Victorguard Care Limited

The Beeches Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Beeches Care Home is a care home providing personal and nursing care to older people and people living with dementia. The service accommodates up to 60 people over two floors in one building. On day one of the inspection, 29 people were using the service. On day two of inspection, 28 people were using the service.

People's experience of using this service and what we found
People were not safe. On the first day of inspection we had serious concerns regarding the inadequate systems and processes which failed to protect people from the risks of infection. On the second day of inspection, we found infection prevention and control had significantly improved throughout the home.

Risks to individuals were not appropriately assessed and managed. Medicines were not always managed safely.

Staff we spoke with told us there were enough staff to meet people's needs. However, during the COVID-19 outbreak and as staff were taking their annual leave, due to the end of the leave year, there were times when staffing was stretched. Health professionals involved in people's care told us delays in staff reporting important updates about people's health status in a timely way presented difficulties in accessing the support they needed.

Staff were recruited safely. The management team understood how to report safeguarding concerns. People we spoke with mostly felt their relatives were safe but some raised concerns about staffing levels.

Systems and processes for monitoring quality and safety of the service were not effective. There was a lack evidence of action taken in relation to issues identified in order to promote safety and drive improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published December 2017).

Why we inspected
We received concerns in relation to infection control and management of risk. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Beeches Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Beeches Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors and an Expert by Experience carried out the inspection on day one. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service, they made telephone calls to relatives of people living at The Beeches but did not visit the service. Two inspectors carried out the inspection on day two.

Service and service type
The Beeches Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We did not give notice of this inspection but made a telephone call, on both days of inspection, to the registered manager on our arrival at the service to let them know we were there.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority, Healthwatch and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, the project and quality lead and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. After the first day of inspection, we sent a letter to the nominated individual with a summary of our concerns and asked them how they would address them. We reviewed their response and actions.

We spoke with eight members of staff. We spoke, on the telephone with nine relatives of people who used the service about their experience of the care provided. Due to COVID-19 we currently minimise the time spent in services. Because of this, we shared contact details with the registered manager for any staff or people living at the home who wished to speak with us.

We reviewed a range of records. This included three people's care records, handover records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the manager and nominated individual to validate evidence found.

We made an organisational safeguarding adults referral to the local authority regarding this service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● Preventing and controlling infection was not managed safely. On the first day of inspection we had serious concerns regarding the inadequate systems and processes which failed to protect people from the risks of infection. For example, personal protective equipment (PPE), wasn't used effectively, hand sanitiser was not freely available and social distancing was not promoted.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day of inspection, we found infection prevention and control had significantly improved throughout the home. There were clear instructions for visitors to the home to ensure the risk of spreading infection was minimised. PPE and hand sanitiser were readily available throughout the home. We observed staff wearing PPE appropriately. Clinical waste bins were now in place in suitable locations within the home.

● Since our first visit, arrangements had been made to make sure staff were designated to each floor and the layout of the building had been adapted to help prevent the spread of infection. This also enabled suitable social distancing. Lounge areas, dining areas, medication rooms, and staff rooms were now available on both floors of the home.

● The new layout was, overall, working well. There were teething issues which the registered manager was aware of, such as how staff communicated between floors when the phone was in use and how people had access to their cups when they were being washed.

● Staff had received Infection Prevention and Control (IPC) refresher training to improve their awareness. The registered manager was arranging mop up sessions for staff who were unable to attend.

Using medicines safely

● On both days of inspection we found systems for managing medicines were not always safe.

● Not everyone who needed a 'when required' (PRN) protocol, had them in place. One person, who was receiving end of life care did not have any PRN protocols in place for their pain management. We found there was no Medication Administration Record (MAR) for this person within the medication room. It would be difficult for staff to know what medication had been provided or what was required to effectively manage the person's pain.

● One person's care record documented they continually refused their medication. This was also documented in handovers, but no action had been taken in response to this. There was no evidence to demonstrate the involvement of other healthcare professionals, whether a medication review had taken place or alternative approaches had been considered in the management of this person's medication.

● We raised this with the senior staff and registered manager who said they would address these issues

immediately.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● On both days of inspection we found risks to people's health and safety were not always identified, assessed and mitigated.
● One person's care record referenced the person was uncomfortable with the use of a hoist and a sling. This person's moving and handling risk assessment had not given any consideration to how this risk was to be managed. There was no record of what alternative equipment or approaches had been considered to put the person at ease.
● People's food and fluid intake was recorded. However, the recording of food was not specific enough to identify the exact amount someone had eaten. For example, one person had 'biscuits' recorded and 'sandwiches'. This may make it difficult for healthcare professionals to effectively monitor a person's weight loss or dietary needs.
● Where it was recorded a person did not have a sufficient fluid intake, it was unclear what action had been taken in response to this to ensure intervention was made at the earliest possible stage.
● We raised this with the registered manager who said they would address these issues as a priority.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● COVID-19 risk management plans were in place. A person's COVID-19 status, test results and vaccine record were contained within the person's electronic care record.

Learning lessons when things go wrong
● Audits in relation to infection control had taken place monthly. The audits dated November 2020, December 2020 and January 2021 all identified that staff were not up to date with infection control training, but action had not been taken to prioritise this training.

The lack of learning increased the risk of poor infection control within the service. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff we spoke with told us there were enough staff to meet people's needs. However, during the COVID-19 outbreak and as staff were taking their annual leave, due to the end of the leave year, there were times when staffing was stretched.
● Health professionals involved in people's care told us delays in staff reporting important updates about people's health status, resulted in delayed access to healthcare.
● Three relatives we spoke with raised concerns about staffing arrangements. One said, "Since [the new care provider] took over staffing levels have reduced considerably making communication difficult, as staff were never available to answer the phone or even contact us."
● At the time of inspection, we observed there were enough staff to meet people's needs. Staff responded promptly to the call bell and when people required support. Staff took time with people and talked with them.
● The registered manager told us they were currently in the process of actively recruiting staff and

acknowledged agency staff were still required to cover night shifts.
● The provider recruited staff safely. They carried out appropriate checks to make sure staff were suitable before they started working at the service.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with mostly felt their relatives were safe. However, one person said, "I do feel [my relative] feels safe, although there are persistent technical issues when [my relative] presses the call button, staff are taking too long to respond. Often, they can take 45 minutes and more to respond."
● Training records showed the majority of staff had completed safeguarding training.
● Referrals to the local authority safeguarding team had been made as needed.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- Significant shortfalls were identified at the inspection. The provider was in breach of two regulations across two key questions; the service has been rated inadequate overall and placed in special measures.
- Systems and processes for monitoring quality and safety were not effective. The management team carried out a range of audits, but there was a lack of evidence of action taken in relation to issues identified in order to promote safety and drive improvement.
- The last medication audit was completed 8 March 2021. It had identified PRN protocols were not in place and this had been added to an action plan. The registered manager sent the medication action plan to CQC following the inspection. The timescale to put PRN protocols in place was recorded as, 'ongoing to be completed by 19/03/21'. This did not recognise the urgency of the action required. The medication audit had not identified one person had been continually refusing their medicines.
- The care plan audits had not identified issues we found on inspection. For example, inadequate recording of food intake, no action recorded where people did not have sufficient fluid intake and risk assessments not meeting people's needs.
- Potential organisational risks were not effectively managed. On day one of inspection we saw the service had not followed safe infection prevention practice guidance.
- On the first day of inspection we saw handover documentation lacked detail and was incomplete. On the second day we saw this had improved. Each person was reviewed, it clearly stated who had a DNACPR and DoLS in place. Despite this there was no information within the handover to highlight what action was to be taken where a person continually declined their medication.
- All relevant information, including a person's COVID-19 status and whether they had received a vaccination was recorded on the NOURISH computer system. However, this wasn't documented separately on the handover documentation, which would make it difficult for agency staff or staff returning to work after absences to have an overview of people's current COVID-19 status.

This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

- The registered manager was aware of their responsibilities to report concerns to safeguarding, the CQC and other relevant agencies.

● The provider had notified us appropriately about significant events within the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The staff we spoke with felt supported and listened to by the management team. Between inspection dates we had been alerted by the Local Authority that one person had been admitted to hospital which was not in line with their wishes, as documented within their care record This was due to staff being unaware of what the person wanted.

● On the second day of inspection we saw symbols had been placed on people's doors to indicate whether they had a DNACPR in place, whether they had completed a 'ReSPECT' plan and what their wishes were in relation to hospital admission. The 'ReSPECT' process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices or 'no admission to hospital'. Staff we spoke with understood what the symbols meant to ensure people's wishes were met.

● People now had end of life care plans in place. We looked at two plans and found they were detailed and contained people's wishes for the end of their life.

● Staff had access to support via the employee assistance helpline and the local authority had also offered welfare support to staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● A 'Relatives/Friend' survey had been completed in November 2020 which indicated a general satisfaction with the service. We did not see evidence of feedback being sought from people who lived at the home.

● Six relatives told us they had experienced issues with communication with the service. Three said they had difficulty in getting through to the home by telephone and four said they did not feel they received effective communication in relation to their relative's health and wellbeing.

● Staff meetings were held on a regular basis. Following the first day of inspection the registered manager held meetings with all staff members which covered topics such as IPC, PPE, IPC training, social distancing and wellbeing. This was to address the shortfalls found at inspection.

● At the second day of inspection, there were activities taking place on both floors of the home, "flower bingo" and a small group choosing music to listen to and chatting.

● People had chosen to move floors to continue to socialise with their friends.

Working in partnership with others

● The local authority and Clinical Commissioning Group (CCG) told us there had been some difficulties in effective working with the service. This included working collaboratively with the local authority COVID team.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of infection. Risks to people's health and wellbeing were not managed effectively. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective in identifying and addressing issues within the service.