of the small pharmacy fridge in the medication room was broken so this facility could no longer be locked. Some medicines need to be kept refrigerated, however there were gaps in the daily recording of maximum/ minimum temperature of the fridge, therefore it was not clear whether medicines had been kept at an appropriate temperature.

The above concerns amount to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because there were not appropriate arrangements for the administration, recording and storage of medicines.

Other aspects of medicines management complied with regulations and promoted safe practice.

The provider had appropriate systems in place for the administration, recording and storage of controlled drugs. We audited the controlled drugs cabinet and found the balance of medicines tallied with the records. Medicines that did not require refrigeration were stored securely.

Medication administration records included a photo of the person and information any allergies, so that new members of staff or agency staff could recognise the person to whom they were giving medicines and had important information about medicines which that person could not take.

People's care planning documents contained risk assessments to make sure that care was delivered as safely as possible. However, for two people who had falls, their risks assessments and care plans had not been reviewed so staff could not be certain how to safely support people. These shortfalls in risk assessments and management plans were a breach in Regulation 9 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home plans for how to respond to any foreseeable emergencies.

Staffing levels were inadequate to meet people's needs. Duty rosters showed that between7:45am to 7:30pm there were three care staff on duty and during the night time period two awake members of staff. Staff confirmed that these were the general levels of staffing and reflected the staff provided on the day of the inspection. In addition the home employed a cleaner and the registered manager, who worked office hours on weekdays. The home did not employ a cook with responsibility for cooking meals resting with the care staff.

Of the 12 people living at the home, four of them spent the greater part of the day in bed, requiring regular checks, repositioning (sometimes requiring two members of staff) and assistance to meet their needs. All the others needed continuous monitoring by staff as well as requiring assistance with many aspects of their daily lives because of their dementia. In the mornings, when one member of staff was responsible for the cooking, this left only two members of staff to meet everyone's needs.

Inadequate

Is the service safe?

Staff told us that they felt staffing levels were inadequate and met people's basic care needs but were not sufficient to meet people's emotional and social needs. This view was confirmed by our observations. The staff told us that they had repeatedly raised this concern with the registered manager but no increase in staffing had been put in place.

Concerning one person, care records stated that on 3 October 2014 the local authority physiotherapist had visited and informed the registered manager that the person needed one to one care to ensure that the risk of their falling was minimised. On 6 October 2014 the local authority occupational therapist also visited this person and reiterated that they required one to one staffing and constant monitoring to reduce the incidence of falls. This was not provided.

The above concerns amount to a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. However, following the inspection when we fed back about our concerns about the staffing levels, the provider informed that us that staffing levels had been increased from three to four carers during the daytime and that the staffing levels would be kept under review.

The home had a long standing team of staff members who were motivated to providing a good service to people and no new members of staff had been recruited since our last inspection. We therefore did not look at how staff had been recruited.

The staff we spoke with all confirmed that they had received training in the protection of adults. They were also able to tell us what constituted abuse and, if this was suspected, the appropriate action that they should take. All staff told us that they had confidence to report suspected abuse should they need to.

Inadequate

Is the service effective?

Our findings

People's legal rights were not fully protected because legal requirements of the Deprivation of Liberty Safeguards (DoLS) had not been followed.

At our inspection in November 2013 the provider had not acted in accordance with the legal requirements of the Mental Capacity Act 2005 and we issued a warning notice to be complied with by 3 February 2014. At our follow up inspection in April 2014 we found that improvements had been made, however; the legal requirements of the Act were still not fully implemented. Mental Capacity Assessments did not always provide sufficient information to determine who had been involved in making 'best interest' decisions on behalf of people who lacked capacity and some assessments were not fully completed.

At this inspection we found that the registered manager was aware of the Supreme Court ruling made earlier this year. This extended the scope for when a DoLS authorisation should be made to include people under continuous supervision and control and were not free to leave, and who lacked capacity to consent to these arrangements. The registered manager had submitted two referrals, which had been authorised, however; they acknowledged that everyone living at the home fell under the criteria of the Supreme Court ruling and therefore referrals for a DoLS authorisation for each person should have been made to meet legal requirements.

Mental capacity assessments identified the areas of people's lives where they had capacity to make decisions but there was inadequate information about who had been involved in making 'best interest' decisions that were being made on behalf of people.

Some people had 'as required' medicines prescribed by their doctor. These people did not have mental capacity, as determined by the capacity assessments within their care documentation, to ask or know when these medicines should be administered. Staff were therefore required to make a 'best interest' decisions on people's behalf for when to administer these medicines. There were no care plans to instruct or guide the staff when to administer these 'as required' medicines.

The above concerns amount to a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff understood about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) as they had received training in this area.

Staff understood when people had the mental capacity to make their own decisions as mental capacity assessments identified those aspects of people's lives where they could make decisions; such as when they wished to get up and go to bed, what food they would like to eat and what clothes they would like to wear.

Staff told us that when they started work at the home they had induction training and that this had been followed up with more in depth essential training. They also told us that they had regular supervision. This had included direct observation of their work practices as well as individual time with their manager to ensure they had the skills and knowledge to meet people's needs.

People were effectively supported with their physical health care needs being registered with local GP surgeries. People were referred and supported with hospital appointments with various health conditions.

People's nutritional needs were met with care plans identifying how to effectively support people at meal times. Some people had swallowing difficulties and been referred to speech and language therapists for dietary guidance. Those people prescribed drink thickener to assist with their swallowing difficulties had appropriate drinks. At lunchtime, people identified as requiring assistance with eating were assisted appropriately by staff.

One relative who told they visited every day, said that the food was generally of a good standard and that they saw people had enough to eat.

Requires Improvement

Is the service caring?

Our findings

People were supported by appropriately by the staff, although at times staff were not available to spend time with people, being busy meeting people's care needs. When staff had the time to sit and talk with people, they spoke with people about things they were interested in.

Staff understood people's preferences and life history. Care plans contained a short life history for each person that relatives had contributed to so that staff could better support people in the manner that they would choose. For example, staff spoke with one person about their family and occupation. They laughed together and obviously enjoyed the interaction from staff.

Some people who were living with dementia were not able to be fully involved in decisions about their care, however, staff did speak to people and involve them in decisions such as where they wished to sit or what they would like to eat at lunch time. Because of their mental frailty, people were not able to sign for consent to their care plan. Records showed that relatives had been involved in developing care plans.

Relatives we spoke with were positive about the staff and the care provided at the home. Relatives told us that they were always kept informed.

People's choices were respected. Two people smoked and they were supported to smoke in the garden when they chose.

When staff were providing personal care, bedroom doors were kept closed to respect people's dignity. People were referred to by their preferred form of address

The home had a core of staff who had worked at the home for many years and speaking with them, it was clear that they had grown attached to people and cared about them. Staff wanted to spend more time with people but said that the demands of meeting people's physical care needs meant that they did not have time to respond to people's emotional and social needs.

People were not able to take part in meaningful activities. There was lack of staff presence in the lounge at times and there were few activities or things other than the television to stimulate people.

Relatives said that they could visit at any time and there were restrictions placed upon them. They also felt the staff were very caring. One relative told us, "I have had no concerns about the care and have always been kept informed". Another relative told us that their relative always looked clean and well groomed when they visited.

Inadequate

Is the service responsive?

Our findings

Staff were not responsive to people's needs. One person had a runny nose and staff did not intervene until the mucus had reached the person's lap. Another person attempted to stand up and indicated they needed to go to the toilet but staff did not acknowledge this and just moved them into the dining room. Another person spilt their drink on their trousers in the morning and staff did not change the person's clothing until after lunch. A further person repeatedly called out but staff did not always have the time to respond or acknowledge the person, which lead to the person becoming increasing upset and agitated.

For most of our observations staff were busy and the television or music was playing in the lounge. There were not any activities or items in people's reach so they could occupy themselves. There were long periods of time when people were just looking around, had their eyes closed or were asleep. People were in a neutral mood which was neither happy nor unhappy for all of the time we observed them. Two people were happy and smiling when staff spent time with them and chatted with them but this was only for the time of the interaction and for the remainder of the time they were also in a neutral mood.

People's charts in rooms to record check on their welfare and position changes did not always show that these had been carried out to the frequency directed in care plans.

One persons' health had deteriorated and their GP had visited and informed the registered manager that this person was nearing the end for their life. There was no care plan in place to instruct staff about how to meet this person's end of life needs; such as, mouth care and frequency for repositioning in bed. Staff confirmed there was no end of life care plan in place and that they were unsure of how to consistently care for that person. One member of staff told us on the 14 October 2014, "I clean inside his mouth with toothbrush and toothpaste and use a cloth, no one told me, I just did it". They told us that they used a cloth as there were no mouth swabs available. We bought to attention the lack of end of life care planning for this service user at out feedback with the registered manager on 14 October 2014. On 16 October 2014 their care plan had been updated to reflect the need for four hourly repositioning. However, on the 17 October we found that this service user's health was deteriorating and there was still no care plan in place to manage this servicer's mouth care and end of life needs.

For a second person their feet were in contact with the end of the bed board and there was a red area on one of their toes. This was not recorded on a body map or within the service user's care records. We spoke with visiting district nurse on 14 October 2014 who confirmed that they had told the staff the day before about the service user's feet touching the end of the bed and that the person required a longer bed and the use of pressure relieving equipment. The district nurses told us that they had not been made aware of the red area of the service user's toe and no action had been taken to address this concern. We spoke with the district nurse again on 17 October 2014 and they confirmed that they had raised the need for a longer bed approximately three to four weeks earlier and that this was recorded in their records.

Paramedics were in attendance for one person who had facial injuries that had resulted from a fall from their bed at 1:24 am that morning. Medical attention had not been sought at the time and the paramedics admitted the service user to hospital and made a safeguarding referral to the local authority.

A further person had being diagnosed with a serious health condition. There were letters relating to hospital appointments on their file but there was no reference to their treatment, outcomes from appointments or how this impacted on their care. We discussed this with the registered manager and found that the person had been supported to attend appointments and there had been discussions with the relatives about 'best interest' treatment choices; however, none of this had been recorded to ensure that staff were able to consistently meet their needs

The above constituted continuing a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because these people were not receiving the care and support they needed to meet their care, support and emotional well-being needs.

The relatives we spoke with said that they thought their relatives were being well-cared for and raised no concerns. They told us that they knew how to complain should they have concerns. The complaint's procedure was displayed in

Inadequate

Is the service responsive?

the home and also within the terms and conditions of residence. The complaints log recorded two complaints. The records also showed the action taken to resolve the concerns raised. The provider has not identified any areas for learning from the complaints.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

The home was led by the registered manager and registered providers. The manager was registered with CQC on 24 June 2014 but was about to leave the service. One of the registered providers visited the home for several hours each day. Both the registered manager and provider were involved in the day to day running of the home; however they had not taken appropriate action to address the shortfalls identified at the previous inspections.

Following our inspection in November 2013 we issued five warning notices relating to breaches of the regulations. We met with the registered provider in January 2014 to share our concerns about the service. When we returned to complete a follow up inspection in April 2014. The provider had taken action to meet three of warning notices, but had not fully met requirements relating to consent to care, and the care and welfare of people. At this inspection we found that they had not met these regulations, and that there were breaches of a three further regulations. This showed that the provided had not taken account of previous inspection reports, and did not have effective systems in place to assess and monitor the quality of the service.

There was no system in place to make sure that care plans and records were kept up to date. The majority of care records had a review date of 26 September 2014. There were no further entries showing actions taken or updating of when people's needs changed, such as for the person who was near the end of their life.

There were audits undertaken and recorded to monitor the quality of service; however, these were not always undertaken to the timescale specified on the record. For example, medication audits were carried out in July 2014 but none had been undertaken since that time. At this inspection we found medication errors that were not picked up because the audits were not taking place.

Accident and incident records showed that accidents were recorded; however, on two occasions people had been noted to have bruising but there was little recorded to establish how people had become bruised.

We discussed the staffing levels with the registered manager, who told us there was no formal quality monitoring system for reviewing staffing levels at the home to ensure that they met people's needs.

The above concerns amount to a breach of Regulation 10 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not effective systems in place to effectively assess and monitor the quality of the service and the provider had not taken of reports prepared by the Commission.

People and their relatives were given the opportunity to provide feedback on the quality of the service through a survey that was carried out in August 2014. The survey did not identify any issues about which action could be taken.

Staff told us that they did not feel supported and that concerns they raised were not managed effectively, such as staffing levels. Staff reported that staff meetings had taken place in the past but did not feel that these were constructive or supportive.

Staff also reported to us that maintenance issues were also not actioned in a timely way. An example given was in relation to a call bell and pressure mattress in one person's room. Staff told us that this equipment had not worked for two or three weeks. We tested the mat and call bell on the 17 October 2014 and found that neither worked. The registered manager ensured that the call bell and pressure mattress were replaced that day.

Overall, this showed that the culture of the service was not open or empowering as the management did not respond or support the staff in meeting people's needs or respond to maintenance issues that affected people's care.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care because they had not assessed, planned and delivered the care to meet service user's needs and ensure the welfare and safety of each service user.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not safeguarded the health, safety and welfare of service users by not ensuring there were sufficient staff to meet people's needs.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had failed to comply with the requirements of the Mental Capacity Act 2005.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Enforcement actions

The registered person had not protected service users against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
We have cancelled the registration of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had failed to protect service users from unsafe or inappropriate care because the registered person did not regularly assess and monitor the quality of service provided.

The enforcement action we took:
We have cancelled the registration of this service.