Justcare Homes Limited

The Beeches

Inspection report

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Mansfield
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
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

About the service: The Beeches 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, both were looked at during this inspection.

The care home accommodates up to 26 older people, some who may be living with dementia, in one adapted building. At the time of our inspection 16 people lived there.

People's experience of using this service:
●The provider had not made sufficient improvements since our last inspection and we found a continued breach of Regulation 17 and Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we found a breach of Regulation 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
●People' did not receive timely care. There were insufficient numbers of staff deployed to meet people's needs safely. Not all staff had evidence that the required pre-employment checks had been completed by the provider.
●At this inspection, the provider had still failed to identify and provide a method to safely evacuate people who resided on the first floor down the stairs in the event of a fire.
●The provider had failed to ensure all pressure relieving mattresses had been set correctly. They had failed to ensure all accidents and incidents were reviewed to identify learning and preventative measures and reduce the risk of reoccurrence.
●We found continued evidence to suggest staffs' competency in moving and handling people required assessment for competency. Staff competency in moving and handling people had not been assessed since our last inspection.
●Some staff had no evidence available to show they had been training in such areas as safeguarding people. Some staff were not confident in what incidents would require a safeguarding referral to be made to the local authority safeguarding team. Incidents of abuse and potential abuse were not assessed in line with the local authority safeguarding criteria to establish when safeguarding referrals were needed and what other actions were needed to reduce the risk of abuse.
●Overstocks of medicine had not always been acted on and returned to the pharmacy. Actions had not always been taken to seek medical advice when a person had refused their medicines for a number of consecutive days. Creams were not always stored securely.
●Not all steps were taken to help prevent and control infections.
●Not all prepared foods were refrigerated in line with the provider's policy.
●Not all steps were taken to ensure people could be actively involved in choosing balanced and nutritious food. Fresh fruit was not always available as a snack as advertised.
●People's care was not always given in a way that promoted their dignity and respected their privacy. People felt most, but not all staff were caring.
●The system to accurately monitor and track the training needs and achievements of staff was ineffective.

There was limited evidence to show all staff had received up to date training to ensure their knowledge in areas relevant to people's needs was up to date.
●Records showed some, but not all decisions had been considered in line with the principles of the MCA.
●Records did not show, apart from people's religious beliefs, how any other equality and diversity needs would be assessed and discussed with people.
●There was limited evidence people and their relatives were actively involved in their care plans and reviews.
●Activities and resources for people living with dementia were not always made available or provided in line with the provider's plans.
●Assessments of people's healthcare needs used recognised assessment tools. However, care plans did not always reflect staff practice and there was the risk people could receive inconsistent care.
●The system in place to manage, respond and to identify learning from complaints was ineffective as not all complaints were included in the complaints book. The provider's information and policy on complaints was inaccurate.
●Policies and procedures still did not clearly reflect the current legislative framework. Comprehensive action plans to secure improvements were absent.
●There was no registered manager in post as required at the time of our inspection. The provider had submitted statutory notifications for incidents they are required to tell us about, however these had not always been reported on the correct forms.
●Meetings had been organised for people and relatives to share their views and the provider had analysed a satisfaction survey. However, we found not all actions identified as a result of people's feedback had been acted on.
●Referrals were made for health care services when people needed this and the service worked well with other agencies involved in people's care.
●People were supported to be independent.
●Improvements had been made to covert medicines and records of medicines administered to people.
●Staff had opportunities for supervision meetings with senior managers to discuss their work and raise any issues.
●The premises had been adapted to meet people's needs. People's rooms were personalised and reflected their tastes and preferences.
●No one was receiving end of life care at the time of our inspection.
●At this inspection we found the provider was no longer in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some improvements had been made in these areas.

Rating at last inspection:
●At our last inspection, the service was rated as 'Inadequate.' (Published 19 November 2018).
●At the previous inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We served a warning notice on the provider requiring them to be compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and placed them in 'special measures.' We expect services placed in special measures to have made significant improvements at their next inspection.
●Special measures means the service will be 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our

enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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.

Why we inspected:
●This is a scheduled inspection to follow up on the warning notice issued and to check on the improvements made since the service was placed in 'special measures' at the previous inspection. At this inspection we found sufficient improvements had not been made and the service remained in special measures.
●The provider submitted an action plan to tell us what actions they would take to become compliant with the other regulations. At this inspection we found the service had not taken sufficient actions to improve and we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider was in breach of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is the second inspection where the service has been rated 'Inadequate.' The service had been rated 'requires improvement' on both inspections prior to this.

Follow up:
●We will continue to review information we receive about the service until the next scheduled inspection. If we receive any information of concern we may inspect sooner than scheduled.

Enforcement:
●Action we told provider to take is only reported when concluded. Please refer to end of full supplementary report when published.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Care Quality Commission

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector and one 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. Their area of expertise was in the care of older people and the care of people living with dementia.

Service and service type:
This service 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 an acting manager in place, however they were not registered with the Care Quality Commission. A registered manager would be, along with the provider, 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.

What we did:
● Before the inspection we looked at the information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about. We contacted the provider to remind them of the requirement to have a registered manager in place at the service.

● We checked whether Healthwatch Nottinghamshire had received feedback on the service; they had not.

Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

● We 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.

● On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

● During the inspection we spoke with five people and four relatives about the service. We also spoke with the manager, the acting deputy manager, a senior care worker, two care workers, a housekeeper, and the cook.

● We looked at three people's care plans and reviewed other records relating to the care people received and how the service was managed. This included risk assessments, quality assurance checks, accident and incident reports, staff training and policies and procedures.

● We reviewed information sent to us from the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. They had completed an audit on the service in November 2018 and had made recommendations for the service to improve. The outcome of the audit resulted in the service's quality banding being reduced.

Inadequate

Is the service safe?

Our findings

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

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our previous inspection on 11 and 17 September 2018, we found a breach of Regulation 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always managed safely, moving and handling had not always followed good practice, people's pressure relieving equipment had not always been set according to their weight and not all the required pre-employment checks had been completed as required. At this inspection we found the provider had not made sufficient improvements and was still in breach of Regulation 12. In addition, we found people's needs were not always met by sufficient numbers of staff and we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to ensure people were safeguarded were not always operated effectively.

We found the provider had made some improvements with the pre-employment recruitment checks and was no longer in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People told us they felt their care was sometimes rushed and sometimes they had to wait for assistance. For example, one person told us, "I asked for water this morning and they bring it when they can. They have other jobs to do." Another person told us, "Some staff try to bully you, they pull your trousers on when you're not ready; when you're still in bed." They added, "It's done jocularly," and told us they wouldn't want to report it as it would be, "Tittle tattling."
● We observed times when people's care needs were not met by sufficient amounts of staff. For example, we saw people waiting for care, were unable to find staff to support or relied on visiting professionals to provide assistance.
● We also observed staff were not deployed sufficiently over lunch time to ensure people received the support they needed. For example, we observed there were not staff present to prevent one person eating another person's meal with the cutlery the other person had used. We observed a person stand up and attempt to walk without staff assistance when their care plan stated and staff told us they needed staff assistance for this. There were no staff present to witness this. This placed the person's safety at risk.
●We observed communal lounge areas where people were seated without any checks being made on them by members of staff for 22 minutes on one occasion and for 18 minutes on another occasion. People did not have call bell buzzers with them. The call bell buzzers in the communal lounge areas would require people to be able to independently mobilise to be able to press the buzzer.
●The acting manager told us the activities coordinator was not at work as planned on day one of our inspection. They told us the activities coordinator would often help out with care when needed. The acting

manager told us they had not been able to find a member of staff to replace them on the rota. The rota for day one of our inspection also showed there should have been two cleaning staff on duty. However, there was only one member of cleaning staff on duty. Staff were not able to tell us how the cleaning duties that would have been covered by the second member of cleaning staff would be covered by just one member of staff.
●Staff had mixed views on whether there was sufficient staff. Some staff thought there was not enough staff to help people, particularly in the mornings.
●We asked the acting manager how they calculated the number of care staff required to provide care to people. They told us they did this based on their knowledge of people's needs but they had not used a recognised staffing calculation tool to inform their decision making. A dependency profile of the service in December 2018 recorded there were 11 people who required two care staff for their care needs and five people who required either one or two care staff for their care needs. We could not see how this had been used to help inform staff planning.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At our previous inspection, we found not all the required pre-employment checks on staff employed to work at the service had been completed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the acting manager told us they had audited the recruitment files and all the required pre-employment checks had now been satisfied. We checked three recruitment files and found all the required pre-employment checks had been completed for two people. However, the provider had not been able to show they had checked the identity of a third person. Shortly after our inspection the provider told us they had obtained and checked this member of staff's birth certificate as a way of checking their identify.

Assessing risk, safety monitoring and management
Learning lessons when things go wrong
● At our last inspection we found the provider did not have suitable equipment to minimise the risks of evacuating people out of the building from the first floor as part of their emergency evacuation procedures. We notified the Fire and Rescue authority of our concerns. At this inspection, staff told us and records showed there were five people who lived on the first floor and would not be able to use the stairs to evacuate the building if there was a need to. We notified the Fire and Rescue Authority of our concerns. Shortly after our inspection the provider told us they would purchase and arrange training for the staff on suitable evacuation equipment for the service. This meant that the provider had not taken action for over six months, from when we first raised our concerns with them
● At our last inspection we found pressure relieving equipment was not set correctly to what people weighed. At this inspection there were two people who used pressure relieving equipment that needed to be set according to their weight. We found this had been done correctly for one person, however for the other person their mattress was set at 89kg and their weight was recorded as 72.8kg. This meant the equipment was still not being used as intended as the mattress had not been set to match the person's weight. This could increase the risk of the person developing pressure ulcers.
● At out last inspection accident and incident forms had not been reviewed to obtain an understanding of what had occurred and whether any learning or preventative measures were needed. At this inspection, we found an accident and incident report stated a person had been found by staff in a tipped back position in their wheelchair. Neither the acting manager or acting deputy manager knew about this incident. This meant there had been no review of this incident to assess risk and ensure appropriate safety monitoring and management.

● At our last inspection we observed a moving and handling technique that didn't follow good practice. We also found accident reports had been completed where people had sustained injuries whilst staff had assisted them to move. At this inspection we still had concerns moving and handling practices were not always safe. This was because we observed one person ask staff for assistance to move into another room however, staff were unable to find the person's walking aid. Staff found one walking aid but were uncertain if it was the one assessed as safe for the person to use, however they decided to support the person to use it anyway. Staff said, "I'm not sure if it's the right frame, but I'll use it anyway because [person] is getting agitated." The person had been sat down for lunch for 75 minutes. We observed staff had not noticed the person's slipper was not properly on their foot and we pointed this out to staff. Incorrectly fitted footwear is known to contribute to the risk of falls. On two other occasions we observed staff assist people to move. This was done without explaining to people each step of the transfer, including when they equipment used would begin to help them rise.

Using medicines safely

● At our previous inspection we found medicines were not always being managed and administered safely. At this inspection we found improvements had been made to the records of prescribed creams, medicines given by a skin patch and medicines subject to additional controls. We saw pharmacist advice was in place for when medicines had been given covertly and staff had had their competency checked if they administered medicines.

●However, we found prescribed creams had been left out in people's bedrooms. There are risks that medicines may not be used as intended and it is therefore important to ensure all medicines are kept secure.

●We also found an overstock of one person's medicines. We made the acting manager aware and they took action to return the overstock to the pharmacist.

●In addition, on the second day of our inspection, records showed one person had refused three of their prescribed medicines on four consecutive days. We checked the person's medicines records for the previous month and found they had also refused all medicines for another period of four consecutive days. These medicines included medicines to treat high blood pressure and coronary artery disease and to prevent strokes. We asked staff when they needed to obtain advice from the person's GP in respect of the person refusing medicines. They told us they had already obtained advice from the GP and showed us records of GP visits for 2018. None of these GP visit records related to the current refusal of medicines.

Preventing and controlling infection

●At our last inspection we identified one area of the service with malodour. We were told the provider had plans to improve this. However, on this inspection we found the provider had still not completed the work required to improve this. We were told the work would take place shortly after our inspection. We were concerned that the provider had not taken action since our last inspection, six months ago to remedy this.

●At this inspection, we observed staff did not always follow recommended guidance to help prevent and control infection. This was because we observed staff tying up a waste bag while not wearing gloves after supporting a person to the toilet. The acting deputy manager told us they would expect staff to wear gloves for this aspect of care.

● The provider had failed to ensure prepared food had been adequately stored. This was because on day one of our inspection we found sandwiches had been made ready for afternoon tea out of the fridge. Staff told us they had been made before 12.00pm as they would not have time to prepare them in the afternoon, they told us this was because they did not have an additional person in the kitchen to help with tea time preparation that day. They told us there was not enough space in the fridge to store them in there. We were told the sandwiches contained choices of meat, cheese and jam. Food products of this type require refrigeration to ensure they remain safe to consume.

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

Using medicines safely and preventing and controlling infection

●People told us they were happy with how staff managed their medicines. One person told us, "Staff look after my tablets and sometimes explain what they are for. No problems with medication; If I'm in pain and I mention it, they'd advise what medication I could have."

●We observed medicines were administered safely to people and staff explained the medicines they gave to people and checked if people required any pain relief.

● Medicines in the medicines room were kept at the correct temperature. Records of medicines were accurate and complete and enabled staff to know what times medicines had been given.

●We checked a number of people's rooms as well as communal bathrooms and apart from one area of the service mentioned previously, found these to be clean.

●Staff with responsibility for domestic duties understood their job role and told us they followed cleaning schedules to ensure all aspects of the service were thoroughly cleaned. Records confirmed this.

Systems and processes to safeguard people from the risk of abuse

● Staff we spoke with understood they could report concerns to the management team and provider, as well as to the local authority and the CQC. However, some staff were uncertain about what type of incidents would require safeguarding referrals to be made. Not all staff fully understood the actions required to safeguard people and training records did not provide assurances training had been provided and competency assessed by the provider.

● We found an accident form that reported a visitor had witnessed a person push another person over. This resulted in the person falling and as they fell they hit their head on the wall. The accident form did not contain any assessment as to whether this incident should have been reported to the local authority safeguarding team. There was no process in place to ensure incidents such as this were assessed against the local authorities safeguarding referral criteria so that appropriate actions were taken to ensure people were safeguarded.

●We reported to the provider that one person told us money and some other things sometimes went missing. The provider responded by saying the person could be 'economical with the truth.' We were not provided with any further assurances from the provider to support their judgement, as such we were not assured incidents of potential abuse were robustly investigated by the provider. This meant the provider did not always take appropriate action to safeguard people.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Supporting people to eat and drink enough to maintain a balanced diet
●People told us they mostly enjoyed the food however they did not feel they had much choice over the meals served. One person told us, "The food is quite good. You just get what staff put in front of you." Another person told us, "The food is alright. You don't really get a choice." We observed staff talking with people over their menu choices. We heard staff say, "It's sausage for lunch today, is that alright?" and, "It's sausage today, do you want that or something else?" One person commented, "That's a change, that they've asked. That sounds alright." On both days of our inspection, we did not see anyone eat anything different to the main meal option provided. We observed most puddings were sponge and custard. Staff spoke with one person about the option of a yogurt, however we saw that staff then continued to provide sponge and custard to the person. We did not see staff show people plates of different meal choices or use visual menus when helping people make decisions over their meals. We did not observe staff telling people what their meal was as it was served. When people are living with dementia, having visual menus or actual plated up meal options can be helpful for people when they choose what they would like to eat. As such, we were not assured that people living with dementia were being offered meal choices in an effective way.
●Meals were plated up in the kitchen with gravy already added. This did not afford people choices as to whether they wanted gravy, or if they did, where they wanted their gravy on their meal.
●We were concerned people were not provided with a nutritionally balanced diet. This was because despite the menu stating people would be offered fresh fruit as a snack, they were served biscuits with no option of fresh fruit offered. We also saw staff changed the planned pudding to another type of pudding; they told us this was because they had just decided to do a different pudding on that day. The food provided did not always follow the planned menu and we were therefore not assured people always received a nutritious and balanced diet.
●On day one of our inspection, some people had been seated, waiting for their meal for 45 minutes. We observed one person told staff their meal was cold; whilst staff offered to heat it up the person refused and continued to eat their meal. On day two we observed lunch was served in a more timely manner.
●Records showed any risks from malnutrition or dehydration were identified and monitored, with food supplements obtained when necessary.

Staff support: induction, training, skills and experience
●The provider could not provide assurances all staff had been trained in areas relevant to people's needs including safeguarding.
●Whilst records showed staff had been trained in moving and handling, their competency in this area had not been refreshed since 2017; since this date there had been a number of incidents that indicated staff competency in moving and handling required checking.

●The provider's system to identify what training they required staff to complete and how frequently staff needed to complete it was not effective. The deputy manager showed us some training records had not been entered onto the training matrix; this meant the provider did not have an effective system to show what training staff had and when it had been completed. We were not assured it was an effective tool at monitoring staff training and ensuring staff were trained to meet people's needs.
●Staff told us and records confirmed they had recently had an opportunity to review their individual work and development needs.

Ensuring consent to care and treatment in line with law and guidance

● 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. The provider had made applications to the local authority when restrictions had been identified.
● The provider had not always demonstrated decision making had been considered in line with the MCA and best interests decision making. This was because some work had been planned for one person's bedroom; however, staff told us they were not certain of the person's capacity to consent to this. However, staff had not completed any records to show how they had considered the MCA for this decision. This meant not all steps had been taken to ensure this person's rights were upheld and considered.
●People had access to advocates and advocates had been involved in decision making when appropriate. Advocacy services provide help to people to represent their views and opinions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●People's care needs and associated health care risks were assessed with nationally recognised assessment tools and regularly reviewed.
●Apart from recording if people had a particular faith, assessments did not show how any other equality and diversity needs would be discussed and considered with people on admission and kept under review.
●The provider's policies and procedures did not always clearly refer to best practice guidance and current legislation.

Adapting service, design, decoration to meet people's needs

●One person described their home as, "Very comfortable, homely." A relative told us, "[Person] is happy here. They say they like it… the caretaker has put all of their pictures up, it looks lovely now." Staff told us people's pictures had been displayed around the home. People's rooms had been decorated to reflect their individual tastes.
●A lift provided access between the two floors and there was some signage to help people orientate around the building.

Staff working with other agencies to provide consistent, effective, timely care

● Care records showed where referrals had been made for assessments or advice from other agencies, such as for occupational therapy reviews of people who had been identified as having falls risks.
● We saw two visiting professionals during our inspection had been involved in reviewing people's care needs.

Supporting people to live healthier lives, access healthcare services and support

● People told us they had access to other healthcare services they needed. One person told us, "I caught my hand on the door latch in my bathroom. Anything like that and the district nurse comes straight away. They're great at sorting things like that." Another person told us, "The chiropody man comes each month, they make an appointment each time. He's lovely. He comes once a month." A family member said, "Staff get in touch with the hospital and doctors very quickly."

● Care plans provided staff with guidance about people's health conditions. Staff told us how they monitored people's health needs and obtained relevant advice from other healthcare professionals when required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence

●On day two of our inspection we observed staff weighing people in the main reception hallway. As well as the person being weighed, there were three other people seated in the area. As it was the main entrance hallway, any visitors would have accessed the building into this main reception and hallway space. We observed staff spoke to people about what was happening as well as telling them what they weighed. The other people seated in this area as well as watching the other person being weighed also heard what they weighed. We did not think this offered people care with privacy and dignity. We raised our concerns with the acting deputy manager who told us they understood our point of view. They told us people had always been weighed there as the floor in that area provided a consistent weight reading. However, it is our view that the service had not prioritised care which promoted people's privacy and dignity as well as ensuring effective weight monitoring.

●People told us staff were respectful of their privacy. We saw staff knock on people's bedroom doors prior to opening them. On another occasion we saw a staff member adjust a person's clothing to help promote their dignity.

●People told us staff promoted their independence.

Ensuring people are well treated and supported; equality and diversity

●People told us they felt most, but not all staff were caring. One person told us, "Most staff stick to the rules, some are a bit bossy. It is not easy on them, but I carry on. But generally, they are fine." Another person told us, "Staff are nice and look after you; we have a laugh occasionally; they are kind when helping me."

●The provider's own satisfaction survey results for January and February 2019 also reported some concerns with the approaches of some staff. The comments quoted included, 'Not all staff approachable,' and, 'Not all staff appear to care.' They stated they would address these points at meetings with staff.

●We observed staff were mostly caring with people. For example, when staff assisted a person with their meal, they sat and chatted about a range of topics, smiled and used lots of eye contact. Staff spoke about people they cared for with fondness. However, we observed two occasions when staff could have offered more reassurance to people when they expressed they felt uncomfortable and unwell.

●Care plans showed where people had any specific needs relating to a disability or religion. The acting manager told us at the current time no one expressed any requests for faith groups to visit. They had however, discussed developing these with a local religious group. The acting manager told us people did not currently have any other equality and diversity needs.

Supporting people to express their views and be involved in making decisions about their care

●People told us they could not recall being involved in developing their care plans. The acting manager told us people were given the opportunity to read their care plans or to have their care plans read to them and to

sign them. We did not always see this involvement had been recorded in people's care plans with them. However, care plans did reflect some knowledge of people's life histories, interests and preferences. This helped to show care plans had been developed with some involvement of people.
●An advocate had been used to help represent a person's views when making care decisions. Advocacy services provide help to people to represent their views and opinions.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
●Some people raised concerns with us about activities at the home. One person told us, "There aren't activities. I suppose they think we are too old." Another person told us, "I said about draughts and one of the staff's mother brought some in, but the pieces are too small. We could do with a bigger one. They have carpet darts, but I'm not bothered for that; I used to build lots of things, I'd still like to do that, if I could sit down to do it." Some people told us external entertainers sometimes visited. One person told us, "A group of singers come occasionally, I can't say it interests me, but it adds something you get out of the place." Another person said, "A lady brings [a local magazine] with her dog. I enjoyed chatting to her."
● A recent satisfaction survey stated feedback had been received that people got bored and there were limited activities. The provider had responded by saying they would now involve more staff with the provision of activities. They also said they would make sure the box of sensory resources for people living with dementia would be made more available. We found this had not occurred. We found the box behind a sofa in the main communal lounge. On day one of our inspection, the acting manager told us the activities coordinator was not at work and they had not been able to cover her absence. As such the activities advertised to people for the morning did not take place. We saw a member of staff play dominoes with two people in the afternoon. The provider had also noted when they visited the service in February 2019 that no activities were taking place. The provider had advised the acting manager to ensure there was a member of staff available each day to provide the planned activities. The activities the provider had advertised to people did not always happen. In addition, resources for people living with dementia to help them engage in sensory activities had not been made more readily accessible as the provider had stated they would do. People were not supported to engage in activities and interests that met their needs.
● The service identified people's information and communication needs by assessing them. People's communication needs were identified, recorded and highlighted in care plans. We did not always see how these communication needs had been met. For example, the acting manager told us care plans would be read to people if this was how they understood information. However, we did not see this had been recorded.
● Care plans ensured that any risks related to people's care needs were identified and assessed with a care plan in place to ensure planned actions were taken to reduce identified risks. For example, risk assessments were in place where people were at risk of pressure damage or of falls. Staff we spoke with were knowledgeable on people's health care related risks and knew what actions to take to manage these. However, some actions staff were completing were not reflected in people's care plans, for example catheter care. Staff were recording urine output however the care plan did not contain guidance for staff on this, or what would indicate a reduced output and what actions staff should then take. This meant that people were sometimes at risk from inconsistent care.

Improving care quality in response to complaints or concerns
●At our previous inspection we found the provider's complaints information incorrectly advised complainants they could refer their complaint to the CQC. We advised the provider people could refer complaints to the Local Government Ombudsman and not the CQC. At this inspection, we found the provider's complaints process on a main display board in the reception area had not been updated. It still advised complainants to refer their complaints to the CQC. This was also the case with the provider's main complaints policy; despite it stating it had been updated in October 2018. We made the provider aware of this and they told us shortly after our inspection they had updated it. We were concerned the provider's information on complaints had not been accurate.

●The provider had introduced a 'complaints' book' and a 'comments book' since our last inspection. These contained five complaints since October 2018. The complaints book did not record when the complaint had been resolved and so the provider could not show evidence that complaints were managed to the timescales identified in their own complaints process. For one complaint, a person had stated the service had been 'short staffed again.' There was no record to show how this had been investigated and no reply recorded to the complainant. The provider could not provide assurances complaints were appropriately investigated, managed in line with their complaints procedure and used to help improve the service.
●We also found the provider's audit report for January 2019 stated a relative had complained as they had been obliged to bring in certain foods for their family member; the provider stated this was unacceptable and the kitchen staff should ensure these foods were available. However, this had not been recorded in the complaints book. Therefore, the information in the complaints book did not fully reflect all the complaints that had been made. This meant is was ineffective at monitoring for trends, and was not a true reflection of the complaints received or how and when they had been investigated.

End of life care and support
● At the time of our inspection, no-one was receiving end of life care. The acting manager told us they were aware of the importance of developing end of life care plans with people, when this was required.

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.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our previous inspection on 11 and 17 September 2018, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued a warning notice to tell the provider to become compliant with this regulation. At this inspection we found the provider had not made sufficient improvements and was still in breach of Regulation 17.

We found the provider had made some improvements with submitting statutory notifications and the provider was no longer in breach of Regulation 18 of the Registration Regulations 2009.

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

- At our last inspection we found pressure reliving equipment was not set correctly to what people weighed. The provider sent us an action plan saying the acting manager would check and record equipment was used correctly and this would be checked by the provider. At this inspection we found pressure relieving equipment was still not set correctly and checked by the acting manager. This meant the actions the provider told us they were going to take in their action plan had not been taken.
- At our last inspection we found accidents and incidents had not been reviewed to obtain an understanding of why they had occurred and whether any learning or preventative measures were needed. The provider had told us the acting manager would now be required to check all accident and incident forms on a daily basis and sign the forms. They told us the acting manager would be required to follow up any actions required including reviewing risk assessments to ensure the same error could not happen again. The provider told us they would also check to ensure this happened. At this inspection we found this had not happened.
- At our last inspection we found policies and procedures were not reflective of the current legislative framework. At this inspection we found an attempt had been made to update the policies and procedures however we found they were still not always clear. For example, some policies and procedures still referred to 'outcomes'. Outcomes are no longer referred to in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, policies and procedures did not have review dates identified so as to ensure they were kept reviewed and updated.
- The system to plan and track what training the provider had identified staff required and what they had completed was not effective. This was because the acting deputy manager showed us a training matrix, however this did not reflect what actual training staff had done as evidenced by an online system or by previously certificated training. For example, the acting deputy manager showed us they had completed safeguarding training in 2017, but this was not on the training matrix. For one member of care staff, the acting deputy manager was not able to show us evidence they had been trained in safeguarding.

● At our last inspection we found accident forms indicated staff required refresher training and competency checks in moving and handling practice as people had sustained injuries when staff had assisted them to move. At this inspection, moving and handling competency assessments had still not been completed. However, the providers own audit stated these were in place. The acting deputy manager showed us the competency assessments the audit referred to. These had been completed in 2017 and were before our last inspection. They did not provide any assurances about the moving and handling competency of staff as the indications that staff needed refresher training and renewed competency checks was identified at our last inspection in 2018. Therefore, the provider audit was not effective.
● Despite records stating checks had been made on the stock of medicines held in stock, an overstock of lorazepam tablets for one person had not been identified. We made the acting manager aware of 119.5 tablets of lorazepam in stock for one person. The person had last had half a tablet of this medicine on 29 January 2019. Records stated checks on medicines had been completed on a daily basis by the acting manager. They had specifically recorded there were no errors with the quantities of medicines held in stock on 21 February 2019. Records showed there was 105.5 tablets of lorazepam in stock on this date. This meant that no action was taken to address the overstock of medicines for this person. Audits of medicines had not identified this overstock and had not taken action to return the overstock to the pharmacist; nor had audits of medicines management identified prescribed creams were not always stored safely. In addition, audits of medicines records had not identified a person had refused medicines for a period of four consecutive days and no GP advice had been sought.
●The Beeches is required to have a registered manager. Registered managers, along with registered providers have legal responsibility for how the service is run. The Beeches had not had a registered manager in post since November 2017.
●Despite the acting manager stating they had audited all the staff recruitment files to ensure they contained evidence all the required pre-employment checks had been completed, we found there was no evidence to show the identify of one member of care staff had been checked. The acting manager's audits of recruitment records had not been effective as they did not ensure recruitment records demonstrated all the pre-employment checks had been completed as required.
●Despite the provider's own audit in December 2018 stating they had updated the complaints policy and had prepared an update for the notice board, we still found the complaints policy and a notice on the notice board still incorrectly advised complaints to refer their complaints to the CQC. The provider's audit had been ineffective at securing an improvement in this area.

Continuous learning and improving care
● There was no comprehensive action plan with target dates set for the completion of tasks and who was responsible to coordinate the actions required to make the necessary improvements. This meant there was no system to track progress and identify when target dates were not being met.
● The local authority had completed a monitoring visit in November 2018, they had made a number of recommendations to improve the service, including amongst other areas, staffing, governance and infection prevention and control. The local authority had assessed the service at a lower quality banding as a result of their findings. We could not see what action the provider had taken to address these concerns, considered this feedback and identified learning and improvements to care. For example, the provider audit in February 2019 confirmed receipt of the local authority report. They stated they would review it and comment further in the next audit. However, on the provider's audit visit report on 6 March 2019, this stated the provider had not had time to review the local authority report at this time and had planned to review it on 20 March 2019. The provider was not able to demonstrate they were taking timely action to secure continuous learning and improvements to care.
● We found the provider had failed to improve on some of the concerns we identified at our last inspection. This included pressure mattresses settings still being set incorrectly and fire evacuation equipment still not

being in place to help the five people residing on the top floor to evacuate safely down the stairs in the event of a fire. Moving and handling competency checks had also not been completed on staff.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
●The provider had failed to ensure person-centred care was planned and promoted. This was because staff told us people had always been weighed in the main reception area. As reported elsewhere in this report, we found people were weighed in front of other people with their weight discussed in front of others. This practice had not been identified by the provider or management in the home as needing to improve to help promote person-centred and high quality care.
●The provider had failed to secure improvements in other areas of person-centred care and support. As despite the provider identifying improvements were needed to activities and resources for people living with dementia, they had failed to ensure these were provided as planned.
●The provider had failed to take action to ensure people's person-centred needs were met at all times during our inspection as sufficient numbers of staff were not always available.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We were not assured the acting manager and provider had a good understanding of the requirements to notify CQC correctly. This was because the acting manager had notified us that a person had sustained a fracture. However, they had notified us by using a statutory notification for an allegation of abuse. We asked the acting manager why they had done this and they told us it was because it was an unwitnessed fall and a visiting professional had advised them to make a safeguarding referral. We were not assured the acting manager was making the appropriate judgements as the primary reason for notification on this occasion was a fracture and should have been reported as a serious injury. As part of that notification they should have then told us they had made a safeguarding referral. The acting manager also told us the provider had advised them to notify us when they had made applications to the local authority for a person's DoLS. However, this is incorrect and providers are only required to notify CQC when DoLS authorisations outcomes are known.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
●It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the provider's office address.
●We had contacted the provider shortly before our inspection to advise them their website linked to the CQC report from 2015 and not the most recent 2018 CQC report. We also advised the provider of the CQC guidance on how to display the CQC rating on websites. Whilst the provider's website was updated to link to the most current report, the CQC guidance on how to display the rating had not been followed. For example, the link to the CQC report was not located on the main landing page and did not use the CQC widget. This is a way of clearly displaying information on the CQC rating.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings had been organised for people and their relatives in order to provide opportunities for them to

give their views on their care and the developments planned for the home.
● Staff we spoke with were positive about working at the service and told us they could contribute their views.
●Staff meetings were held and provided opportunities for staff to share their views
● People and their relatives had had opportunities to give their views through a questionnaire that asked them about their experiences of care and life at the service.
●The acting manager told us they would read people's care plans to them if this was their preferred style of communication to ensure people understood their planned care. However, we did not see this had been recorded as having been completed for anyone. Not all people had signed to say they had been involved in developing and reviewing their care plans.

Working in partnership with others
●The service had worked in partnership with people, relatives and staff to develop the service. However, actions identified as a result of listening to people and relatives had not always been implemented. For example, the box of sensory resources for people living with dementia had not been accessible as previously stated by the provider.
Other professionals such as advocates were also involved in people's care.
●Advice and guidance from other healthcare professionals was known by staff and included in people's care records for reference. For example, when district nurses or pharmacists were involved in people's care.

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 Not all reasonably practicable steps were taken to reduce risks to people; not all equipment was used in a safe way to reduce identified risks; the proper and safe use of medicines was not always followed; infection prevention and control measures were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not always established and operated effectively to prevent abuse of service users.