Homebeech Limited

Homebeech

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 February and 3 March 2017 and was unannounced.

The last inspection took place on 11 February and 9 March 2016. As a result of this inspection, we found the provider in breach of three regulations relating to safe care and treatment, dignity and respect and person-centred care. We asked the provider to submit an action plan on how they would address these breaches. An action plan was submitted which identified the steps that would be taken. At this inspection, we found that insufficient improvements had been made and that these three regulations were still not met. We are in the process of considering our regulatory action to respond to this and will publish the action we have taken. In addition, we found one further breach of regulations.

Homebeech is situated close to the seafront in Bognor Regis and within walking distance of the town centre. Homebeech is registered to provide accommodation and nursing care for up to 66 people with a variety of health conditions, including dementia, physical disability and frailties of old age. At the time of our inspection, 51 people were living at the home. Homebeech is arranged into three units. The main part of the home called 'Oakside', but commonly referred to as 'Homebeech,' supports people who have health care needs. Daffodil unit is for people under the age of 65 years who have a range of physical disabilities. Beechside unit is a secure unit that accommodates nine people living with dementia. The main part of the home has a large sitting room and dining room, with an adjacent conservatory. A further sitting room is available to people on the ground floor. The Beechside unit has separate facilities, including a lounge and dining area. All bedrooms have a toilet and sink ensuite. Accommodation is provided over three floors and lifts enable easy access. People have access to outdoor spaces.

A registered manager was in post and their registration had been completed recently. Prior to their appointment, the registered manager post had been filled by the person who is now the senior manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were at risk of unsafe care or treatment because risk assessments did not provide sufficient information and guidance for staff on how to support people safely. People's risk of malnourishment was not managed consistently nor were regular assessments carried out. Referrals were not always made to healthcare professionals in a timely manner where people had sustained falls. We observed instances of poor communication relating to moving and handling. Premises were not always managed to keep people safe.

Staff did not always treat people with dignity and respect. We observed occasions when people were either not listened to or ignored. People and their relatives had mixed views about the care and support provided by staff. Staff did not always treat people in a warm and caring way.

An activities co-ordinator arranged activities for people on a daily basis, but these did not reflect people's interests or hobbies. Some people felt the same activities were offered every day, such as jigsaws, painting or colouring. No programme of activities was on display and a record to confirm group activities had taken place had not been completed since October 2016.

People were at risk of not receiving personalised care that was responsive to their needs. Care records were inaccurate or incomplete and documents relating to people's individual care needs were not kept in one place. Some care plans were printed off and located in people's rooms, some assessments were stored electronically and other records were stored in the nurses' office. This meant that staff may not always have had ready access to people's information or guidance on how to support them. Hourly checks on people were not always completed on time.

Opportunities had been missed to create a dementia friendly environment, especially in the Beechside unit. We have made a recommendation to the provider about this.

There was no evidence to confirm that staff received regular supervision or annual appraisals. Staff could not confirm they met regularly with their line managers. Staff meetings had taken place in 2017, but records relating to 2016 were unavailable for us to see.

Residents' meetings had not been organised in 2017 to date. Systems to obtain feedback from people or their relatives were ineffective and the response to questionnaires sent out by the provider was poor as only two responses had been received. People were not involved in developing the service nor were their views sought.

Medicines were managed safely. Risks to people living with diabetes, or people who had developed pressure areas, were managed safely.

Staffing levels were within safe limits and the service used agency staff on a regular basis. However, some people felt their needs were not addressed by staff in a timely manner. Recruitment systems were in place to carry out checks for potential new staff, however, the registered manager was unclear about the requirements of safe recruitment in one instance.

People told us they felt safe living at Homebeech. Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Staff completed a range of training in line with the standards of the Care Certificate, a universally recognised qualification. In addition, they received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people were assessed as lacking capacity, the registered manager had completed the necessary applications and sent these to the local authority.

People had sufficient to eat and drink and were encouraged with a healthy diet. People had mixed opinions about the food on offer. The lunchtime experience in the main dining area of the home was not always a sociable experience for people. Some people had to wait for their meal to be served. People were encouraged to maintain good health and, in the main, had access to a range of healthcare professionals and services.

Where staff had time to spend with people, positive, caring relationships had been developed. We observed people were involved in day-to-day decisions relating to their care. Complaints were managed satisfactorily.

Staff felt supported by the management team and the registered manager operated an 'open door' policy. A range of systems was in place to monitor and measure various aspects of the service. However, these were not always effective in ensuring that areas in need of improvement had been rectified.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risks to people had not been identified or assessed adequately to ensure staff received guidance on how to support people safely. Records were not always reviewed consistently to ensure people's most up to date needs were met or communicated to staff. People were at risk of unsafe care or treatment.

Medicines were managed safely.

Staffing levels were sufficient to meet people's needs.

Staff had been trained to recognise the signs of potential abuse and explained how they would report any concerns.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Opportunities had been missed to create a dementia friendly environment in the home. We have made a recommendation to the provider on this aspect of the service.

Evidence was not available to confirm that staff received regular supervision or annual appraisals. Some staff meetings had been held in 2017; there were no records available to confirm meetings had taken place in 2016.

People were supported to have sufficient to eat and drink, although the lunchtime experience was not a particularly sociable occasion. Some people had to wait for their meals.

Staff completed training that was relevant to their job role.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Relationships between people and staff were not always positive.

Some staff did not treat people with dignity and respect. People and their relatives had mixed views about staff working at Homebeech.

People were encouraged to be involved in day-to-day decisions about their care when staff had time to spend with them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities on offer had not been organised to reflect people's interests or to provide mental stimulation.

Systems were not in place to ensure that records relating to people's care were accurate or contemporaneous.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Feedback from people or their relatives was not routinely sought.

Various aspects of the service were monitored and audited. Audits to monitor various parts of the home were in place, but where issues were identified, action was not always taken or recorded. Breaches of Regulations identified at our last inspection had not been met.

Staff felt supported by management.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 February and 3 March 2017 and was unannounced.

Four inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. In addition, we had received information which required investigation from the local safeguarding authority, as well as information of concern from a healthcare professional and local authority contracts team. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including sixteen care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

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. At the inspection, we met with 14 people living at the service and spoke with three relatives. We spoke with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the senior manager, the chef, the administrator, two agency registered nurses and two care staff.

Requires Improvement

Is the service safe?

Our findings

At the inspection conducted on 11 February and 9 March 2016, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because risk assessments were not always written in sufficient detail to guide staff on what action should be taken when risks were identified; in particular relating to people at risk of malnutrition. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. The action plan stated that staff would be trained in the management of risks associated with malnourishment and that care plans would be reviewed and updated, to ensure people's risks in this area were managed safely. At this inspection, we found that insufficient improvements had been made relating to the screening of people at risk of malnourishment. Overall risks were not managed to protect people and keep them safe; this breach was not met.

One person had been identified as at risk of malnourishment and had been assessed by staff who used the Malnutrition Universal Screening Tool (MUST), a tool specifically designed for this purpose. Within the care record, there was a separate nutritional assessment that provided detail of the person's nutritional intake, but this was incomplete. Their risk of malnutrition, weight loss and dehydration were all referenced in the care plan, but the MUST score had not been completed every month as needed. Scores were only recorded for February, August and September 2016. On the person's nutritional chart, there was no record of the person's food likes, dislikes or preferences which would have aided staff in supporting the person to eat and drink in sufficient quantity. We checked a further three MUST assessments and found that information was recorded inconsistently or there were gaps in recording. This meant that people's risk of malnourishment was not monitored effectively. MUST risk assessments were not always reviewed on a monthly basis, despite guidance in their care plans to do so when a person was at high risk. There were some separate nutritional assessments in place, but these related more to people's eating habits and details, rather than people's food preferences, although these may have been recorded separately. Overall, people's wellbeing was put at risk because their MUST assessments were not fully completed.

Risks to people had not always been identified or assessed appropriately. Guidance to enable staff to understand the actions required to support people safely was not always sufficient and referrals, for some people, were not made to relevant healthcare professionals. We looked at the care plan for one person who had been admitted to hospital following a fall in early February 2017 and discharged back to Homebeech on 8 February 2017. On 21 February 2017, the same person sustained another fall and received treatment from the Accident and Emergency Department at the local hospital. Whilst there was evidence that on the person's discharge from hospital, hourly checks were made by staff on them, no referral was made to the Falls Team. We discussed this with the registered manager who told us, "The hospital did say they would refer to the Falls Team. [Named deputy manager] and I discussed and decided the Falls Team would say she did not fit the criteria yet". The registered manager added that they had checked for signs of infection which might account for an increase in falls for this person. We discussed the registered manager's understanding of the criteria under which staff would make a referral to the Falls Team and were told that

people had to have experienced at least three falls in a week before a referral could be made. Care plans also recorded similar criteria, which is inaccurate, as account should be taken of a person's underlying health condition or new circumstances which may contribute to elevating their risk of falls. The registered manager said, "We have told staff if a resident has a fall, they must use the Frase assessment, but whether that has been done or not I don't know. I only told them recently". Falls Risk Assessment for the Elderly (FRASE) was a screening tool available for nursing staff to complete electronically within people's care records.

Bed rail assessments had been completed where people were at risk of falling out of bed and these assessments were kept in a separate file. However, we observed one person trying to climb over their bed rails and that their legs were hanging over the bars on the side of their bed. The person was obviously distressed and was shouting out for staff for 10 minutes, before a staff member came to their assistance. We discussed this with the registered manager since the risk assessment was in need of review as this person was at risk of falling out of bed. The use of bedrails for this person may not have been appropriate or safe as they could sustain injury if they attempted to climb over the bedrails.

At inspection, we observed one person propelling themselves along in their wheelchair with their feet and that no footplates were deployed. This person had a diagnosis of dementia so may not have known the risk to themselves of using their wheelchair in this way. We discussed this with the registered manager who was aware of this issue and told us that this person was usually mobile, with the use of their walking frame, but that a sore leg prevented them from walking independently. On the second day of our inspection, we saw a member of care staff pushing a person in a wheelchair and that the footplates had been removed. Not using footplates when transporting people in wheelchairs puts them at risk of foot entrapment or injury and is not a safe moving and handling method. We raised this with the registered manager who told us that she was continually reminding staff of the need to use footplates and that this was an ongoing issue.

Some risk assessments were drawn up as separate documents, whilst other risk assessments appeared to be within people's care plans. Risk assessments, where these had been completed, were recorded electronically, however, at the time of our inspection, care staff had only just been provided with a code to access people's care plans and risk assessments on the computer. Some people's risk assessments had been printed off and were contained within their care records located in their rooms or in the nurses' office. However, when we checked some hard copies, the most recent risk assessments had not always been printed off, even though this latest information had been recorded electronically. This meant that people were at risk of unsafe care and treatment because care staff did not always have access to the latest information and guidance on how to support people.

Premises were not always managed to keep people safe. In Beechside, we observed a rubber grip had come loose on the floor near the sitting room and housed dirt underneath. In addition to being unclean, this was a potential slip or trip hazard. The courtyard area adjacent to Beechside was poorly maintained, but people did not have access to this area at the time of our inspection. A boiler room door on the first floor had a sign affixed stating, 'Keep locked shut when not in use', but the door was found to be unlocked and would have been accessible to anyone passing. We observed some ground floor carpeting in communal areas was stained. The senior manager told us there were plans to replace stained carpeting with laminate flooring in the near future. Environmental audits were completed around the home. Between 1 December 2016 and 7 February 2017, the audit identified that tiles had fallen off behind the toilet in one person's ensuite facility. Action had not been taken promptly to address this issue since at least three audits identified the same problem. Several other areas required the attention of maintenance staff to rectify various problems that had been highlighted, however, there was no record of whether or when remedial action had been completed.

We observed clinical waste left in bags in an open yellow bin on the first floor corridor in the Daffodil unit and brought this to the attention of the registered manager. In the first floor bathroom, there was a smell of urine and wheelchair footplates had been left on the floor in a corner of the bathroom. Some unwanted screws and nails were left next to the wall. In one person's bedroom we observed that foam cladding to a bedrail had split and would have been difficult to clean. In another room, we found a split in the wall, which had rough edges. One staff member told us they commenced employment at Homebeech in November 2016 and that the wall had been in that state since they started working at the home.

The above evidence demonstrates that the provider had not ensured that care and treatment was provided in a safe way for service users, including assessing and mitigating risks to service users and ensuring safe premises were maintained.
This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to this repeated breach and will publish the action we have taken.

Risks relating to people living with diabetes had been assessed and we saw records that confirmed people's blood sugars were monitored regularly within the Medication Administration Records (MAR). People at risk of developing pressure areas or ulcers had their wounds checked and monitored and referrals were made to tissue viability nurses where needed.

Medicines were generally managed safely. Most people we asked said that their medicines were well managed by the staff and they received their medicines on time. However, one person said, "The nurses bring you medication, but it was late today. I think this was because you [referring to the inspection team] are here. It is morphine and I had to wait, so my breathing is not so good at the moment". We discussed this issue with the registered manager who agreed that there may have been a delay in people receiving their prescribed medicines due to the inspection process. Another person told us, "They bring me my medicines, but I have to have eyedrops every day. The night staff do the morning one, but the care staff can do the one at 4pm. Almost every time I have to ring my bell to ask for someone to do it. You would think they have it registered that I need the drops every day at 4pm". We brought this issue to the registered manager who explained that this person did not require eye drops to be administered at 4pm on a regular basis, but as required. Some people were prescribed medicines to be taken 'as required' (PRN). Guidelines were in place for staff regarding the administration of PRN medicines and these were given in accordance with people's needs.

We observed medicines being administered to people at lunchtime. Staff carried out the appropriate checks to make sure the right person received the correct medicines and dosage at the allotted time. People were asked if they needed assistance to take their medicine and any help given was undertaken in a caring way by staff. Staff only signed the MAR once they saw that people had taken their medicines. Medicines were recorded on receipt and unwanted or outdated medicines were disposed of safely. Medicines we checked corresponded to the records, which showed that people received their medicines as prescribed. Medicines were stored securely. Medicines that were required to be stored at a lower temperature were kept in a dedicated refrigerator. The refrigerator temperatures were recorded, as was the temperature in the medicines storage room, to ensure medicines were stored safely. Two agency registered nurses on duty told us they had received training in medicines handling from the agency which employed them. They told us that they felt confident and competent in the administration of medicines and our observations confirmed this. Medicines were stored in five trolleys in different areas of the home. Weekly and daily audit checks were completed of medicines relating to the supply, storage, administration, recording and disposal of medicines.

We asked people if they thought there were enough staff on duty to care for them safely. One person said, "On the whole I think there are enough. Sometimes I ring my buzzer and you have to wait a bit longer". We observed that people had their call bells within reach to summon help if required. One person said, "If I want any help I ring my buzzer". However, one person said, "They do take a long time to answer the buzzer". The registered manager told us that they monitored staff responses to people's call bells as there were systems in place to record response times.

A relative told us, "I think they could always do with more staff. Mum gets tired around 4.30pm, but it is always quite difficult to find staff to help her back on the bed. It is dinner time and they are getting people ready for that. So now we make sure we ask a little bit before or ask her to be first on the list at 6pm". Most people we spoke to mentioned the high usage of agency staff. One person said, "I think they are short of staff and use a lot of agency staff, especially at weekends". A relative told us, "Generally there are staff around, but not always. They seem to use a lot of agency staff, most weekends there are different staff here".

During the day, two registered nurses were on duty who were allocated to the home on a regular basis from an agency. In addition, the registered manager and deputy manager were also qualified as registered nurses and could provide support if needed. In total 14 care staff were on duty in the morning and 13 care staff in the afternoon. At night, seven care staff were on duty and one registered nurse. Of this total, one person received 2:1 staff support during the day and 1:1 support at night. At the time of our inspection, 51 people were living at Homebeech, 10 of whom were supported by two care staff in Beechside, a secure unit accommodating people living with dementia. We checked the staffing rotas for February. These showed that on some weekends, agency staff were employed to ensure safe staffing levels. The registered manager told us that sickness levels were high amongst certain permanent members of staff and that this could be particularly problematic, especially over some weekends. They added that they were advertising for weekend staff, but the majority of full-time, permanent staff were expected to work every other weekend. The registered manager also said that agency staff had to work alongside a permanent member of staff and said, "We do try and anticipate staffing needs. If staff are on holiday, we try and cover with our own staff". Agency care staff covered sickness or unplanned absences. We asked the registered manager how they assessed staffing levels were sufficient to meet people's care and nursing needs. They said that the provider's head office staff would complete dependency assessments using people's Waterlow scores. (Waterlow is a tool that estimates people's risk of developing pressure ulcers).

We recommend that the provider puts a local system in place to assess staffing levels based on people's individual care and support needs. An increase in staffing levels may be needed where agency staff are deployed since agency staff always work alongside permanent members of staff.

We checked whether safe recruitment practices were being followed. The administrator explained that new staff could not commence employment until two references had been received and a check made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting. Of three staff files we looked at, two potential new staff had completed application forms, DBS clearance obtained and two references were obtained to confirm their suitability and good character for the job role. A third file contained incomplete information and a second reference indicated that the potential staff member had been subject to investigation, but had resigned from their employer before the investigation could be completed. Their employment history only recorded their most recent employer and not their complete work history. The registered manager told us they knew the applicant well and did not feel they would pose any risk. However, the registered manager was unclear about the requirements of safe recruitment of staff and the need to obtain full employment histories. We advised them of the relevant guidance at inspection and their

responsibilities under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with felt safe living at the home. However, one relative told us, "My wife was in a different room to start with and there was another resident nearby who used to call out really loudly and sometimes be abusive and swear. My wife said she was frightened. We told the manager and we wrote to head office. She was moved to a different room within two days, but you can still hear him and I think she still feels vulnerable. It is difficult for the staff as they are so busy and he calls out constantly, so I go and say something to him sometimes". We asked staff about their understanding of safeguarding and what action they would take if they had any concerns about people's safety or felt they were at risk of abuse. Staff told us they would report any concerns to the registered manager or to CQC. One member of staff appeared to be unaware of the role of the local safeguarding authority who investigate any safeguarding concerns. However, they knew what constituted a safeguarding concern and what action they would take. Previous issues that had resulted in safeguarding alerts being investigated by the local authority had been completed and closed.

Requires Improvement

Is the service effective?

Our findings

The registered manager was not able to evidence that staff received regular supervision or appraisals or how often staff meetings took place. We asked the registered manager how often staff received supervision to ensure they were supported effectively and as an opportunity to discuss any issues relating to their work or performance. The registered manager stated that supervisions were held every three months and appraisals annually. We saw some documents relating to 2017 and asked to see supervision records from 2016, to check that staff received supervisions on a regular basis. The registered manager stated that supervision and appraisal records for staff relating to 2016 had been archived and were unavailable. They added they did have an appraisal matrix, but there was no supervision matrix which might have shown when staff received supervision. We were told that team leaders completed some supervisions and registered nurses were also required to hold supervision meetings. We were given a blank staff supervision template which gave an outline of what might be discussed with staff during a supervision meeting. However, there was no evidence to confirm that staff received regular supervision, the content of these discussions and how frequently they occurred. The records of this supervision were not readily available to inform on-going discussions about staff competency, development and areas for improvement.

One member of staff said they did have meetings with the registered manager but that these related to specific matters. They said, "We have meetings whenever possible, usually if something happens, not on a regular basis". We asked other staff about their supervision and support. One staff member said they had received supervision soon after they started and attended another supervision meeting six months later. They had not attended any further meetings in the two years since commencing employment, but did feel supported. Another member of staff, who had been in post for 18 months, confirmed they had seen the registered manager but had not attended any formal supervision meetings on a 1:1 basis. A third member of staff had not received supervision since at least October last year. We asked the registered manager how they monitored staff and they said, "I monitor staff from afar".

We recommend that the provider puts a system in place that ensures staff receive regular supervision opportunities, in line with the provider's policy, together with an annual appraisal as appropriate.

The registered manager told us that staff meetings took place and we saw records relating to 2017 which confirmed staff meetings had taken place for nursing staff and for care staff. A staff meeting held in January 2017 showed that breaks, annual leave, maintenance, clocking in and out, sickness, rotas and uniform had been discussed. Staff confirmed they had attended meetings and that they could discuss or raise any issues. There was no documentation available to show how often staff meetings took place as records relating to 2016 had been archived and were unavailable for us to see.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. We asked people and relatives if they thought staff were trained to meet their needs. One person told us, "Pretty good, they get the job done".

We saw the training programme which showed training sessions available for staff in 2017. This training was

devised to cover the 15 essential standards of care as part of the Care Certificate, a universally recognised qualification. All new staff were required to complete the Care Certificate. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Mandatory training which was considered essential for staff to deliver effective care included safeguarding, food hygiene, basic first aid, health and safety and infection control. This training was refreshed annually. In addition, staff completed training in moving and handling, dementia care, mental capacity, documentation and record keeping and epilepsy awareness, as well as other training related to specific health conditions. The registered manager told us that community matrons also visited annually to deliver specialised training such as diabetes awareness. Dieticians came in to advise nursing staff on Percutaneous endoscopic gastrostomy (PEG) where a person is fed through a tube passed directly through the abdominal wall, where swallowing difficulties have been identified.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where required, capacity assessments had been completed for people. Where people were deemed to lack capacity, and required restrictions placed upon them to ensure their safety, DoLS had been applied for. We asked staff about the MCA and staff we spoke with were able to demonstrate their understanding of this legislation and how they would put this into practice. All people living with dementia in the Beechside unit, which was a secure unit, were subject to DoLS.

People were supported to have sufficient to eat, drink and to maintain a balanced diet. We asked people if they were happy with the food and drink on offer at the home. One person said, "The food is okay; if you don't like it you can just leave it. They will give you a choice, but I just have some crisps in my room". Another person said, "The food is not very good. I couldn't eat the braised steak today as it was too tough and the potatoes were solid and hard. It looks okay, but it is not cooked properly". We asked if they had reported this and they told us, "I always say something but it doesn't seem to get back to anyone. I told the person who collected my plate and they said everyone has been saying the meat was tough". We discussed this with the registered manager who explained that this was an isolated issue. They explained there had been some difficulties recently with the chef and that the chef had since resigned from their employment at the home. A new chef was due to commence employment. In the meantime, an agency chef had been employed.

We asked people how their individual preferences were supported and they told us their menu choices were discussed the day before; people could choose between two options. However, it was not clear if any provision was made for people who were unable to express their own likes and dislikes. For example, one relative told us, "My mum has a good appetite, but she doesn't like pasta. One day I was here they served up pasta and a tomato sauce. She didn't eat it and I had to send it back and ask for something else". Another relative said, "My mum is not good at the moment with eating and is having some swallowing difficulties. Sometimes they come around and offer choices which are really not appropriate and she will choose something that is not good as she doesn't really understand".

We observed the lunchtime experience in the dining area. Twelve people sat at tables of two in the main dining area and a further six people sat at communal tables in an adjacent lounge area. Four people remained in their armchairs and had tables put next to them. The majority of people had already been sitting in the dining room throughout the morning and staff assisted others to their tables.

The chef plated up meals in the kitchen and a number of care staff were collecting meals from the hatchway. People were served drinks at the tables, but there was no food served in the dining area until the care staff had taken all the meals to people in their rooms. People sat at their tables without any food being served for approximately twenty minutes and there was little interaction between people or staff. Once the staff started to serve food in the dining area, meals were presented without any explanation of the choice on offer. People were sat on communal tables, but there was no attempt to make the dining experience a social occasion. For example, people were served their meals at different times, with one person on one table waiting 10 minutes or more after the other person at their table received their meal. A number of staff were observed walking through the lounge area through to an outside door and we heard a loud 'beeping' sound from the call system which was going off repeatedly. One person was calling out from their room and a member of care staff shouted from the dining room, "I'll be there in a minute". Another person began asking in a loud voice, "Where is my food?" Care staff reassured them as they walked past.

Once the meals were served, we observed care staff sat at tables were supporting and encouraging people to eat. Most of the staff we observed assisted people in a caring and discreet manner. They engaged in conversation where possible and proceeded at a pace that suited the person. We observed one person had not eaten their meal because they said the meat was too tough and the care staff offered them an alternative. However, another member of care staff supporting someone in an armchair, away from the dining area, fed the person in silence.

In addition to food available at mealtimes, people could help themselves to crisps, snacks, fruit and chocolate which were available throughout the day. We talked with the chef who explained that the menus were planned over a four week cycle. Some people needed special diets, such as to have their food pureed if they had swallowing difficulties or were at risk of choking. Other specialist diets were catered for, such as for people living with diabetes and people who were allergic to some food groups. People at risk of malnourishment, or who were underweight, received fortified diets or drinks. The chef explained, "We try and build people up when they've lost weight. For example, we use cream and butter in the mashed potato. In milk pudding, we use cream. Nurses will do smoothies for some residents". The chef told us they did not routinely ask people what they thought about the menus and food choices, but said this had happened in the past. They said that people enjoyed a roast lunch served on Sundays and fish on Fridays. The chef said that once a month, a mid-week roast was on offer too. They said that some people had microwavable meals brought in by their relatives. People confirmed they were offered choice. One person said, "If I ask for something different, I will get it. I asked for jacket potato over coleslaw and they got it for me. It's good".

On the second day of our inspection, we observed people eating breakfast in the Beechside unit. The majority of people were eating toast with jam and some people had porridge. Drinks were on offer. Staff cleared away the breakfast at 11.19am, although one person still had their toast in front of them at 11.45am. Staff allowed people sufficient time to eat their meals at their own pace, even though the lunchtime meal was served soon afterwards.

People were supported to maintain good health and had access to a range of healthcare professionals and services. We asked people how they were supported to maintain good health. One person said, "They were worried I wasn't eating enough and I told them it was because I have no teeth and needed to see a dentist. They contacted the hospital and said I would have to be on the waiting list for two years! It went on and on

and then I told another nurse and they got on to the hospital and sorted it within two days. I am just waiting for the appointment to come through". A relative told us, "Mum has deteriorated in the past couple of weeks. She was taking so many tablets and was having difficulty swallowing them. We mentioned this to the nurses and they have got the speech and language therapy team to see her and she has seen a paramedic practitioner to review her tablets".

People's individual needs were not always met as the environment, especially in Beechside unit, was not conducive to the needs of people living with dementia. In the unit, contrasting colours could have been used to good effect to aid people's orientation as they moved around. We spoke with one person who agreed to show us their room, but then had difficulty in locating it. More use could have been made of accessible signage and memory boxes placed outside people's bedroom doors are a way of prompting people about their lives and interests. Some people had their names on their bedroom doors, but opportunities had been missed to plan Beechside in a 'dementia friendly' and accessible way. We observed a board in Beechside which depicted the date and weather for the day ahead, however, the date shown was 2 March, which was incorrect. This would have been confusing for people. We were told by the management team that there were plans to refurbish the garden adjacent to Beechside during 2017. We recommend that the provider seeks advice and guidance from a reputable source on how to provide an environment that empowers people living with dementia to lead fulfilling lives and which promotes their independence.

Requires Improvement

Is the service caring?

Our findings

At the inspection conducted on 11 February and 9 March 2016, we found the provider was in breach of a Regulation associated with dignity and respect. We asked the provider to take action because some staff did not always treat people in a respectful way and their wishes and preferences were not always listened to. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. The action plan stated that staff would be reminded of the need to respect people's choices and wishes. In addition, staff would attend training sessions to improve their communication skills and compassion awareness. At this inspection, we found that insufficient improvements had been made relating to the concerns raised at our last inspection and that this breach was not met.

We observed that not all staff displayed a caring attitude and several instances of staff ignoring people when they entered a room. Staff appeared to be task orientated and not open to engagement with people. For example, two members of staff were helping someone to their room and a hoist was required. The staff offered instructions to the person on what to do, such as, 'Lift up your feet', but there was no explanation to the person about what they were going to do or time to obtain the person's understanding and consent. In another situation, we observed care staff respond to a person who had been calling out. When they reached the person, they said, "Ready?" as they moved them in their wheelchair to another room. There was no eye contact or explanation and the care staff spoke to another member of staff, ignoring the person, as they walked along.

Some people were not positive about the care and support they received from staff. One person said, "It is hard to say they are all caring. You can tell sometimes when I call for help they come in and don't want to do it. They say they need someone else and go off and you don't see them again. There is no kindness. They will change my pad and get out of the room as soon as they can. There are one or two who you can have a chat with. You can tell, they really care about you as a person and not just a task".

A relative said, "I think on the whole the care is okay most of the time, but you do get glitches from time to time. I don't think they change people enough. It would seem they have a new pad on in the morning when they get up and are not changed until they go to their room in the evening".

Another relative commented, "Communication can be difficult as my wife is blind and can't always say what she wants. Sometimes the staff, mainly the agency staff, don't understand that. I have put these notices up to remind them that she is blind and has a weak left hand, but it doesn't always get through". A third relative said, "On the whole they seem to be okay, but sometimes I come in and they have forgotten to put her hearing aid in or her glasses on. Today she hasn't got her teeth in. I think these things are quite important. Her hearing and sight are quite bad". In some cases, there was a lack of attention to detail to ensure that people received the best possible care.

On the first day of our inspection, we spent time in Beechside unit and completed a Short Observation for Inspection (SOFI). During the afternoon, we observed four people and two staff in the lounge area. The two staff immediately left the lounge area when we walked in. One person, who was seated in a wheelchair, was

obviously distressed and was shouting out and hitting a nearby table. Their slippers had dropped off their feet and their trousers were rolled up. Another person, who was sat in an armchair next to them, was asleep and their pudding had been left on a table in front of them. Staff returned to the lounge area, replaced the first person's slippers on their feet and left. No reassurance was provided and nothing was said. Another member of care staff came in, gently stroked the arm of the second person who was asleep and said, "Wake up darling", then immediately left. The first person in the wheelchair continued to shout and said, "Please can you help me? Can you take this?" We saw that a sling used for hoisting had been left underneath them and was proving to be uncomfortable as the person was trying to pull it out. No staff were present to reassure the person or to remove the sling. The person then put one hand in the second person's pudding and smeared the contents over the protruding sling; small quantities of pudding dripped onto the floor. After a few minutes, a staff member returned to the area and said to the second person, "[Named person] eat your pudding, open your eyes". The pudding would have been cold by this time and the inspector, who was observing, had to tell staff not to let the second person eat the pudding because the first person had put their hand in it. Staff then removed the pudding and cleaned up the mess. No reassurance was offered to people and there was no conversation. A while later, we observed that the first person, who had been so distressed at having their sling left underneath them, had been put to bed by staff. The person did not appear to be happy with this solution and kept calling out, but was ignored by staff for several minutes.

Two inspectors spent time in Beechside during the afternoon of the first day and it was clear that people enjoyed speaking with us and showing us their rooms. One person was happy and smiling and seemed extremely pleased to have some 1:1 time spent with them.

At the end of the first day of our inspection, we discussed our concerns with the registered manager. The registered manager felt that the lack of fluent English from one staff member might have accounted for the lack of communication. They said, "Dementia residents don't always communicate clearly", appearing to suggest the fault lay with people, rather than staff. People were not always treated with dignity and respect.

The above evidence is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we returned on the second day, different staff were working on Beechside. We observed people with staff in Beechside on our second day and observed good interactions and that staff were caring. One person felt cold, so a staff member brought a throw to keep them warm. Another person refused to eat and a staff member waited patiently with them, encouraging them to eat. Staff were chatting with people and there was good eye contact. We asked staff if they felt people were looked after and one said, "Definitely. We give 100 per cent, I think we all do".

Some positive, caring relationships had been developed between people and staff. We observed care in communal areas in the main part of the home throughout the day. Good interactions took place between people and a member of staff who was serving drinks; they were happy, cheerful and caring towards people and their relatives.

We asked people if they thought the home provided a caring atmosphere. One person told us, "Everybody is lovely here from the very top to the bottom, night staff included". Another person said, "They are very good. If my breathing is bad and I can't do anything, they respect that and leave me alone". A relative told us, "We are always welcomed with a smile and 'hello' from everyone". One person, who had recently moved into the home, told us, "It's okay and they treat me well, staff are kind. I had a shower yesterday, but will ask to be washed in bed in future as it's too painful".

As much as they were able, we observed people were involved in day-to-day decisions relating to their care, when staff took time to spend with them. A notice on a board in the hallway stated, 'All relatives, next of kin, advocates. If you wish to discuss care plans, please ask the named nurse … or you can discuss with [named the previous registered manager] at any time'.

Requires Improvement

Is the service responsive?

Our findings

At the inspection conducted on 11 February and 9 March 2016, we found the provider was in breach of a Regulation associated with person-centred care. We asked the provider to take action because people were not consistently supported to follow their interests and take part in social activities. There was a lack of activities or opportunities for people to be occupied in a meaningful way and in line with their interests. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. The action plan stated an 'activities person' was now available to 'Assist in the promotion of activities for all and for all age groups living in the home'. At this inspection, we found that insufficient improvements had been made relating to the provision of meaningful activities and that this breach was not met.

The home employed a full-time activities co-ordinator and we observed the co-ordinator during the morning. A number of people were sitting at tables with jigsaw puzzles or colouring in front of them. Two people were involved with painting and colouring, but most people in the room did not seem engaged or interested in taking part in the activity in front of them. One person said, "I don't want to do puzzles, I'm not interested". Another person said, "I did this yesterday and don't want to do anymore". The activities co-ordinator was moving between tables and provided encouragement.

We asked if there was an organised activity schedule. We were shown a board in the lounge with days of the week denoted. The activities co-ordinator told us, "I used to write up on the board what we would be doing, but people were not really interested. I find it a struggle to get people to engage in anything. Some of the residents have poor sight or lack understanding and so it is difficult to find group activities for everyone". They added they did have entertainers visiting the home, but we did not see any information displayed in the communal areas or any organised programme of events which would have advised us of planned activities. Some notices posted in the hall referred to exercise classes being held two or three times monthly and another monthly activity, but that was all. A notice referring to activities stated, 'The home will offer a range of activities for you to participate in or simply observe. The choice will always be yours to make. Details will be displayed in the home with a programme of events'. No such programme of events was seen.

We asked how activities were chosen for people and the activities co-ordinator said, "I try different things, but I don't have a lot of time as I have to stretch my time for the people in Beechside and I go to people in their rooms. I think it is too much for one person". We did not see any evidence that group activities or one-to-one sessions were organised around people's hobbies and interests gained from their life histories and backgrounds. For example, one person told us, "I used to like fishing and I like motor racing". When we mentioned this to the activities co-ordinator, they were surprised. They said to the person, "You didn't tell me that".

Some people were unable to take part in the activities in the lounge and spent their days in their bedrooms. We spoke with one person who spent most of their time in their room. They told us, "They come in and do the job and get out as soon as they can. None of them come and just have a chat. Sometimes I don't see anyone from 7.30am when the night staff come in with breakfast, right up to lunchtime". On the first day of

our inspection, we did not observe any one-to-one activities being offered to people who remained in their rooms due to choice or health needs. On the second day of our inspection, we were given a file where the activities co-ordinator logged their individual visits to people's rooms and the activities that had been completed. However, another file relating to the recording of group activities offered to people at the home had not been completed since October 2016. The activities co-ordinator admitted they had not completed the recording of activities for some time. The registered manager and the senior manager were unaware of this until the file was produced. We asked the managers whether the activities co-ordinator had received a supervision recently which would have highlighted this issue and they confirmed no supervision meeting had taken place.

We spoke with people and staff about the provision of meaningful activities within the home. People we spoke with were aware that there was an activities co-ordinator who provided puzzles or games in the communal lounge. One person said, "They ask me if I want to do the puzzles, but I like to read my newspaper or watch TV, I don't really want to do much else". Another person said, "I like to make my own entertainment. I come down for the music and theatre productions sometimes. I am lucky because I can get out. One of the care staff takes me out in the wheelchair". Whilst some activities were offered, these were not personalised to reflect people's interests or hobbies. We did not see any evidence to show that people had been asked about what they would like to do and overall people did not have access to meaningful activities that provided mental stimulation. This is particularly critical for people who were living with dementia or who may not be able to initiate their own independent activities. The risk of social isolation, withdrawal and low mood as a result of this lack of engagement is high for these individuals.

The above evidence is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were not in place to ensure people's care records were accurate, complete or up to date. Information relating to people's care was recorded in a variety of places and the location of care plans was inconsistent. For example, some records were stored in the nurses' office, some care plans had been printed off and were kept in people's rooms, whilst other information was recorded electronically. It was difficult to see how staff could easily locate information relating to people's support needs that would enable them to provide appropriate care and support. The senior manager explained they were in the process of changing the recording of care plans from one software program to another. We have already stated that care staff did not routinely have access to care plans kept electronically, as a 'read only' access code had only just been put in place (see the Safe section of this report). As the service frequently used agency staff, it is essential that staff less familiar with people's histories and needs had easy access to accurate records to inform the care delivery.

Where care records were kept in people's rooms, we saw that the hard copy on file was not always the latest version shown electronically as this information had not been printed off. It was evident that information in one care plan contained incorrect information because one part of a female resident's care plan referred to a male service user's name. Information had been copied and pasted between care plans which could lead to inaccurate information being recorded. This might mean that people did not receive care that was appropriate to their needs. Staff maintained a daily record for each person, but information logged was task orientated and did not provide any clue as to people's well-being. We saw one member of staff incorrectly record that hourly checks had taken place when they had not. The member of staff was seen to enter both people's rooms for a few seconds only and did not speak to either person.

The registered manager told us they had introduced a new document 'About Me' which included people's admission date, photo, name, preferences, biography, communication, food likes/dislikes, relationships,

professional involvement and activities for daily living. These documents contained statements rather than information to provide clear advice and guidance to staff. The registered manager told us that information was collected when a person was admitted to the home. However, not every person living at Homebeech had this detailed information completed on file. We looked at eight advance care plans which relate to how people wish to be cared for in the future. The records had some evidence of personalisation, but did not always state that the person or their family was involved. Information in one advanced care plan had not been updated relating to an application for power of attorney. In four advanced care plans, we found repetitive wording and phrasing that indicated information was not personalised or completed in consultation with the person or their relatives. For example, we read, 'All elements of care are important' and, 'Wish to be pain free and content'.

The above evidence is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were managed in line with the provider's complaints policy, which was on display at the home. The policy gave information on who to contact and that complaints would be responded to within 28 days. One complaint was received from a person at the time of our inspection; the registered manager responded and managed the complaint promptly.

Requires Improvement

Is the service well-led?

Our findings

We asked the registered manager how people were involved in developing the service and how their feedback, including that of their relatives, was obtained. The registered manager told us that residents' meetings had taken place in the past, but that none had occurred in 2017 to date. They added, "It is on my list to do. I try and have them three times a year". Records to confirm that residents' meetings took place in 2016 had been archived and were unavailable for us to see. The senior manager said that relatives' meetings had taken place, but that only two relatives had attended the last meeting. They told us that it might be a good idea to contact relatives to see when the best time might be for them to attend meetings, so these could be organised. The senior manager told us that not many relatives lived close to the home. We asked whether any questionnaires had been sent to relatives to obtain their views about the service. The senior manager told us that questionnaires had been sent out in November 2016, but only two responses had been received. Documents relating to this were not made available to us. Feedback was not obtained to evaluate or improve the service. The senior manager stated they were thinking of introducing a new system whereby cards could be available for relatives or visitors to complete when they came to the home.

A range of systems was in place to monitor and measure various aspects of the service. However, these were not always effective in demonstrating that improvements identified had been completed. In addition, systems were not in place to demonstrate the service operated effectively to ensure compliance with the Regulations. Breaches of three Regulations found at our inspection in 2016 had not been met. Audits were completed on the environment, infection control, wound care and accidents and incidents were analysed to identify any emerging trends.

The above evidence is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought the home was well run. One relative said, "It is well run. When we have raised concerns things have happened and been acted on". People we spoke with could recall the name of the registered manager. However, one person, who spent most of the time in their room, said, "It would be nice to see her more. It would be nice if she could come around once a month. You never see her up here". The registered manager told us they operated an 'open door' policy and that any issues from people, staff or relatives could be discussed promptly. We saw staff had easy access to the registered manager's office throughout our inspection and any matters were dealt with straight away. We asked staff about the philosophy of the home. Staff told us they treated people like one of their relatives and each person was treated as an individual. One staff member said, "We all act like we're their family members. If people are reaching the end of their life, we give them love and attention in their final days. We work as a team". Another staff member told us, "The manager is good and any changes are put into place straight away". It was evident that staff felt supported by the management team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not in place to ensure that accurate, complete and contemporaneous records were kept in respect of each service user. Feedback from relevant persons, to evaluate and improve the service, was not obtained. Regulation 17 (1) (2) (a)(c)(d)(e)(f)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not provide care in a way that met service users' needs or reflected their preferences. Regulation 9 (1) (a)(b)(c)

The enforcement action we took:

We issued a Warning Notice requiring the provider and the registered manager to take action to address this breach of Regulation by 2 June 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: Service users were not always treated in a respectful way by staff and their dignity was not upheld. Regulation 10(1)(2)

The enforcement action we took:

We issued a Warning Notice requiring the provider and the registered manager to take action to address this breach of Regulation by 2 June 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risk assessments were incomplete and did not provide sufficient advice or guidance to staff on how to support people safely. Premises were not always managed safely. Equipment to support service users was not always used in a safe way. Regulation 12 (1) (2) (a)(b)(d)(e)

The enforcement action we took:

We issued a Warning Notice requiring the provider and the registered manager to take action to address

this breach of Regulation by 2 June 2017.