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Beacon House Nursing Home

Inspection report

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Date of inspection visit:
14 January 2019
15 January 2019

Date of publication:
25 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Beacon House Nursing Home on 14 and 15 January 2019.

Beacon House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beacon House Nursing Home can provide accommodation and nursing care for up to 22 people with general nursing needs and end of life care. At the time of the inspection 16 people were receiving care at Beacon House Nursing Home.

We previously inspected Beacon House Nursing Home on 25 and 27 July 2018 and we identified breaches of regulation in relation to person-centred care (Regulation 9), dignity and respect (Regulation 10), need for consent (Regulation 11), safe care and treatment of people using the service (Regulation 12), safeguarding service users (regulation 13), good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper person employed (Regulation 19). The provider was rated inadequate in the key questions of Safe and Well-led and overall. The key questions of Effective, Caring and Responsive were rated requires improvement. As a result, the service was placed into Special Measures.

At the time of this inspection the service did not have a registered manager. The provider had recruited a manager in November 2018 and they were in the process of registering with the Care Quality Commission. 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.

The provider had a medicines policy and procedures in place but these were not always followed which resulted in issues with administration. Adequate checks were also not undertaken to ensure records of medicines were accurate.

The provider had not ensured that risk management plans were always developed to provide guidance for staff on how to reduce possible risks to people and others when providing care and support.

A process was in place for the recording of incidents and accidents but information was not always recorded in relation to the actions taken to reduce the risk of reoccurrence.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. Support was not always provided in the safest way.

The provider had not ensured some areas of the home were clean and suitable for the purpose for which they were being used for example we identified concerns with the cleanliness of bathrooms and food storage.

Some members of staff had still not completed training identified as mandatory by the provider but improvements had been made in relation to staff induction and supervision.

We saw care workers, in general, treated people in a kind and caring way but there were occasions where there was a lack of communication or focus on the needs of the person.

Care plans and other records relating to people using the service did not always provide up to date information relating to the support they needed.

The provider had a range of quality assurance processes in place but these did not always identify areas where improvement was required.

People were supported in accessing healthcare professionals but if there was a change in their support needs the information was not always transferred into the care plans so staff had all the necessary information about the support people received with their healthcare needs.

Improvements had been made in relation to recruitment, identifying and reporting safeguarding concerns and staffing levels.

People complemented the food options provided at the home and felt they had choice in relation to food and drink.

Personal Emergency Evacuation Plans provided sufficient and up to date information to enable people to be evacuated safely from the home in care of an emergency.

People felt the care workers were kind and caring and treated them with dignity and respect when providing care.

People knew how to raise concerns regarding their care and they told us they felt safe when supported by the staff.

We found six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person centred care (Regulation 9), need for consent (Regulation 11), safe care and treatment (Regulation 12), premises and equipment (Regulation 15), good governance of the service (Regulation 17) and staffing (regulation 18). You can see what action we told the provider to take at the back of the full version of this report.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service has been in special measures and has been inspected within six months as we state in our guidance. As insufficient improvements have been made and there remains a rating of inadequate for the key question of well-led the service therefore remains in special measures.

Services in special measures are 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.

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?

Requires Improvement

Some aspects of the service were not safe.

Risk management plans were not always developed to provide guidance for staff on how to reduce possible risks when providing support to people.

There were issues with the administration of medicines and adequate checks were not undertaken to ensure records of medicines were accurate.

A process was in place for the recording of incidents and accidents but information was not always recorded in relation to the actions taken to reduce the risk of reoccurrence.

Improvements had been made in relation to staff recruitment, identifying and reporting safeguarding concerns and staffing levels.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People did not have maximum choice and control of their lives and staff support was restrictive. The policies and systems in the service did not support good practice.

Some members of staff had still not completed training identified as mandatory by the provider but improvements had been made in relation to staff induction and supervision.

People complemented the food options provided at the home and felt they had choice in relation to food and drink.

People were supported in accessing healthcare professionals but if there was a change in their support needs the information was not always transferred into the care plans.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Care workers, in general, treated people in a kind and caring way but there were occasions where there was a lack of communication or focus on the needs of the person.

People felt the care workers helped them maintain their independence and involved them in decisions about their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not always accurate and their care was not always provided in line with their wishes.

Activities were not structured or planned to meet people's areas of interest and were not always meaningful.

People knew how to raise a concern regarding their care.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had audits and other checks in place but these were not effective to identify all areas where improvement was required so these could be addressed.

People told us they felt the service was well led. Staff felt they were supported and liked working at the home.

Beacon House Nursing 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.

This comprehensive inspection took place on 14 and 15 January 2019 and was unannounced.

The inspection was carried out by an inspector and a member of the medicines team on the first day and two inspectors on the second day.

We reviewed the information in notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with two people who used the service, the manager, the deputy manager, the clinical lead, the provider and five staff. We also observed the care provided and interactions between staff and people using the service, we looked at records, including seven people's care plans, the daily care records for four people, two staff records, medicines administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in July 2018, we found a breach of regulation in that medicines were not managed safely. At this inspection we found the provider had made some improvements, however medicines were still not being managed safely.

We looked at medicines administration records (MAR) and care plans for seven people. The provider had recorded important information such as the name, photograph and medicines sensitivities to help staff give people their medicines safely. Care plans and risk assessments were not always person specific and lacked details about people's medical conditions and current medicines lists. For example, staff measured blood glucose levels regularly for people with diabetes, however care plans did not include details of the desired blood glucose level for individuals and therefore staff could not act on the results.

Some people were prescribed medicines to be given when required. There was guidance in place to advise staff when and how to give these medicines and these were kept with the MAR. However, these were not always kept up to date and we saw one example where the information was for a medicine that was no longer prescribed. Staff did not record details of when and why these medicines were administered to people and therefore it was not always clear why medicines were given to people and if they were effective.

One person was receiving a medicine in the form of a patch, however there were no records in place to document the location for the application and removal of the patch. This meant that the staff did not have the information they needed to apply these patches safely and in line with the manufacturer's guidelines.

We saw evidence that people's medicines had been periodically reviewed by their GP. This meant people were being prescribed medicines appropriate for their health condition. However, we saw a note made in December to stop a medicine for a person and on the day of inspection, we found the staff had continued to administer this medicine. Staff had failed to follow this up and this meant that the person was receiving a medicine that they should not have had as the GP had stopped it.

During our inspection we observed medicines being administered by nursing staff. We observed staff administer inhaled medicines. However, we saw for one person the inhaler was not used according to the manufacturer's instructions. Therefore, the medicine may not have the desired therapeutic effect. Staff told us that this was the person's preferred way of using the inhaler even though it was not the indicated and most effective way of delivering the medicine to the person. Staff had not discussed this with the GP or chemist for guidance on the management of the person's condition.

In our previous inspection we found that the medicines policy had not been reviewed since September 2010. At this inspection we saw the provider had a new policy in place to manage medicines dated July 2018. The policy also included information about the safe disposal of medicines. The clinical lead told us that there were no processes in place to assess the competency of nursing staff, although the provider policy stated that the competency of staff administering medicines should be assessed by a pharmacist. Therefore, the competency of staff in relation the administration of medicines was not assessed to ensure staff carried this

out in a safe manner.

In July 2018 we saw the provider did not have risk management plans in place and did not always assess the risks to the health and safety of people using the service in a comprehensive way. At the January 2019 inspection we saw some changes had been made but there were still issues with the assessment of risks.

We saw the risk assessment for nutrition for one person, which had been reviewed in December 2018, stated they did not have any issues with swallowing and this was a low risk. Other sections of the care plan we looked at identified the person had problems with swallowing and required a soft diet but this was not reflected in the nutritional risk assessment.

The risk management plans for using the stairs for two people stated they could use the stairs as they could mobilise but they needed to be supervised when doing so. During the inspection we saw the people walking around the home and accessing the stairs without supervision. This meant the risk management plan identified actions to reduce the risk which were not practical as staff were not available to supervise these people whenever they used the stairs.

We saw that where a person had been identified as living with a medical condition, such as epilepsy or diabetes, risk management plans had been introduced but these provided general information about the condition and did not relate to the person's specific needs. For example, for a person who was living with epilepsy the risk management plan did not identify the types of seizures experienced and did not provide guidance for staff as to what they should be looking out for and how to support the person when they had seizures.

The care records for one person identified they were living with a degenerative medical condition but there was no risk management plan in place to provide staff with guidance as to how they could reduce possible risks and provide appropriate care while promoting the person's independence.

This meant staff were still not being provided with appropriate guidance to enable them to reduce possible risks for people using the service.

At the previous inspection we saw checks had not been carried out to ensure pressure relieving mattresses were working correctly. At the January 2019 inspection we saw these checks were now carried out three times a day but the record forms only indicated if the mattress was working and not if it was at the correct setting for the person. The form did not include guidance for the care worker as to the correct setting for each person to ensure the pressure relieving mattress was providing the required support.

Support to people was not always provided in a safe manner. We saw one person who was brought into the lounge in a wheelchair that did not have foot plates. This resulted in their feet catching on the carpet as the care worker pushed the wheelchair, which exposed them to the risk of injury. We raised this with the care workers but they could not locate the foot plates for the chair so they used a pillow behind the person's knees and lower legs to ensure the person's feet were clear of the floor when the wheelchair was being moved.

We also saw two care workers who were using a hoist to move a person from a wheelchair to an armchair in the lounge. The care workers had not moved the foot plates from the wheelchair out of the way and the person's foot had become caught under the foot plate as they started to hoist them. We discussed our observations with the manager who spoke with the care workers and confirmed they would be reviewing their moving and handling training to ensure they fully understood best practice and how to ensure people

were supported safely.

Following the inspection in July 2018 we found incidents and accidents had not always been investigated and actions were not taken to reduce the risk of reoccurrence. At the January 2019 inspection we found some improvements had been made but the provider's process was not always followed.

The manager explained they were working with staff to ensure the incident and accident form was completed an incident or accident occurred. We looked at the incident and accident records and found there were no records on file for the period between June 2018 and 21 December 2018. The manager provided some additional incident and accident records from this period with the actions they had taken, written on the front page. Two incidents and accidents records had been completed at the end of December 2018. One incident related to marks found on a person's wrist and we saw a body map had been completed. There was no record if any action was taken to deal with the incident and the person who had completed the form, had not signed it.

We saw information relating to another accident which occurred when a person had a fall but this had not been recorded under the incident and accident process. It had been recorded in the nurse's notes in the person's care plan folder but there was no record of any further actions that had been taken. The manager provided email evidence that the person's GP had been contacted and other action had been taken but there was no record as part of the incident and accident process of the action taken to deal with the incident. This meant trends had not been monitored so learning took place and action had not been identified to reduce the risk of reoccurrence of similar incidents and accidents.

The issues highlighted in the paragraphs above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured the premises were clean and suitable for the purpose for which they were being used.

During the inspection we found the tinned and dried food was stored in an external cupboard in a courtyard outside the kitchen. The cupboard contained tinned food and bags of flour and rice, some on a small elevation from the floor. The cupboard was made of brick but had a wooden door which did not close. This meant the bags of rice and flour were not being adequately protected from the risk of contamination from rodents and other insects.

We saw the toilets in a number of communal bathrooms were stained and the toilet bowls appeared black. The shower in one bathroom appeared to have mould on the shower tray and the tiles. This was despite each of the bathrooms having a cleaning checklist to show they were cleaned every day. This meant the bathrooms were not maintained in a suitable and clean enough condition for people using the service to use.

The fire door from the lounge to the courtyard area was kept open by a hook attached to the external wall and did not have an automatic closing system linked to the fire alarm system. When we raised this with staff they explained the hook was only used when wheelchairs or trolleys were being taken through the door but we saw during the inspection that the door was regularly left open for periods of time. The doorway also led to the area used by people as a smoking area in the courtyard. This meant the fire door could not provide appropriate protection in case of a fire as it was regularly left open by both people using the service and staff used the door to access the other parts of the home including bedrooms and the smoking area.

The issues highlighted in the paragraphs above are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people using the service and asked them if they felt there were enough staff on duty. They told us that sometimes there were enough but not at other times. They said "Sometimes I have to wait but most of the time it is ok. The staff are always telling me that they are lacking today for one reason or another, but it doesn't stop me doing what I need. If I use my call bell they always come straight away, night or day" and "Sometimes yes and no, most of time[staff]say we are lacking staff today, sometimes [we] have to wait for things."

At the inspection in July 2018 we identified that the provider did not always deploy sufficient numbers of suitably qualified staff to meet the support and care needs of people using the service. At the January 2019 inspection we found the number of people using the service had decreased which had slightly increased the staff to person ratio.

There were four care workers on the rota between 8am and 2pm with three care workers between 2pm and 8pm. There was a nurse on duty between 8am and 8pm. At night there was one care worker and one nurse between 8pm and 8am. At the time of the inspection the deputy manager confirmed there were 16 people using the service of which eight people required the assistance of two care workers, five people who needed support from one care worker with three people who sometimes needed the support of one care worker.

During the inspection we saw there were times in the day when people were left in the lounge for up to 20 minutes without support from a care worker. Care workers were also required to organise activities as part of their role in addition to providing care.

On both days of the inspection we saw that people were not supported to come into the lounge until late morning as the care workers were busy providing support and personal care in people's bedrooms.

During the previous inspection we saw the provider had not raised safeguarding alerts with the local authority as required, to ensure people received appropriate and safe care that met their needs. During this inspection we found there had been improvements in relation to safeguarding.

We asked people if they felt safe when they received care and support from care workers and nurses. Both people we spoke with told us they felt safe and they felt staff were gentle when they helped them move and they were confident with them.

We saw the manager had introduced a new checklist for staff responding to a safeguarding concern to explain the process and what action should be taken. There had been no safeguarding concerns raised since the last inspection. The manager explained they were in communication with the local authority to identify any safeguarding concerns which had been previously raised and ensure the related documentation was on file.

At the previous inspection we saw the Personal Emergency Evacuation Plans (PEEP) were in place for people using the service but these did not include information in relation to how they should be assisted to evacuate the building. During the inspection in January 2019 we saw the PEEP documents for people living at the home had been reviewed and now included guidance on how to undertake a horizontal evacuation, where the person is moved to a safe location on the same floor to await the emergency services. There was also guidance for staff on how they should support the person to leave the building.

We found that fire doors, including those to access the stairwell have been checked and made good, so that they closed properly and would be able to sufficiently contain fire and smoke in the event of a fire.

We saw clinical waste had been disposed of appropriately with specific bins in place and in general chemicals including cleaning products and washing up liquid were now stored securely but we did see shower gel and shampoo had been left in the communal bathrooms.

During the inspection in July 2018 we saw the provider had a recruitment process but this was not always followed. At the January 2019 inspection we saw improvements had been made and the provider was now meeting the regulation. We looked at the recruitment records for two care workers that had joined the home since the previous inspection and had recently completed their induction. The records included the applicant's employment history, their right to work in the UK and proof of their identity. The recruitment records for one care worker included two references but the records for the second care worker had one reference on file. We saw the manager had sent a follow up email to the employer who provided the second reference on the morning of the inspection.

Records showed care workers and nurses had completed infection control training during 2018 and had access to protective aprons and gloves which we saw they used when providing care and support to people.

Requires Improvement

Is the service effective?

Our findings

During the last inspection in July 2018 we found a breach of regulation in that the provider was not always providing support in line with the principles of the Mental Capacity Act 2005. During this inspection we found whilst some improvements had been made whey were still not always working within the principles of the Act.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We saw a new mental capacity assessment form had been introduced but we saw the form that was being used for assessments in relation to specific decisions included questions that did not relate to the ability of the person to consent to that decision. For example, we saw the mental capacity assessment for one person which had 'Personal hygiene' written at the top of the page. The mental capacity assessment included questions relating to the person's ability to decide when they wanted to go to bed and get up, if they could manage their own medicines, use hearing aids, decide if they should see a GP or dentists and decide what they wanted to eat and drink. These questions do not all relate to the activity of personal care and the person's ability to consent or make decisions in relation to one or all these specific issues do not impact on their ability to consent to personal care.

This also occurred in relation to mental capacity assessments relating to medicines as questions about the person's ability to undertake specific activities which did not directly affect if they could consent to the administration of medicines were included in the assessment.

The mental capacity assessment for this person had been completed by a member of staff identified as a health advisor but the training records state the member of staff was a senior care worker. The form was also signed by another member staff who was identified as an advocate for the person. The care plan however did not explain why an advocate would be used when the person had relatives who could have been involved in the person's care. Also, it was stated the assessment was done in the best interests of the person. Completing an assessment of a person's capacity to consent to specific aspects of their care is not a best interests decision.

A best interests decision form has been completed for the provision of personal hygiene and we saw the

form included a section to record the discussion with the person's friends and family but the only information noted was the name of a relative and their telephone number. There was no record of the relatives being consulted and the best interests form was signed by two members of staff. The deputy manager explained the person's relatives were not always involved in decisions about the care but we saw the end of life section of the care plan for this person stated states the relatives were involved in the discussion. The way relatives were being involved in the care of the person was therefore not consistent.

The mobility section of this person's care plan stated a DoLS was in place to restrict the person from leaving the home but a DoLS application had been made in June 2017 and a decision had not been received from the local authority. Therefore, a DoLS authorisation was not in place to deprive the person of their liberty to leave the home.

The consent to care forms used in relation to provision of care, taking photographs and sharing information had been completed on each person's care plan folder. We saw the form for one person stated they were unable to sign and the form was signed by and witnessed by two staff members. The mental capacity assessment for the person indicated the person had capacity to consent to care. There was no indication as to the reason the person could not sign or if the document had been discussed with them and their consent could be given verbally.

The above meant that people were not always supported to consent to their care and mental capacity assessments were not always appropriately carried out to assess the person's ability to consent to a specific aspect of care.

The issues highlighted in the paragraphs above are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained DoLS applications had been made to the relevant local authority for people who had been assessed as lacking capacity to consent to care but some of these applications had been made in 2017 but had not yet been reviewed or authorised. The manager confirmed the local authorities had been contacted to get updates on the applications. This meant the information included in the DoLS application could have been out of date and did not provide an up to date assessment of the person's capacity. We discussed this with the manager who confirmed new DoLS applications would be submitted for people who had been waiting for an outcome since 2017.

Following the previous inspection in July 2018 we found the provider did not have appropriate arrangements in place to support staff to fulfil their roles. During the January 2019 inspection we saw there had been some improvements but some staff had still not completed training identified as mandatory by the provider. The deputy manager provided the training records for all the staff who could work at the home following the inspection. We reviewed the training records relating to basic life support, moving and handling, infection control, health and safety and fire safety. We did note that most of care workers and nurses had completed the training in relation to fire safety, health and safety and infection control. The records indicated three nurses and 11 care workers had not completed moving and handling training in 2018 and basic life support training. The records also indicated the clinical lead had not completed any of these five training courses during 2018 so they were fully up to date with training in these topics.

We also saw three of the eight nurses had completed training during 2018 in the management of a Percutaneous Endoscopic Gastrostomy (PEG) as there was one person using the service who received their medicines and nutrition in this way. A PEG is a way of introducing food, fluids and medicines directly into the stomach of a person by using a thin tube which has been inserted surgically through the skin and into

the stomach.

The training records indicated none of the nurses had completed management of medicines training during 2018 even though this had been identified at the last inspection. The clinical lead told us they had been developing an assessment of competency in the management of medicines but this had not been introduced.

The records for three nurses indicated they had completed training with another provider, via the NHS or a GP but there was no indication of the dates they completed the training courses that had been undertaken outside the home.

We saw the training records showed only one of the four housekeeping staff had completed Control of substances hazardous to health (COSHH) training. This training relates to the safe handling of chemicals and hazardous substances which includes those used for cleaning. We also saw only one of the housekeeping staff had completed fire safety, infection control and health and safety training during 2018.

This meant staff had not completed training to enable them to carry out their role in a safe and appropriate manner.

The issues we found highlighted in the paragraphs above are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection in July 2018 we saw staff did not have regular supervision meetings or an annual appraisal. At this inspection the manager told us they had met with each of the staff to have an initial one to one meeting since they joined the home. The manager had plans to have regular meetings with staff on either a one to one or group basis. We saw the notes from these meetings. Annual appraisals were to be completed during 2019.

New staff completed an induction and shadowed an experienced staff member before they started their new role. We saw records demonstrating new staff undertook a period of shadowing and completed an induction.

Both people we spoke with complimented the food. They said they had the choices they needed, that the chef was brilliant and went out of their way to offer choices or make something different, if they wanted. They liked the food and ate well. During the inspection we spoke with the chef who explained the menu planning involved people using the service. The chef demonstrated a good understanding of people preferences and they also accommodated different tastes. For example, we saw different meals were made available for two people and food was provided to meet cultural preferences.

We saw the chef had a good understanding of people's additional nutritional needs if they were at risk of malnutrition. They ensured people who required fortified meals and other extras such as smoothies and hot chocolate received these to meet their nutritional needs. We noted the chef had limited understanding in relation to diabetic and texture modified diets and we raised this with the manager during the inspection.

People were supported to access healthcare professionals including the GP, district nurses, dietician and the wheelchair service. Visits from healthcare professionals were recorded in the notes section but we did see that information recorded was not always transferred into the care plans or risk assessments to ensure staff had access to up to date information. This was discussed with the manager during the inspection.

There had been no new admissions to the home since the last inspection so we could check on the assessments of their needs prior to their admission to the home. We saw assessments of people's support needs had been completed before they had moved into the home prior to the last inspection in July 2018.

Requires Improvement

Is the service caring?

Our findings

We saw that in general the care workers treated people in a kind and caring way but there were examples of where there was a lack of communication or focus on the needs of the person.

We observed one person, who could propel their own wheelchair, was brought into the lounge by a care worker who was pushing their wheelchair. The person then told the care worker they must tell them before they started to push their wheelchair when their hands were still on the wheels. They explained to the care worker that their hands would be pulled forward which could result in them falling from the wheelchair. The care worker apologised and told the person they were not aware that could happen.

We observed lunch on the second day of the inspection and we saw staff did not always communicate with people when they were supporting them with their meals. We saw staff placed aprons or paper napkins without asking them if they wanted them or explaining what they were doing so they were not given a choice. There were jugs of water and squash drink available but when care workers brought a person a drink they just referred to the drink as juice and did not tell the person the flavour or offer them a choice. We observed staff were discussing the care provided for specific people in front of other people in the lounge which did not show respect for their privacy.

Nevertheless, we saw the staff showed genuine affection in relation to people when talking about them. They knew about the person's individual likes and needs. There was an emphasis on promoting people's choice and they all talked about this and how they would offer choices.
Staff told us they spoke a range of languages which were the same as the people they were supporting and some share the same cultural background. The staff knew their likes and cultural needs. We also noted some good interactions between some staff and people eating their lunch and staff spoke with people in their preferred language during the meal.

People we spoke with told us they were happy with the care they received and the staff were kind and caring. They said, "I feel reassured that the staff team know me and how I like to be cared for. I am nervous if I do not feel comfortable with the staff and the ones here all know what they are doing, they train up new staff well and I am happy" and "Yes they are alright".

We asked people if the care workers talked to them about their life and what was important to them. One person said, "They are interested and talk to me about my family and ask me questions, not just about care but also about what is important to me."

People told us the staff helped them maintain their independence whenever possible. They said "I used the walking frame yesterday because I want to practice this and they supported me and we are going to try again today. I am able to do anything I can for myself, they do not try to do things for me'' and "They are always let me do what I can myself, in fact they encourage it and try to get me to do it."

People told us they were involved in the decisions about how their care was provided. They commented

"The do ask me, and it is up to me, they listen and they know what I like" and "They are very good at that, they always ask me what I want to do, where I want to be, what I want to wear, they give me choices and they respect this."

At the previous inspection in July 2018 we saw people were not always supported to be involved in their community and follow their religious beliefs. During the inspection in January 2019 we asked people if they had been supported to follow their religious beliefs. People told us
"My [family] take me to the Gurdwara'' and "'I am a catholic and am making contact with the local priest. I am happy to do this myself. The home supports my religion and I do not have any concerns." Staff we spoke with said people used to go to their places of worship but with the colder weather it meant this did not happen as often as they would like. The manager explained they were in the process of identifying local religious and community groups who would be able to visit the home and meet the cultural and religious needs of the people using the service.

Requires Improvement

Is the service responsive?

Our findings

During the previous inspection in July 2018 we found a breach of regulation because people's care and support was not always provided in a person-centred way based upon their wishes and preferences. The care plans were task focused and information was not always accurate and consistent.

At the inspection we found the manager had started to review the information in the care plans but information was still not accurate and did not provide staff with a clear picture of the support people required.

At the previous inspection we saw one person had been assessed by the wheelchair service and guidance had been provided for care worker to support the person to move from their bed to an armchair in preparation to use a wheelchair. During this inspection we saw a wheelchair had been provided for this person to enable them to move around the home and not be in bed all the time. We looked at the records of care completed by the care workers and we saw between 1 January 2019 and 14 January 2019 the person had refused to be moved from bed on one occasion and there were no other record of care workers encouraging the person to transfer to the armchair or wheelchair. This meant the person was not being regularly assisted to be more mobile.

Also during the previous inspection, we identified one person who was unable to have a shower as they did not have the appropriate equipment to enable them to access the shower safely. At the inspection in January 2019 the person told us ''The only thing is, when I first came here, I used to have shower but since I nearly had accident, [they] now don't give shower anymore and I would like one.'' We asked the manager who confirmed a referral had been made to the occupational therapy team in September 2018 but the person had not been visited yet to be assessed for equipment and they were waiting for an appointment to be made for the assessment.

The records for one person indicated they were living with diabetes and the records from a GP visit on 20 December 2018 indicated the GP had directed the staff to stop administering medicines to control the diabetes as it would now be managed using diet. The multi-disciplinary team records showed a dietician had been contacted by the home and visited the person on 8 January 2019. The dietician had recorded guidance for staff on appropriate food types for the person to assist with the management of their diabetes including not missing meals and making fruit available with other appropriate snacks during the day. This information had not been transferred to the nutrition or diabetes care plan and the chef was not aware of the information provided by the dietician. We also noted that the nurses were still administering the diabetes medication at the time of the inspection even though the GP had confirmed it should stopped as the MAR chart had not been amended to indicate the GP's decision.

The care plan summary document for one person indicated they could eat a normal diet but the nutrition care plan stated the person was at risk of choking and required a soft diet. This was also reflected in the 'at a glance' document which had been implemented to provide an overview of the person's care needs. The summary document also stated the person needed to drink a lot of fluids as they were at risk of urinary tract

infections but this was not reflected in the care plan. The care plan for this person also identified they wanted to have a shower instead of a bed bath. We looked at the records for personal care which had been provided between the 1 January 2019 and 15 January 2019 which showed that they had four showers during this period with the rest being bed baths. The records of the care provided which were written by the care workers did not indicate if the person was offered a shower on the other days or if the person had refused a shower.

The records for a second person also stated they preferred a shower instead of a bed bath. The records of the care provided each day indicated they had only bed baths since the 1 January 2019 and the records did not indicate if the person had been offered a shower and if they had refused.

In the care plans we looked at the gender of the person it referred to kept changing throughout some of the care documents which indicated the information for the person was inaccurate and had not been personalised.

We asked people for their views on the activities which were provided by staff. They told us "It would sometimes be nice to do some more things. I really enjoyed going to feed the ducks at the local canal and watching the boats. There is not a lot to do, but it is nice when we get together' and "I am happy doing what I do.''

During the previous inspection we saw that there was a lack of meaningful activities for people using the service and at the inspection in January 2019 some improvements had been made but activities were still not planned and were not meaningful. The activities board on the wall listed pamper yourself days, reading, one to one chit chat session and international hug day. We saw there had been a delivery of equipment including a sensory bubble tube and a table top game involving catching a plastic fish in an inflatable pond. At one point there were two televisions on in the lounge, one with a film and the other on playing music which meant the sounds were competing and made the lounge area noisy. Not everyone in the lounge were watching the television or listening to music so it was not a relaxing space for them. We did see pictures on the wall of birthday parties and other events but the planned activity in the lounge during the day was not clear. There was also no organised activity planned with people who were cared for in their bedroom.

The deputy manager set up the new equipment in the lounge during the inspection. Any activities were organised by the care workers on duty in addition to their care responsibilities. The manager explained they were identifying suitable training for the provision of activities for care workers and they were reviewing the choice of activities provided. Staff told us they took people out to the canal to feed the ducks but activities outside the home were not undertaken when it gets colder.

The issues we found highlighted in the paragraphs above are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the previous inspection we saw a sign on the front door restricting the time people could be visited in the home to between 11.30am and 7.30pm. At the January 2019 inspection we saw the sign had been amended to state that if a visitor wanted to come to the home outside of these hours they had to contact the nurse in advance.

People's wishes in relation to how they wanted their care provided at the end of their life were identified in the care plan. We saw there was an end of life care plan completed for each person. The care plan identified when a discussion with the person about their wishes occurred and recorded their wishes.

We asked people if they knew how to make a complaint and they confirmed they were aware of what to do. Their comments included "Yes that is not a problem" and "I am happy talking to any of the managers if something is wrong and they listen. During the inspection we looked at the complaints records and we saw they included information about the complaint, the response to the complainants and any actions taken to resolve the issue.

Inadequate

Is the service well-led?

Our findings

At the inspection in July 2018 we identified the quality assurance processes the provider had in place were not effective and did not always provide the necessary information to enable improvements to be made. At this inspection we found the provider had introduced some new processes to monitor and assess the quality of the care provided but these did not always provide information that was necessary to identify issues where improvement was required.

We saw daily audits of MARs were carried out by nursing staff from December 2018. The manager told us that they carried out random spot checks and gave staff feedback. However, we saw evidence that the audits were not robust and were not being completed accurately. On the day of inspection, we found that a person was still receiving a medicine that their GP had previously asked to be stopped and there was a discrepancy between what was recorded by staff on the MAR and the quantity of one medicine. As a result, people were not always protected against the risks associated with medicines

Monthly checks were carried out on the window restrictors in place around the home but these checks were only in relation to them being fitted and not if they were working correctly. There was therefore a risk that assurance was being received when the restrictors might not have been effective in making sure windows did not fully open.

We saw a range of environmental audits had been introduced but some aspects of the audits were not clear and where they had been completed there was no indication of what action needed to be taken to resolve the issues identified. The 'residents room' audit completed on 17 December 2018 identified that the wiring in nine rooms needed tidying but there was no evidence of any follow up action completed to make this issue good. The infection control audit focused on the facilities provided at the home and the procedures for example hand washing but did not review the cleanliness of the home. As identified earlier in the report we saw the bathrooms were not well maintained, which a robust audit would have identified.

In the environmental audit also completed on 17 December 2018 we saw notes had been made identifying areas requiring action, for example in relation to the carpet and floors which needed repair or had a tear which needed attention. There was no record of any action being taken to resolve these issues.

An audit of the care plans for people using the service had been completed when the new manager started at the home but these had not identified the issues found during the inspection. This issue was identified at the inspection in July 2018. For example, the discrepancies noted between the frequency some people received their showers and their preferences about personal care had not been noted so these could be rectified.

Therefore, the quality assurance processes put in place were not always robust enough to provide the information required and there was a lack of recording about whether actions had been taken to make improvement where issues were identified.

The issues we found highlighted in the paragraphs above are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had introduced a range of new audit forms to record and monitor the reasons for incidents and accidents and we saw them in the folder but they were not in use yet. The use of the audit forms were due to start from the end of January 2019.

We asked people for their views on the home and the staff. They told us "They make every effort to make everyone feel special, when a new resident moved in they make them feel like they are the most important person in the world, they really do'' and "I have met the new manager and [they] made an effort to say hello."

We spoke with staff and asked them what they felt was the best thing about working at Beacon House Nursing Home. Their comments were positive and they said, "Before I joined never realised people lived this way, safe here and not ignored, time to give them attention and support and care, it feels really nice to work with them", "Makes me happy looking after elderly people like my family, spending time with them, very friendly and they need us to look after them properly. It is their house and we look after them properly", "I like to work as a team, I appreciate they help me a lot, good communication and [senior staff] tell me what to do and help me with everything", "Trained from here, the provider is very helpful, whenever request holidays, [they] give this, pay good money. I am very happy all the time", "Manager is very good with us, both the deputy manager and clinical lead are very good and I love them" and "It's a family atmosphere, management [is] very good, take care of whatever is possible in their hands, go out of the way to do whatever the best they can do. I just love this job, passionate about this job. In a day I feel if you give and get a smile, I am more than satisfied."

We also asked staff what they thought would make the home better and they told us "Too early to say", "Already changing everything, new plans, getting better -everything change all new manager listens to what we need, for example anything we tell him and he gets it for us", "Think it is ok and would not want to change anything", "Nothing to change as everybody is good but if we are more competent, cooperative and team work with working on existing qualities all are very good" and "The nurses are all very supportive of each other."

Staff told us they felt supported and their comments included "I feel supported, everything [is provided] when need help [with] anything. Regular meetings, [the] last one was two weeks ago. The new manager is a nice guy, new plans [for the home], very friendly, try to do everything according to him and he listens to us" and "The manager is very supportive, boosted us and is happy. He has good ideas, he listens to our ideas and it doesn't feel like I am working."

The manager told us relatives of people using the service had been contacted via email in January 2019 asking for their comments on the service. The last meeting with relatives occurred in early 2018 and a separate meeting with relatives had not yet been arranged but they were planning to invite them to attend the residents' meeting planned for the end of January so they can support their family members and provide feedback.

Following the last inspection in July 2018 the provider and senior staff have worked closely with the local authority and the Clinical Commissioning Group, who commission care at the home, to identify and make improvements at the service.

The provider had also recruited a manager in November 2018. The home last had a registered manager in

November 2015. The manager is in the process of registering with the CQC. There is also a deputy manager in post.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure the premises and equipment used by the service were clean, suitable for the purpose for which they were being used and properly maintained. Regulation 15 (1) (a) (c) (e)