Le Flamboyant Limited

Beeston Lodge Nursing Home

Inspection report

15-17 Meadow Road
Beeston
Nottingham
Nottinghamshire
NG9 1JP

Tel: 01159259014

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11 December 2020
21 December 2020
22 December 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Beeston Lodge Nursing Home is a nursing home registered to provide personal and nursing care for up to 28 people, including people living with dementia. At the time of our inspection, on 11 December 2020, there were 26 people living at the service. Accommodation was provided over two floors and a lift was available. There were three communal living areas.

People's experience of using this service and what we found
Systems and processes in place were not sufficient to protect people from abuse or neglect and incidents were not reported effectively.

Risks to people were not reviewed regularly or kept up to date or actioned when required. Care plans and record keeping was poor which put people at risk of harm.

Staffing levels were not adequate, and the service relied heavily on agency nurses to cover shifts on a daily basis. Concerns were identified around the competency of nursing staff and training records were unclear.

People's nutritional needs were not managed effectively.

The environment was not clean, not effectively maintained and unsafe in areas. Measures for evacuation in the event of an emergency were insufficient and not up to date.

Infection control procedures were inadequate, staff were not wearing protective personal equipment (PPE) or following government guidance effectively. It was unclear if regular COVID-19 testing was performed.

Medicines were not managed safely, and it was not clear staff were trained or supervised in medicines management.

Lessons were not learned when things went wrong, this meant people were at risk of incidents reoccurring.

There was poor leadership and poor oversight of the service. Systems and processes to monitor the service were ineffective and this had impacted on the quality of care and treatment people had received.

We reported our concerns to the management team who sent us an action plan of improvements. However, following further concerns from the local authority and on our return ten days later, significant improvements had not been made, this left people at ongoing risk of harm.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
This service was registered with us on 12 March 2020 and this is the first inspection, therefore this service is inspected but not rated.

Why we inspected
We received concerns in relation to people's nursing care needs including; poor pressure area care, neglect of people, records not being up to date, a lack of staff, high use of agency nurses, poor use of PPE, lack of accurate weight recording, and a lack of referral to external health care professionals. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. 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.

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 have identified breaches in relation to Regulation 12 (Safe Care and treatment), Regulation 13 (Safeguarding from abuse), Regulation 15 (Premises and equipment), Regulation 17 (Good Governance), Regulation 18 (Staffing) Registration Regulation 18 (Notification of other incidents) at this inspection. These are requirements for the Health and Social Care Act 2008 (Regulated Activities).

After the first inspection site visit, we sent the provider a letter of intent of possible urgent enforcement action and requiring an action plan for immediate improvement of the concerns identified.

We were not reassured by the response from the provider and on 15 December 2020 we issued a notice of decision to impose conditions on the registration. These conditions prevented the provider from admitting new service user's without prior written agreement of the Commission and set specific compliance improvement required by 18 December 2020.

When we returned to the service on 21 December 2020, we identified that improvements set out in our notice of decision had not been made and people were still at risk of harm. We therefore wrote a notice of proposal to the provider proposing that we would take further enforcement action to remove the location of Beeston Lodge Nursing Home from the provider's registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated.	**Inspected but not rated**
Is the service well-led? Inspected but not rated.	**Inspected but not rated**

Beeston Lodge Nursing 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.

Inspection team
The inspection team consisted of three inspectors onsite over three separate days. Another inspector provided office support for enforcement procedures off site.

Service and service type
Beeston Lodge 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 did not have a manager registered with the Care Quality Commission. The provider is therefore legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We checked the COVID-19 status of people onsite when we were in the building.

What we did before the inspection
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.

We reviewed information we had received about the service and sought feedback from the local authority, healthcare commissioners and safeguarding team. We used all of this information to plan our inspection.

During the inspection-
We spoke to two people living at the service and four members of staff, including three agency nurses. We reviewed the care plans, risk assessments and daily records of four people. Multiple medicines records, maintenance records, personal evacuation plans and a variety of records relating to the management of the service, including audits, were also reviewed. During the inspection we spoke to a visiting GP and Advanced Nurse Practitioner. We spoke to members of the Continuing Health Care team, Care Consultancy staff, Local Authority representative, Safe-guarding lead, and a Tissue Viability Nurse.

After the inspection
We spoke to a member of staff and two relatives. We received feedback from relatives, social workers, and services people had been transferred to from Beeston Lodge, during the inspection.

Inspected but not rated

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This service has been inspected but not rated.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded against the risk of abuse. We were alerted to concerns about standards of care at the service by visiting external health care professionals. They had also alerted the safeguarding authorities around concerns relating to pressure area care.
- It was not clear from the training matrix what training staff had in safeguarding, or if it was up to date. This meant that staff may not be able to recognise signs of abuse and not know how to report it.
- There was a lack of reporting of incidents and accidents. People had sustained falls, and there had been medicines errors which had not been reported. This meant that potential abuse and neglect may go unreported.
- We found people's care had potentially been neglectful as four people had sustained tissue-damage due to poor pressure care. This had not been reported to the local authorities or Care Quality Commission (CQC) as required.
- Care staff had been told not to document concerns, but to report to the nurse in charge. Due to the high level of agency staff, this meant concerns were not passed on effectively. This put people at risk of abuse or neglect.

People were not kept safe from abuse and neglectful care. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- People's clinical care needs and risks, were not effectively assessed, monitored or reviewed and exposed people to the risk of harm.
- Handover documentation was poor and did not contain sufficient information to ensure the nurse on duty was aware of people's clinical needs and risks. There was a lack of orientation of agency staff to the service to ensure they were safe in the service.
- We found one person had an out of date mobility assessment stating they could walk with a frame however they were immobile and nursed in bed, this meant that staff would not know how to assist them safely.
- We found records of temperature and oxygen checks on people who had COVID-19 were not always completed, this meant that any deterioration in their condition may be missed.
- Concerns were found in the care and treatment of pressure ulcers. One person who developed a pressure ulcer had not had their skin risk assessment actioned when it identified high risk. Equipment in place was insufficient, and there was a lack of recording of the tissue damage sustained or dressings required. The impact of this exposed the person to further harm.
- One person who was at risk of malnutrition and who had lost weight had not had their malnutrition

universal scoring tool (MUST) updated or actioned when they were identified as high risk and a referral to a dietician had not been made. Another person's care records showed they had lost weight, however sitting scales were broken, so checks on their weight had not been completed for over two months.

● People were not protected against the risk of dehydration, and there was no evidence that records were monitored to ensure people were eating and drinking sufficiently. There was a lack of drinks and snacks available to people in the home. This put people at risk of harm.

● The kitchen did not have sufficient information about people's dietary needs, allergies or choke risk to ensure safe nutrition.

● Staff did not complete records until the end of the shift, this meant they would not be able to accurately remember what care every-one had received.

● The service did not maintain a safe environment. A stairway did not have secure locks, this meant people living at the service could access a steep staircase. Call bells were out of reach which put people at risk of harm of falls when trying to summon help

● People's personal evacuation plans (PEEPs) were not kept up to date. We found several PEEPs had incorrect names or room numbers on them and had not been updated when people moved rooms. A fire door downstairs was locked. This meant that people may not be evacuated quickly and safely in the event of an emergency.

● There were people at the service who were nursed in bed and were immobile who were in rooms upstairs. Due to the steep staircase, this meant their evacuation was difficult and required assistance from the Fire Service when they were moved out of the service.

Using medicines safely

● The service did not order, store, administer or dispose of medicines safely. Medicines profile charts did not contain enough information to correctly identify people, such as a full name, photograph or allergies to ensure safe administration of medicines.

● We observed two medicines records than only contained a first name and room number. However, room numbers were not up to date. The agency nurse administering medicines did not know people and told us they were administering medicines by room numbers. This meant we could not be sure that people received the correct medicine.

● People were not assessed for pain or given adequate pain relief. We found pain-killing medicines for one person had run out, this meant the person did not receive them when requested. We observed time sensitive medicines being significantly delayed.

● We found medicines stored at temperatures that were too high, which may reduce the effectiveness and cause people harm.

● We found medicines for disposal that had not been collected for a significant time and there was an excess medicines surplus in overflowing containers. We found sharps bins in a cupboard overflowing with hazardous waste. The medicines trolley was left unlocked and not secured to the wall. This put people and staff at risk of harm.

● Medicines records were not kept up to date, stock checks identified some medicines unaccounted for and others that showed a surplus stock, so we could not be assured they had been administered as recorded.

● Controlled drugs were not checked regularly, and some were missing, this had not been investigated or reported to the correct authorities.

Learning lessons when things go wrong

● Systems and processes to record, review and analyse incidents and consider actions to reduce further occurrence were ineffective.

● The manager told us there were accident and incident forms somewhere but could not locate them.

● There was no analysis of falls, accidents or incidents to identify themes, learn lessons and prevent re-

occurrence. We saw one person had fallen three times, but there was no evidence of follow up and monitoring of these falls.

Risk associated with people's physical needs were not safely managed. Medicines were not safely managed. Incidents had not been effectively reviewed to improve the care provided. Concerns were identified with nursing staff's clinical skills. Premises were not safe. This was a breach of Regulation 12 (Safe Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● The service did not protect people against the risk of infection, the service did not follow current infection control guidelines.

● Staff were using a communal toilet to don and doff PPE equipment which was lying around the room, this meant it could be easily contaminated.

● We observed staff not wearing PPE appropriately or washing their hands between people, staff were not wearing masks correctly and we observed gifts being brought into the home without decontamination.

● Staff knowledge of current guidance was limited. People were not being isolated effectively. PPE was not disposed of correctly and we observed open bins of rubbish. Outside, hazardous waste had been mixed with clinical waste and had not been removed.

● The service was not clean or hygienic, there was no regular cleaning of frequent touch points recorded. The domestic staff we spoke to had not received any training. The manager could not tell us what products were in use to clean the home. We observed areas of the home that were visibly unclean. Furniture was not wipeable and floors were not intact which impacted on them being sufficiently cleaned to prevent cross infection. The laundry room was not clean or organised.

● It was not clear from the training rota that staff were up to date with handwashing or infection control training.

The service was not clean, and the service was not cleaned in line with current guidance. Staff had not received appropriate training and cleanliness was not monitored effectively. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● There was a lack of permanent nursing staff at the service and staffing levels were inadequate. There had been a high turnover of staff and the service relied heavily on agency staff to cover nursing shifts. Staff did not always turn up for duty which left the service short of staff.

● The manager did not coordinate the staffing rota or book agency nurses and did not know who was on duty on a daily basis. The continuous use of agency nurses on a daily basis meant that information, record-keeping and nursing care was inconsistent which put people at risk of receiving poor care.

● The manager was unable to produce a dependency tool or a register of people's clinical needs to identify how many staff were required. They were unclear of who should be receiving 1:1 care, this put people at risk of harm if they were not receiving the care they required.

● Profiles of agency nursing staff on duty were not up to date. This meant the manager did not know the skills, experience or qualifications of the nurse on duty. The nurse on duty informed us they were mental health trained, which meant they may not have the correct skills to assess wounds.

● Concerns were identified with the competency of nurse's clinical skills, training and clinical leadership. There was no evidence of clinical supervision and gaps in training. Less than 50% of staff had hand-hygiene competencies logged. The manager did not have any training logged on the training or competency records.

There were insufficient staff to support people safely and it was unclear if staff were suitably competent and skilled. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inspected but not rated

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.

This is the first inspection for this newly registered service. The service has been inspected but not rated.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance measures in place were not reliable or effective. There was no registered manager at the service and a lack of effective leadership.
- The manager was newly appointed and on the day of the inspection had no other management or administrative support. Most of the nursing staff were from an agency and unknown to the manager. The manager did not have oversight of what was going on within the service and could not answer our questions.
- There was a lack of management oversight of staffing levels, people's needs, risk assessments, documentation and training at the service to ensure safe care.
- Oversight of handover documentation was poor. It was out of date, hard to read and did not contain enough information to ensure an agency nurse, new to the service, could provide safe care.
- Monitoring systems to check the quality of the service were ineffective. Audits had been performed by the area manager, however, concerns they highlighted were not followed up or actioned. We found concerns with medicines management, poor documentation, poor cleaning and infection control procedures that were not improved by audits performed at the service.
- Oversight of record keeping was unsafe. Nursing care records, carers records and medicines records were not filed in date order, were not secure in files, contained incorrect names or a lack of identifying information. Daily records were completed at the end of the day not at the time of care.

Systems and processes to assess, monitor and improve the quality and safety of the service were not effective. Risks were not assessed effectively, records were not complete and contemporaneous. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- From reviewing records, we identified the management team had not notified CQC of deaths, incidents and injuries they have a statutory responsibility to report.

The service had failed to notify CQC about injuries to four service users. This is a breach of Regulation 18 (Notification of other incidents) CQC (Registration) Regulations 2009 (Part 4)

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 service was not open and transparent . One relative told us that the service did not act with 'Duty of

Candour' and did not always inform them in a timely way when their relative was ill.
● A relative told us they found it very hard to get through to the service on the phone and communication was very poor.
● There was a lack of team meetings in place for staff to be updated and express their opinions. We observed poor communication with staff on duty about events at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People at the service did not always achieve good outcomes. Care was not person centred and four people had experienced deteriorating skin injuries.
● One relative told us they had been asking for a care plan to be written for their family member but evidence of this was hard to obtain. They also questioned specific care they were receiving but could not obtain a satisfactory response.
● The manager did not have oversite of staff meeting people's personal care needs. People at the service looked unkempt. We received feedback from one person that they had not had a bath for a year.

Continuous learning and improving care; Working in partnership with others
● Incidents and accidents that had occurred at the service, had not been assessed or analysed for any themes or patterns, as discussed in the safe domain. This meant that there was no opportunity for continuous learning and improvements.
● The service had not engaged with external health care professionals appropriately when required. People who had developed pressure ulcers were not referred to district nurses or tissue viability nurses, this meant that people had experienced skin damage.
● People who were losing weight had not been referred to dietitians for advice and continued to lose weight.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Notification of other incidents Care Quality Commission (Registration Regulations) 2009 (Part 4) There was a failure to notify Care Quality Commission of deaths and Grade 3 & 4 pressure ulcers. This is a breach of Regulation 18 Notification of other incidents. Regulation 18 Notification of other incidents (1) (2) a, b,

The enforcement action we took:

Notice of proposal to vary conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe Care and Treatment Concerns with nursing staff's clinical skills. Poor risk assessment of people's care and treatment needs. A lack of mitigation actions following incidents. Poor medicines management systems. Poor infection control practice placed people at risk of harm. These concerns were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment (1), (2)a, b, c, d, f, g, h, i

The enforcement action we took:

Notice of Proposal to vary conditions and remove location

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not robust enough to ensure safeguarding of people was effectively managed. This put people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13 Safeguarding (1), (2), (3)

The enforcement action we took:

Notice of proposal to vary conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services were not protected against the risks associated with unsafe premises because of inadequate maintenance. Regulation 15 Premises and equipment (1) b

The enforcement action we took:

Notice of proposal to vary conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance The service was poorly managed, this resulted in poor outcomes for people. Systems were not robust enough to demonstrate safety was effectively managed. This is a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated

	Activities)Regulations 2014 Regulation 17 Good Governance (1), (2) a, b, c,

The enforcement action we took:

Notice of proposal to vary conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of permanent nursing staff to ensure safe consistent nursing care. There were insufficient staff to support people safely. Staff training was not up to date. This is a breach of regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1), (2)a

The enforcement action we took:

Notice of proposal to vary conditions