Care Concept HCP Ltd

The Beeches

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 is a residential care home providing personal care, it can accommodate up to 22 people aged 65 and over. There were 19 people using the service at the time of the inspection.

The service is also registered to provide personal care to people in their own homes. At the time of the inspection, no people were receiving this service and the provider told us they would not be continuing this service.

People's experience of using this service and what we found
The provider had failed to ensure improvements were implemented since the last inspection. Governance systems were not effective to identify and prevent risks to people's safety. The provider had failed to recognise their system for identifying how many staff were needed on duty was not robust.

Risks to people's safety were not always assessed or mitigated. People were not always supported to take their medicines safely. There were environmental risks to people's safety with furniture that wasn't safely secured. One person had not been protected from the risk of choking. The provider had not followed best practice guidelines in relation to infection prevention and control. Staff were not always safely recruited.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support good practice.

Staff were kind and caring and wanted people to achieve good outcomes. People told us they felt safe.

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 requires improvement (published 29 September 2020). This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We received concerns in relation to provider's response to incidents, the level of care being provided and risks in the service environment. 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.

You can see what action we have asked the provider to take at the end of this full report. The provider had

taken some action to mitigate risks highlighted in this report and some of this was effective.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service is inadequate. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to people's health and safety, management of the service and staff recruitment.

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

Follow up
We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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 Health and Social Care Act 2008.

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
This inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Beeches is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Beeches is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is also a domiciliary care agency. It provides personal care to people living in their own homes. However, the service did not currently support any people in their homes and the provider confirmed they planned to deregister this service type.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was in post and had applied to register. At the time of this inspection, their application was being assessed.

Notice of inspection
This inspection was unannounced.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the nominated individual and the manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 5 staff members including a member of the housekeeping staff. We spoke with 3 people and 11 relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of care records, including 5 people's care plans and risk assessments. We also reviewed 3 staff members' recruitment files. We observed people being supported by staff.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not always mitigated following incidents. In an incident record, a person had been recorded as choking on food and a staff member supported them with backslaps. A Speech and Language Therapy (SALT) referral to assess this person's eating and drinking was not made until over a month after the incident. This left the person at continued risk of choking.
- Known risks to people were not mitigated safely. A person was involved in an incident of alleged abuse which put another person at risk. The provider was aware of this but failed to assess or mitigate ongoing risks. Once raised by inspectors, a risk assessment was put in place, but this failed to clearly specify how staff could keep people safe. There was a further incident involving this person during the inspection period. The provider had failed to do anything to reduce the risk of this happening.
- Medical intervention was not always sought immediately following incidents. One person was recorded in an incident form to have had an unwitnessed fall where they banged their head. The person was recorded as having a headache following the incident. However, there was no evidence the person was offered support to access medical advice immediately following this incident and this left the person at risk.
- Risks to people in the environment were not always mitigated. Several wardrobes in the service were not attached to walls and this created a risk of them falling onto people who used furniture for support when walking. Hazardous materials such as scissors, nail varnish remover hand sanitiser bottles and anti-bacterial spray were accessible in communal areas, and these posed a known risk to one person. Following the inspection, the provider told us that wardrobes were now fixed to walls where required and the activities cupboard was cleared of hazardous materials.
- People were at risk of scalding from excessively hot water from some taps. The provider was aware of this risk but did not take action until this was raised by inspectors.

Using medicines safely

- Medicines were not always administered and managed safely for people.
- 'As required' (PRN) medicines were not always administered in line with best practice. One person did not have a PRN protocol to inform staff when their medicine should have been given. PRN protocols did not always include information such as whether the person could request their medicine independently or what staff should look for to know if people required these medicines.
- Staff had not always recorded why people had taken PRN medicines, which is recommended in best practice guidelines. This meant health professionals may not be able to identify if people's health was declining.
- Medicine Administration Records (MAR) were not always completed safely. Multiple gaps were found in people's MARs which meant it was unclear if people were supported to receive their medicines as prescribed.

Preventing and controlling infection

● The service environment did not always support the prevention and control of infection.

● Areas of the service were not hygienic. A toilet area was unclean, with dirt on the grouting. The flush on this toilet was also not in working order which increased the risk of bacteria remaining in the toilet. A bed sheet was found on a person's made bed to have a large stain. This was removed immediately once raised to the manager by inspectors.

● There was damage to fixtures and surfaces throughout the building which made surfaces more difficult to clean and increased the risk of them harbouring bacteria. There was also a bath with heavy limescale, and radiator covers had damage to them.

● The laundry area had damage to the flooring, a foot pedal bin was not in working order and there was no soap available for the hand basin for staff to wash their hands.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

The provider had failed to ensure that medicines were managed safely and that risks relating to the health, safety and welfare of people and the service environment were robustly managed, monitored and assessed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they would be completing competencies again with medicines trained staff to ensure safe practice.

● People were admitted safely to the home and staff wore PPE appropriately.

Staffing and recruitment

● Safe recruitment processes were not always followed. This risked people being supported by staff who were unsuitable. Staff did not always have records of their application form, relevant qualifications, or full employment history. Where there were gaps in employment history, these were not explained.

● One staff member did not have evidence of an enhanced Disclosure and Barring Service check in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider had failed to always undertake safe recruitment procedures. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff, people and relatives we spoke with gave mixed views on staffing levels. One relative said, "Sometimes you can tell that there is not enough [staff] to go around. [My relative] told me that on occasions they have to wait for [staff] to attend to them." Most relatives felt there were enough staff. One told us, "Yes, I feel there is enough staff. I normally visit in the mornings. The staff themselves are very multitasking and I think they have a super attitude to work."

● The provider recognised the need for more staff and told us recruitment was difficult in the current climate. The provider had taken steps to only use permanent staff to ensure continuity for people.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not always working within the principles of the MCA.
● People did not always have recorded consent, mental capacity assessments or best interest decisions in place for the use of bedrails. Once this was raised by inspectors, the provider did put these in place.
● People gave mixed responses about being supported to make their own decisions. Two people told us they could make their own choices and the service supported them to do this. However, a person told us they could become, "Frustrated and tired" as they wanted to go to their bedroom after tea but, were being left in the lounge area of the service.
● Appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse following incidents.
● Staff had not always received training in safeguarding. One staff member had been employed at the service for over 6 months but had not received this training. Once raised by inspectors, the provider ensured this staff member completed their training in this area.
● Staff we spoke with understood how to spot the signs of abuse and how to raise concerns. Staff also understood how to whistle blow about poor practice.
● Incidents of alleged abuse had been reported to the local safeguarding authority where required. The manager told also they were implementing the local safeguarding procedures as suggested by the local authority.

Visiting in care homes

People and relatives consistently told us there were no concerns with visiting the service. People could be visited in an area of their choosing, such as communal areas or in their rooms. A relative told us, "Yes, I have absolute freedom to come and go as I want and almost now feel like it is my home as well. They are all very welcoming there."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders did not assure the delivery of high-quality care.

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

- The provider had failed to improve the quality of the service. The service has been rated requires improvement for the last 3 inspections and further concerns were identified at this inspection.
- Quality assurance systems were not effective in assessing, monitoring, and improving the quality and safety of the services provided. For example, the provider had identified concerns in medicine administration previously in audits, but had failed to ensure these issues were addressed. This was evidenced in continued concerns in medicine administration recording discussed in the safe section of this report.
- There was not an effective accident and incident audit and analyses in place. Incident reports were not always reviewed by the manager or the provider and therefore there was no learning from these.
- Monthly analyses of incidents were in place, but this did not identify themes or trends and therefore there was no learning from these.
- Monthly audits identified some concerns at the service, but these often did not outline what actions were to be taken to rectify these issues. For example, the most recent infection control audit highlighted several areas which needed improvement, but this did not state specifically what this improvement was. The scoring system and action plan had not been completed for this audit.
- Systems to determine staffing levels were not effective. A staff dependency tool was used to calculate the number of staff required for safe staffing levels. However, this failed to explain how the provider determined it was safe to have only 2 staff working at night when there were people who required both staff to support them, this left other people wating for care.
- The provider failed to ensure policies and procedures were followed and up to date. For example, the recruitment policy in place failed to set out clear processes. The policy did not outline the information required to ensure safe recruitment, such as staff having a full employment history from education.
- Multiple policies at the service were identified by the manager as needing updating 2 months before the inspection, but these policies had not been replaced since this was identified. The provider told us they had been updating their policies and purchased new policies to replace policies which were not sufficient.

The provider failed to ensure that effective governance systems were in place. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider was open about improvements being needed at the service and was working with the manager to rectify concerns.

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 provider had not always ensured they adhered to the duty of candour. One relative told us they had not been informed officially about an incident and only discovered this happened after being told informally by staff.

● Some relatives told us they felt engaged by the service, whereas others said they had not been asked for their opinion. The provider told us they had sent surveys out to people's relatives, and they also hosted a monthly meeting for residents and relatives. The main concerns highlighted in surveys was around low staffing levels and the provider had failed to take any action from this.

● People, staff and relatives felt the manager was approachable and felt able to raise concerns to them.

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

● The provider did not always ensure people achieved good outcomes from their care. For example, the activities co-ordinator's role was to support people to access activities they enjoyed and they were observed to do this. However, we also observed them supporting care staff with their duties which interrupted the activity they were engaged in and left people waiting for a prolonged period for them to return.

● The staff were kind and caring and helped to create a positive atmosphere. A person told us they felt part of a, "Very good community'. A relative also told us, "It is very personable, and all the staff know [my relative's] name and interests. I feel happy with the way they are treated, and all the staff are very kind. When [my relative] is out with us, when they come back the staff have said it has been strange without them and that they have missed them, which makes [my relative] feel wanted."

● Staff felt close to people and wanted to improve outcomes for them. One staff member said, "A [person] was upset about a bereavement. I was comforting them and making them happy. I told them we were here for them. I wanted to cry with them."

Working in partnership with others

● There was evidence of partnership working. For example, people were supported with visits from district nurses and contact had been made with the GP when required. However, as outlined in the safe key question, referrals to health professionals were not always made in a timely manner.

● The provider had hospital 'grab' sheets in place for people. These sheets summarise information about the person's care for healthcare staff should they need to go to hospital.

● Relatives told us they were confident the service would support people to access healthcare services and gave examples of when this had happened.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure robust recruitment processes were in place.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's health and safety were assessed, monitored and managed.

The enforcement action we took:

We have served a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance systems were in place.

The enforcement action we took:

We served a Warning Notice.