Uniquehelp Limited

# Beacon Hill Lodge

**Inspection report**

18 Beacon Hill,
The Downs,
Herne Bay CT6 6BA
Tel: 01227 375536
Website: www.njch.co.uk

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## Ratings

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| **Overall rating for this service** | **Inadequate** |
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

## Overall summary

This inspection was carried out on 28, 29 and 30 July 2015 and was unannounced.

Beacon Hill Lodge provides accommodation and personal and nursing care for up to 30 older people and to people living with dementia. The service is a large, converted property. Accommodation is arranged over three floors. A shaft lift is available to assist people to get to the upper floors. The service has 20 single and five double bedrooms, which people can choose to share. There were 23 people living at the service at the time of our inspection. Accommodation is provided for four staff on the top floor of the building.

A registered manager had not been working at the service since April 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run. A new manager began working at the service in June 2015 but was not registered with CQC.

# Summary of findings

The service lacked leadership and direction. There was a lack of leadership and oversight by the provider and this had impacted on all areas of the service. Some staff had resigned and the remaining staff were demotivated. People, their families and staff had not been asked about the quality of the service they received and were not involved in the way the service operated. Processes were not in operation to continually improve the service.

A system to make sure there were enough staff available to meet peoples' needs at all times was not in operation. The manager had used agency staff to increase staffing levels on the second day of our inspection. Staff did not have time to spend with people and people received little interaction from staff during the day. Staff were unclear about their roles and responsibilities.

Staff recruitment systems were in place. Adequate information about staff had not been obtained to make sure staff did not pose a risk to people and had the right skills and knowledge to meet their needs. Disclosure and Barring Service (DBS) criminal records checks had been completed.

Staff were not supported to provide good quality care. The provider and manager did not know what training staff had completed and what skills and experience they had. Checks had not been completed on the competency of staff to complete their role. A training plan was not in place to keep staff skills and knowledge up to date. Staff did not have the opportunity to meet with a senior staff member on a regular basis to discuss their role and practice and any concerns they had.

Staff knew the possible signs of abuse and who to report any concerns to. Guidance was not available to staff, including new or agency staff, about the provider's safeguarding or whistleblowing processes. Equipment and plans were not in place to evacuate the building in an emergency. Risk to people's health and wellbeing had not been fully assessed, and action had not been taken to keep people as safe as possible. Some moving and handling equipment had not been safety checked and areas of the building and equipment were not clean. Accidents and incidents were not continually reviewed to identify and address patterns or common themes.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Staff were unclear about their responsibilities under Deprivation of Liberty Safeguards (DoLS). The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. Care for people who had DoLS authorisations had not been planned to keep people safe and to ensure restrictions were kept to a minimum. Some people were at risk of being restrained because staff had failed to check that using equipment, such as bedrails, was the least restrictive way of keeping people safe. Some people were not encouraged and supported to get out of bed. Systems were not in operation to obtain consent from people or those who were legally able to make decisions on their behalf. The provider had failed to act in accordance with the Mental Capacity Act 2005.

Information and guidance was not provided to care staff to make sure they provided the care people needed in the way they preferred. People and their relatives had not been involved in planning and reviewing their care. People were not supported to remain as independent as they could be. Care was not planned to make sure that people received consistent care and treatment, including wound and catheter care. People who had lost weight had not been referred to appropriate health care professionals for advice and support.

People did not always get their medicines at the correct time. People's medicines were not stored in a clean environment or disposed of when they were no longer required.

Meals times were not social occasions at Beacon Hill Lodge and people were not supported to get out of bed to eat or to sit together at tables. We found that people often had to wait for their meal and there were long gaps between courses. People told us that they enjoyed the food but did not know what they were eating. People had not been involved in planning the menus. Food was prepared to meet some people's specialist dietary needs.

Staff were not sure how to offer people choices in ways that people understood. Some staff were unable to understand what people were saying to them because English was not their first language. People told us they could not understand some staff as they had strong foreign accents. We observed that staff did not always respond appropriately to peoples' requests.

# Summary of findings

People were not always treated with dignity and respect. People who used net underwear with their incontinence products did not received their own underwear back from the laundry. People were referred to as room numbers and tasks by staff and were not treated as individuals.

People's privacy was not maintained. Staff, including the manager, did not knock on people's bedroom doors before walking in and did not ask their permission to enter their rooms. People's records were not held securely and information about them was accessible to other people and visitors to the service.

Information had not been obtained about people's preferences and personal histories. People were not supported to continue with interests and hobbies they enjoyed. People told us they were bored and wanted things to do and people to chat to. People were not supported to build relationships with staff or other people using the service. Staff did not chat to people about people who were important to them or things that mattered to them.

An effective complaints system was not in place and was not accessible to everyone. People and their relatives had made complaints about the service but these had not been investigated and people had not received a satisfactory response.

The provider and manager were not aware of the shortfalls in the quality of the service we found at the inspection, and had not completed regular checks of the quality of the service provided. The provider had not obtained information from people and staff about their experiences of the care.

Records were kept about the care people received and about the day to day running of the service. Some records, including medicine administration records, were not accurate and did not provide staff with the information they needed to assess people's needs and plan their care.

The registered provider had not notified the Care Quality Commission of significant events that had happened at the service. During our inspection the provider made a commitment not to admit any new people into the service until the concerns around staff and their knowledge and skills and other concerns had been resolved.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We met with the provider on 30 July 2015 and again on 23 September 2015. We had several telephone discussions with the provider about what they intended to do to improve the service. We asked the provider to send us evidence, urgently, about the immediate action they would take to ensure peoples' safety and well-being. The provider sent us an action plan and evidence of the immediate action they had taken. They have sent us regular updates to the action plan and further supporting evidence. We considered everything the provider sent us and will follow this up at the next inspection. After the inspection, the provider informed CQC that they planned to close the service for refurbishment.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have asked the provider to take at the end of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Staff knew the signs of abuse, but guidance was not available to support them to take the right action to keep people safe.

There were not enough staff with the right skills and experience to meet people's needs and provide their care safely. Recruitment checks were not thorough.

All risks to people had not been consistently assessed. Action had not been taken to reduce risks to people.

The service was not clean in some areas. Equipment people needed was not always available and had not always been checked.

Systems were not in place to make sure that people received their medicines at the right time. Medicines were not managed safely.

**Is the service effective?**

Inadequate

The service was not effective.

People's ability to make decisions had not been assessed. People were deprived of their liberty but this had not always been assessed and authorised.

Staff had not been inducted and trained to meet people's needs. Staff were not supported to provide safe and appropriate care to people.

People's health and treatment needs had not been consistently assessed and care had not been planned to meet their health care needs.

Meal times were not a social occasion and people were not encouraged to sit at tables to eat. People often had to wait for their meal. Some people had lost weight and no action had been taken.

Some staff did not have the skills to communicate with people as their English was not good.

**Is the service caring?**

Inadequate

The service was not consistently caring.

Most staff did not treat people with kindness and compassion. Staff provided care to meet people's basic needs but did not acknowledge them as individuals.

The routine of the service was not flexible to suit people's preferences. People, and those who knew them well, were not involved in planning their care and in the day to day running of the service.

Some staff did not maintain people's privacy, including knocking on their bedroom door before entering.

People's wishes for their end of life care and care after their death were not known.

# Summary of findings

**Is the service responsive?**

Inadequate 

The service was not responsive.

People and those who knew them well, including care staff, were not involved in planning or reviewing their care.

Care staff were not provided with guidance about how to provide people's care safely and in the way they preferred.

People were not supported to take part in activities they enjoyed, inside and outside of the service.

The provider's complaints procedure was not followed and people did not receive a satisfactory response to their complaints.

**Is the service well-led?**

Inadequate 

The service was not well-led.

The provider and manager did not have a clear set of values, including involvement, equality and safety for the service.

There was no consistent leadership and staff were demotivated. Staff were not clear about their roles and responsibilities and were not held accountable for the care they provided.

Checks on the quality of the service had not been completed regularly. People, their relatives and staff had not been asked about their experiences of the care.

Records about the care people received were not accurate and up to date.

# Beacon Hill Lodge

**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.

This inspection took place on 28, 29 and 30 July 2015 and was unannounced. The inspection team consisted of one inspector, a specialist professional advisor, whose specialism was in nursing older people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not receive the completed PIR from the provider because the provider used the incorrect email address. After the inspection the provider gave us a hard copy of the PIR. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. Before our inspection we had information from the local authority safeguarding team.

During our inspection we spoke at length with 14 people and briefly with six people. We spoke to seven people's relatives and the staff on duty at the service. We looked at the care and support that people received. We looked at people's bedrooms, with their permission; we looked at care records and associated risk assessments for six people. We observed medicines being administered and inspected medicine administration records (MAR). We looked at management records including three staff recruitment files, training and support records and health and safety checks for the building. We observed the support provided to people in the lounges.

A new member of the provider's senior management team was visiting the service for the first time on the first day of our inspection. They were present at the service during the whole of the inspection.

We last inspected Beacon Hill Lodge in June 2014. At that time we found that the registered provider and registered manager were complying with the regulations.

Inadequate

# Is the service safe?

## Our findings

People did not always feel safe at the service. One person told us, "I call at night and it can take an hour to answer." Another person told us, "I feel sorry for the staff as there is not enough of them and they are so busy, they don't have time to stop and chat". A third person said, "The ratio of staff to residents is far too low, especially at night. You can wait forever for a bell to be answered, I can't say that the care is good here, especially at night if you need someone". One staff member told us, "It's a nightmare working here at the moment, there aren't enough staff".

The manager did not have a process in operation to help them decide how many staff were required to keep people safe and meet their needs. The manager did not know if the provider had a process in place. A nurse worked at the service during the day and the night to provide the nursing care and treatment people required. Care staffing levels were not consistent across the week. People's preferences, needs and the layout of the building, had not been considered when deciding how many staff to deploy at different times of the day. Following the inspection, the provider took action to make sure that there was a process in place to work out how many staff were needed to meet people's needs. The provider told us he had taken action to make sure there were always enough staff on duty to meet people's needs safely.

People had to wait for the care they needed, sometimes for a long time. On the first day of our inspection we observed one person wait for an hour and three quarters to be given a hot drink that had been made for them by staff. People's call bells rang for a long time before they were answered and people were given the care they needed. One staff member said, "We are so short of staff and we cannot be in two places at once".

Another staff member said, "The care is task orientated because we are short of staff". They told us they began getting people up at 8am and were still getting people up at 1pm. We observed that people were left without the support they needed at lunchtime, because staff were still getting people up. People struggled to eat their meals on their own. Staff told us that people received their meals when staff had time to take them to them. People waited for long periods of time for their meal to be brought to them, and we saw some people fall asleep whilst waiting for their meal. Following the inspection, the provider told us he would make sure that there were enough staff on duty to meet people's needs.

During the first day of our inspection the senior manager increased the number of care staff working on each shift from the following day. The service had a number of staff vacancies including nursing and care staff. Some staff had left the service before our inspection and one was working their notice. A cook was not employed to work at the service and care staff were covering this role. Following the inspection, the provider took action to make sure that there was a dedicated cook working at the home every day. The manager told us, "I will recruit staff who have the skills to meet people's needs and I will check their competence". Agency staff who had worked at the service before were used, when possible, to increase the number of staff working on each shift. Cover for staff sickness and vacancies was provided by permanent staff members on occasions, but more frequently by agency staff.

Staff were allocated tasks to complete during each shift, such as working together in pairs to support people who required two staff to meet their needs. These tasks were not allocated based on staff competency. Agency staff were paired with experienced staff at the beginning of each shift, however, they did not always work together. We observed a senior care worker instruct an agency staff member to go to a person's room and help them select their clothes for the day, and get the equipment ready to provide their personal care. The agency staff member did not know who the staff member was talking about, and was not given the information they needed to support the person in a way they understood. Following the inspection, the provider took action to make sure that agency staff were booked a month in advance and the same staff were requested for continuity. They told us they had taken action to make sure that all staff, including agency staff, were aware of each person's needs.

The provider had failed to deploy sufficient numbers of suitably competent, skilled and experienced staff to keep people safe and meet their needs. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the signs of physical abuse, such as bruising or a person being withdrawn. They knew how to raise their concerns with relevant people, such as the manager and

# Is the service safe?

the local authority safeguarding team. Staffs' understanding of safeguarding had not been checked to make sure they had the knowledge they required to keep people safe. Following the inspection, the provider told us he had taken action to make sure that staff had awareness of the safeguarding protocols and that staff were competent in recognising abuse and raising an alert.

Guidance on safeguarding and how to protect people was not available to staff, including new and agency staff, at the service. The manager had recently made copies of the provider's policies and guidance available to staff but had not identified that important guidance including the provider's whistleblowing and safeguarding policy and procedures and the local authority safeguarding policy, protocol and procedure were not in the service The manager printed out a copy of the provider's safeguarding policy for staff during our inspection.

People were at risk of being isolated and neglected. A call bell system was fitted in people's bedrooms and in communal areas. People did not always have the call bell within their reach in their room and were unable to call staff if they needed them. One person was alone in their bedroom and told us they felt unwell. They had been unable to tell staff as their call bell had not been placed within their reach. We asked staff why people did not have call bells within their reach, they replied, "I have no idea, no-one has said why". Call bells in communal areas were not accessible to people as they were behind furniture or out of peoples' reach. There were periods when no staff were in the lounges with people. People relied on staff checking on them or other people alerting staff to their needs to keep them safe. Following the inspection, the provider told us that he had taken action to make sure that call bells were within people's reach and that people who could not use a call bell, were regularly monitored. We observed staff turning call bells off in corridors before they attended the person's room. Other staff members who were nearer to the person's room did not respond as they believed the call had been responded to. After the inspection the provider told us that they had taken action to address this.

The provider had failed to establish systems and processes to protect people from the risks of abuse. This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal emergency evacuation plans (PEEPs) were in place for each person, some included how many staff were required to move them to another place of safety in the building, others did not. One person had two PEEPs in place which contained contradictory information. Guidance on how to move people safely was not provided to staff. Three people's plans stated, 'Should it be necessary to evacuate down a stairway this could be achieved by:- Use of blanket, mattress or evacuation chair/mat/pad/ sheet by 2/3/4 people'. The piece of equipment to be used and the number of staff required had not been identified. Some of the equipment detailed in the PEEPs, including evacuations chairs, was not available to move people downstairs when the lift could not be used, such as in the event of a fire. The manager told us that she had not seen these plans.

Some staff had received fire safety training but action had not been taken to assess their competence in the fire safety procedures. Fire drills had not been completed regularly and did not involve all staff working at the service during the day and night. Staff told us they had not been trained in how to move people safely using equipment detailed in the PEEPs and gave us different descriptions of how they would move people safely. We reported our concerns to the local fire and rescue authority. Following the inspection, the provider told us that he had taken action to make sure that all staff had attended fire awareness training which included taking part in a fire drill.

The provider did not have plans in operation to respond and manage major incidents and emergency situations such as fires and make sure people were safe and any risks to their care were minimised. This was a breach of Regulation 12(2)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had been assessed; however people and those who knew them well had not been involved in the assessments. Risk assessments had not always been completed correctly. One person's nutritional assessment (MUST) showed that they were at high risk of malnutrition because they did not eat very much. The assessment showed that the person had lost a significant amount of weight but this had not been used as part of the assessment. The assessment was reviewed after approximately two weeks but the person's weight was not recorded. No action had been taken to reduce the risk of the person losing more weight. Systems were not in

operation to inform staff of any changes in the way risks to people were managed. Following the inspection, the provider told us they had taken action to make sure that action was taken promptly when a person lost weight.

Moving and handling risk assessments were in place for people who needed support to stand and transfer. These had not been consistently followed. Guidance for staff about how to move people safely was stored in their care plan. Care staff followed an 'At a glance' care plan when providing people's care and these guidelines about moving and handling people were not included. Some staff told us they used the sling that was on the hoist. Other staff told us they used what they thought 'was best'. Staff did not know if they were moving people safely. Following the inspection, the provider told us they had taken action to make sure that staff knew how to move people safely and which slings to use.

Accidents and incidents involving people were recorded. These had not been reviewed in line with the provider's policy to look for patterns and trends, so that care may be changed or adjusted or advice sought. The manager was unaware of the provider's process for analysing accidents and incidents. A log of accidents was maintained in the service but was not up to date. Following the inspection, the provider told us they had taken action to make sure accidents and incidents were all recorded and analysed.

Four staff lived in a flat at the top of the building and had access to all areas of the service. An assessment of the risks posed by staff living in the service, such as any risks from the staff's visitors, had not been assessed and action had not been taken to keep people as safe as possible. Environmental risk assessments for the building had been completed in 2009. These had not been reviewed to ensure they remained current.

The provider had failed to assessed and mitigate risks to people. Plans for managing risks were not available to staff and staff did not follow them. This was a breach of Regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff were using a stand aid hoist to move one person. We asked the staff why they had used the strap. They told us that there was only one strap and they used it for everyone. We would expect a range of straps to be available to meet each person's needs. The stand aid had not been safety checked for over 18 months and was not clean. All other moving and handling equipment required checking by the end of July 2015. This had not been noticed by staff at the time of our inspection. Following the inspection, the provider told us they had taken action to make sure individual straps were used and that all equipment was safety checked in line with the manufacturer's instructions.

Prescribed equipment such as catheters had not been ordered for some people and were out of stock. They were not available should people require them. Medicines received into the service from the pharmacy had not been double checked to make sure they were correct. Following the inspection, the provider told us they had taken action to make sure that people had the equipment they needed and all medicine received into the service was double checked.

Systems were not in place to protect people from unwanted visitors to the service. The identity of visitors was not checked when they were allowed access to the building and people. Following the inspection, the provider told us they had taken action to make sure that all visitors' identity was checked. People could not use the garden without the support of staff or their relatives because it was not easily accessible or safe. Following concerns that a person had left the service without the knowledge or support of staff, new security measures had been implemented at the service.

Some areas of the building and pieces of equipment were not clean, including a bath seat and a stand aid. Some areas of the service did not smell fresh. An infection control audit had been completed before our inspection and a plan had been put in place to improve the cleanliness of the service. The audit had not identified infection control risks in the laundry. Areas of the laundry were dirty and difficult to clean, including the unsealed concrete floor where dirty laundry was stored before being washed. During our inspection carpets were steam cleaned and a programme of deep cleaning people's bedrooms was started.

Moving and handling equipment had not been properly maintained to make sure it was safe for people to use. Equipment suitable to meet people's health care needs, including catheters, was not available at the service.

Inadequate

# Is the service safe?

Security of the building was not maintained. Some areas of the premises and pieces of equipment were not clean. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Refurbishment and improvement plans were not in place for the building, grounds or equipment. Maintenance staff were employed to complete day to day maintenance work, including checks of the building and equipment. Hot water temperatures were checked regularly to make sure that people were not at risk of scalding. A check on the safety of the building had been completed and plans to complete basic maintenance work had been put in place. Staff confirmed that the provider had given them sufficient funds to complete the necessary works.

Some refurbishment of the building and furniture had taken place in communal areas of the building such as lounges and new furniture had been purchased. Furniture was designed for use by people who had difficulty standing and sitting and were easy to keep clean. There was enough space in communal areas for people to move around safely. During our inspection a senior manager reviewed the use of all the communal spaces, and put plans in place for these to be rearranged to provide people with a larger and more accessible dining area. Following the inspection, the provider showed us plans and planning permission to extend and improve the home.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. Sufficiently detailed information about staff's previous employment had not been obtained. Staff's conduct in previous social care employment had not been thoroughly checked. Information on one staff's reference showed that they may not be suitable due to their language skills for the role had not been considered. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff. Information about applicant's physical and mental health had been requested and other checks, including identity checks had been completed. Following the inspection, the provider told us they had taken action to make sure that a full employment history would be obtained for all new staff and staff's conduct in previous employment would be checked during the recruitment process.

The provider had failed to make sure that staff they employed were of good character and had the skills they required. Satisfactory evidence about staff's conduct in previous employment concerned with the provision of health or social care, detailed on Schedule 3 had not been obtained. This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's medicines management policy required that the manager have systems in place to receive, store and dispose of prescribed medicines. These were not in place at Beacon Hill Lodge. The process in place to receive ordered medicines did not make sure that all the medicines people were prescribed were recorded on their medicines administration record (MAR). One person's 'when required' pain relief medicine had not been written on their MAR and had not been offered to them for 2 days. Other medicines that were not recorded on the MAR had been added by hand. These records had not been checked to make sure that they were accurate. Following the inspection, the provider told us they had taken action to make sure that checks were made on medicines management, people were offered pain relief medicines regularly and entries added by hand were checked. They also told us they had updated their medicines policy

People told us that they did not always receive their medicines on time and that this often happened when agency staff were on duty. On the first day of our inspection an agency nurse was working at the service and administering medicines. They had begun administering people's 8am medicines at 9am and had not finished at 11:20am. The nurse told us that she was checking the medicines carefully before she gave them because she did not know people and the pharmacy had previously made some errors in dispensing people's medicines. People were at risk of not receiving their medicines at regular intervals and at the times they were prescribed. The service had begun the process of changing to another pharmacy.

Medicines were not stored securely. Some medicines were stored in a fridge to stop them going off. The provider's policy was that medicines fridges should be kept locked to keep the medicines secure, the fridge was not locked. The temperature of the fridge was not monitored to make sure that medicines were kept at the correct temperature. Increases or decreases in the temperature of the fridge could not be identified, and so action was not taken to ensure people received effective medicines.

Other medicines were stored in locked trolleys and cupboards. The provider's medicines policy did not refer to current guidance and did not include guidance for staff

Inadequate

# Is the service safe?

about the safe storage of medicines. There was a risk that staff practice was not up to date with current guidance. Most medicines were stored in a locked medicines room. The temperature of this room was not monitored to make sure that the effectiveness of medicines was not affected by heat or cold. We found that one person's liquid medicine had been left on a shelf in the lounge, was accessible to other people using the service and posed a risk to them. The medicines storage room was not clean and there was a risk that medicines and other items such as dressings could become contaminated.

During the inspection we found a tablet on the floor in the medicines room and an out of date flu vaccination in the fridge. Staff disposed of these. Some medicines for disposal had been placed in a medicines disposal bin. Most of the medicines that required disposal were stored in locked cupboards and had not been disposed of correctly. A special kit was not available to dispose of some medicines. Following the inspection, the provider told us they had taken action to make sure that medicines practice was safe.

The provider failed to operate safe systems to protect people from the risks associated with medicines. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

The choices people were offered were limited. People who were confident and able to tell staff how they preferred their care to be provided were given choices. Other people were not offered choices and there was a culture of 'we know best' in the staff team. Following the inspection, the provider told us they had taken action to make sure that staff were offering people choices.

Some people were able to make decisions for themselves about all areas of their life. Other people were not able to make complex decisions for themselves and some people were unable to make simple decisions. Assessments of people's capacity to make individual decisions had not been completed. The provider had a system in place to assess people's ability to make specific decisions, when they needed to be made, this was not being followed by staff at the service. Following the inspection, the provider told us they had taken action to make sure that people's capacity to make decisions is assessed.

Staff did not know what decisions people were able to make for themselves and how to support people to make decisions. Staff gave us different opinions about what decisions people would be able to make and how best to support them to make decisions. Some staff were not able to understand what people were telling them, as they did not speak English fluently. There was a risk that staff would not understand what people were saying and that they would not be supported to make decisions when they were able.

Staff did not have a good understanding of the requirements of the Mental Capacity Act 2005. The manager did not know if staff had received training in relation to the Act, and had not checked their understanding or application of the Act to make sure it was lawful and correct. Staff were not clear about their responsibilities to assess people's capacity to make decisions. Some staff told us that they would only assess someone's capacity once and this would not be in relation to a particular decision. Other staff had made decisions on people's behalf without assessing the person's capacity. Staff were not clear who would be responsible for assessing people's capacity to make decisions.

We found that decisions people had made and consent that had been given had not been reviewed to understand if the person had changed their mind. One staff member told us that they were going to take a picture of someone as part of their care plan. They were unclear if the person was able to give consent to having their picture taken and relied on consent the person had given in March 2010. Other records showed that the person had capacity to make decisions, and would have been able to tell the staff member if they were happy to have their picture taken, so support was not consistent.

Some people's relatives had given consent for areas of their relative's care. Staff did not know, for every person, if someone had been appointed to lawfully make decisions on the person's behalf in their best interests. Following the inspection, the provider told us they had taken action to make sure that staff understood and applied the MCA.

The provider did not have processes in place to make sure that care was only provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The service was not meeting the requirements of DoLS.

The provider did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. Staff were unclear about their responsibilities under DoLS. Assessments of the risk of people's liberty being restricted unlawfully had not been completed. Many people were subject to continuous supervision and were not free to leave. Therefore their liberty was restricted. At the beginning of our inspection the manager did not know if applications to deprive people of their liberty had been made to the local authority DoLS Office, to ensure the restrictions were legal.

At the end of our inspection the manager gave us a list of five people who had DoLS authorisations in place. Care for people with a DoLS authorisation in place had not been planned to support them to be as independent as possible and remain safe. One authorisation had conditions

requiring, 'That the Managing Authority should consult with the Relevant Person's Representative, when appointed, about any proposed changes to (the person's) care regime'. The staff did not know that the authorisation had conditions on it and had not acted to ensure that the Relevant Person's Representative would be consulted about proposed changes to their care. Following the inspection, the provider told us they had taken action to make sure that the manager and staff met the requirements of DoLS and were aware of any DoLS applications.

The provider had failed to act in accordance with the Mental Capacity Act 2005. The risk of people being unlawfully deprived of their liberty had not been assessed. Where people had a Deprivation of Liberty Safeguard authorisation in place the provider had not planned their care to manage the risks of excessive restrictions on their liberty. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and other new staff had not completed an induction to ensure they knew and understood their roles and responsibilities. The manager told us, "I didn't have a thorough handover and induction when I started working at the service". The provider was using the new Care Certificate, an identified set of standards that social care workers adhere to in their daily working life to induct new staff. One staff member had begun this process but had not received any guidance or support and had stopped working towards the certificate. They told us they had shadowed other staff to learn how people preferred their care to be provided, but had found that each staff member provided people's care differently, and the care people received was not individual to them. Following the inspection, the provider told us they had taken action to make sure that staff completed an induction including the Care Certificate.

One person's relative told us, that they thought that the training the staff were given was inadequate to provide the care people required. The provider did not have a system in place to ensure staff received the training they needed to perform their duties. There was no training plan and the manager did not know if the information in the service about staff training levels was correct. The manager told us that the nurses working at the service required training to increase the skills and competence to the required levels.

Staff told us that they had completed some training but were unclear about the training they had completed. One staff member told us they had been given some information to read and questions to answer at home. They told us they had also been given the answer book. They were concerned that they would not learn if they could refer to the answers without reading the information.

Assessments of staff competencies and skills to complete specific tasks had not been completed. The provider and manager did not know if staff had the competencies, skills and experience required to meet peoples' needs. The manager told us they had not had time to assess the competency of nurses and other staff. Following the inspection, the provider told us they had taken action to make sure that staff competencies would be checked.

Staff told us they did not feel supported to deliver safe and effective care. Staff had not met with the provider or a manager regularly to talk about their role and the people they provided care and support to. Development plans were not in place to support staff to develop their skills, knowledge and experience. Staff were not supported to identify areas where their practice required improvement. Steps had not been taken by the provider to support staff to develop the attitudes and behaviours they needed to complete their role. Following the inspection, the provider told us they had taken action to make sure that staff were supported to develop positive attitudes and behaviours.

Staff were not supported, skilled and assessed as competent to carry out their roles. Staff had not received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not been consistently supported to maintain good health. Before our inspection we had received concerns about the ways in which the staff supported people to maintain healthy skin and manage catheters. These were being investigated by the local authority safeguarding team.

We spoke with one person with a catheter. They told us that the catheter tube 'hurt sometimes'. We observed that the catheter bag was hanging down the side of the bed and was not attached to the holder. We arranged for the bag to be put on the holder, and the person told us that it felt

much better. The person's needs and wishes in relation to the catheter had changed since they moved into the service. Their care plan had not been updated to reflect this and provide clear instructions to nurses about how they were to manage the person's catheter. Following the inspection, the provider told us they had taken action to make sure that people had the right support to manage their catheters.

People's skin health had been assessed and pressure relieving equipment was available to people who needed it. Assessments had not been reviewed to ensure that they remained current. One person was lying on a pressure relieving mattress, set for a person who weighed 130kg, this person weighed less than half of this. Lying on a mattress that was too firm would not have given the person the best protection from developing skin damage. Some people needed to change their position regularly to keep their skin healthy. We observed people were not consistently supported to be repositioned as required. People were at an increased risk of skin damage because of the lack of support to be regularly repositioned. Following the inspection, the provider sent us evidence that they had taken action to make sure that people were repositioned regularly and pressure relieving mattresses were set correctly.

Some people had wounds and pressure sores that were being treated by nurses working at Beacon Hill Lodge. Wound care plans were in place for people. These did not give clear instructions to nurses about how to provide consistent care and treatment to people. Agency nurses told us they did not know who had wounds, or when their dressing should be changed and would rely on what was written in the diary. Care staff did not know how to recognise that people were developing pressure sores. One staff member told us, "I have had no training on recognising changes in skin but I would report a grade 1(pressure sore)". They were unable to tell us what that meant or how they would recognise it. Following the inspection, the provider told us they had taken action to make sure that there were clear treatment plans to manage wounds.

The provider had failed to make sure that people received appropriate care and treatment to meet their needs. This was a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food at the service. They told us that they got their meals "when it's ready". On the first day of our inspection lunch was served late and people had to wait for their meal. People complained to us that they were hungry.

People's weight was recorded and monitored to identify any weight loss. However, action was not consistently taken when people lost weight. In June 2015 staff identified that one person had lost a significant amount of weight, 10kg, approximately one and a half stone, in a month. Staff did not take any action and the person was not referred to a health care professional. A food and fluid intake chart was in place to monitor the person's food and fluid intake. This had not been completed consistently and no system was in place to monitor the person's intake effectively. The person continued to be at risk. Following the inspection, the provider told us they had taken action to make sure that prompt action was taken if a person lost weight.

Jugs of squash were available to people who could help themselves, most people were not able to do this. Staff did not encourage or support people to drink often, people were given drinks by a kitchen assistant but did not always get the support they needed from staff to drink them.

We observed one person struggling to eat their meal by them self. Staff had identified the person was at high risk of losing weight and becoming malnourished. Their care plan stated that they were able to feed themselves but required help and encouragement. Staff were unclear about the levels of support the person required and did not provide the person with any support. We asked for the person to be given a spoon to assist them and they ate most of their meal.

Some people were unable to eat or drink and received their nutrition through a feeding tube directly into the stomach called a percutaneous endoscopic gastrostomy (PEG). Before our inspection, concerns were raised about how nurses at the service responded to concerns about people's PEGs. These were investigated by the local safeguarding team. Clinical guidelines for staff about people's PEGs was not included in people's care plans placing them at risk of receiving the wrong support.

Meal times at the service were not special occasions. The majority of people ate their meals either in bed or sat in their arm chairs, in front of the television, where they spent all their time. People were not offered the opportunity to

Inadequate

# Is the service effective?

eat in the dining room or at a table. Some people struggled to eat as they were too far away from their meal. Following the inspection, the provider told us they had taken action to make sure that people had a choice about where to eat.

People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed separately and presented in an appetising way. People were able to taste the separate flavours of each food. People were offered a choice of food at each meal. If people did not like the choices offered the cook prepared an alternative of their choice. Most people chose the main menu choice each day. Meals were homemade and included fresh vegetables.

Staff preparing meals understood the different diets people needed to keep them healthy. Low sugar varieties of the puddings were on offer, such as sugar free jelly and cakes. Some people needed food 'fortified' with additional calories as they were at risk of losing weight and this was provided.

People's nutrition and hydration needs had not been regularly assessed and reviewed and action had not been taken to respond to people's changing needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service caring?

## Our findings

People and their relatives told us that some staff were kind and caring. One person told us. "I am happy here. I am well cared for and have no complaints. My room is kept clean and tidy". A person's relative said, "The staff are lovely, they cannot do enough for my relative. They have a lot to put up with but are always so cheerful".

Some staff knew people well but their knowledge was not always used to provide care in the way people preferred. Some agency staff did not know people's names, or the care they needed. We observed staff and people in the lounges and other areas of the service. Some staff spoke with people individually and people responded to them.

People were not involved in their care. Communication between people and staff was not always effective. One person told us "It's difficult to speak to some of the staff, most don't speak English very well". They told us they could not understand some staff and staff could not understand them. One person's relative told us that many staff's spoken English was not good and this made it difficult for people to understand them.

Some staff did not take time to listen to people and check they understood what the person had said. We observed one person at lunchtime ask a staff member for a piece of equipment to be given to them at night. The staff member did not understand what the person had said and gave them the piece of equipment then. The person told the staff member they required the equipment later, but the staff member did not understand what they were saying and laughed rather than trying to understand what the person had said. The manager told us that she had concerns about the communication skills of some staff at the service.

Information was not always provided to people about their care and how it would be provided. We observed one staff member move someone from the lounge to their bedroom without talking to them. The staff member approached the person from behind and moved their wheelchair backwards. The person was unable to see where they were going and was not told by staff. The person looked concerned by this but was unable to tell the staff member.

Some people and their relatives had been asked for information about their life before they moved into the service and had provided this. The information had not been used to plan people's care. Information had not been requested from other people and staff had little knowledge of their life before they moved into the service, their likes and dislikes and how this affected their preferences of care. People had not been supported to express their views about the care and support they received and had not been given the opportunity to share their views about staff with the provider. Following the inspection, the provider told us they had taken action to make sure that everyone was asked about their life history and was supported to express their views.

The routine of the service had not been planned to include people's preferences and did not respond to changes in people's needs. Staff told us the routine of the service was designed to meet people's basic care needs. One staff member told us, "I can't care for people the way I want to, there just isn't the time". Many people spent most of their time in bed or in their bedroom. One staff member told us, "It's the routine of the service not to offer people the opportunity to get up and go downstairs".

The care that people wanted at the end of their life had not been planned with them and their relatives. Staff did not know about people's preferences, including their spiritual and cultural needs. Most people had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions in place. These had been made in people's best interests by a doctor and had been discussed with the person or their relative. Most decision documents were stored at the front of people's records and staff knew where to find them, however, some were not easy to find in people's records. Staff made sure the decisions accompanied people to hospital in an emergency, so that hospital staff knew about the decision.

The provider did had not taken action to give people and their relatives opportunities and support to be involved in making decisions about their care and treatment. This was a breach of Regulation 9(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity was not protected. Some people used net underwear with their incontinence products. The provider told us that each person had a named washable laundry bag which was used to keep people's underwear together during the laundry process. This system was not in operation at Beacon Hill Lodge and people did not receive their own underwear back from the laundry.

Inadequate

# Is the service caring?

People were not always treated with respect. We observed one person sleeping in a chair in a lounge on their own. A staff member came into the room and began to play music very loudly. They did not ask the person if they wanted to listen to music. Staff told us another person enjoyed listening to this music, the person was not in the room at the time.

Staff did not pronounce some people's names correctly or talk about people in a respectful way. People who needed support to eat and drink were referred to as 'the feeds'. Other people who required two staff to provide their care were referred to as 'the doubles'. Some people were called by their preferred names.

Staff did not act to protect people's privacy. Staff, including the manager, did not knock on people's bedroom doors or ask for their permission before entering their bedroom. Personal, confidential information about people and their care and health needs was not stored securely. Staff told us that although the cupboards had locks on them they were never locked. Staff had not recognised that people's confidentiality was not being maintained and people's personal information was accessible to other people and visitors to the service.

People appeared relaxed in the company of some staff, and told us they were "lovely". Some staff treated people with kindness and compassion. We observed staff speaking kindly and providing reassurance to some people who were upset or worried. One person was worried about their children, staff reassured them that their children were safe. This calmed the person. However, we observed that other people did not receive the reassurance they needed when they became agitated, because staff were not present and did not check people regularly.

Staff sat next to some people while supporting them to eat a meal. Staff chatted to people as they helped them. People were not provided with information about what they were eating and were not asked if they would like any support. One person told us, "This is my pudding but I don't know what it is".

There were no restrictions on people's family and friends visiting the service. People and their relatives told us that they visited often.

People were not treated with dignity and respect at all times. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

People were not involved in planning and reviewing their care to make sure it was provided in the way they preferred. All the people and their relatives we spoke with told us they had not been offered the opportunity to be involved in planning their care and did not know if their care plan reflected their preferences. One person's relative told us, "I have not seen my relative's care plan".

Assessments of people's needs had been completed before they were offered a service. A dependency assessment showing how much support was needed was included in the assessment. One person's dependency assessment had not been completed but the outcome was recorded as 'nursing'. Their assessment stated, 'family are very supportive of their relative and wish to be involved in all of their care'. We found that subsequent assessments and reviews had not included the person or their family. Following the inspection, the provider told us they had taken action to make sure that people and their loved ones would be involved as much as they wished.

Further assessments of people's needs, such as assessments of their communication and mental health needs had been completed once people began to use the service. These assessments had not been consistently reviewed to ensure that any changes in people's needs were identified. Care plans were written based on the assessments of people's needs. Assessments and care plans were completed by nurses and did not involve people, their relatives and care staff who knew people well.

Each person had a care plan in place. These did not include information about how people preferred their care and support to be provided or what they were able to do for themselves. Information about the care people needed and had received was stored in several different files. Staff told us it was a "nightmare" trying to find the information they needed to provide people's care. Care staff, agency staff and the agency nurse told us that they had not read the care plans and did not know what was in them.

Care staff were provided with an 'At a glance' care plan which contained very brief information about the care people required. This care plan had not been written with the person, did not give staff guidance on how to provide the whole range of care or what the person was able to do for them self. For example, 'I require full assistance with my personal care??'. Care was not provided consistently as staff did what they thought was right and not what was best for the person. Staff did not refer to each other or the different care records when delivering people's care.

Some people's care plans had been reviewed, with the aim of making sure they remained current. Changes had been noted on the review form but the care plan had not been changed. On occasions care plans had not been reviewed but changes had been made on the advice of health care professionals such as speech and language therapists. These changes had not been made on the 'At a Glance' care plan and so care records contained contradictory information. For example one person's fluid and dietary intake care plan stated, 'does not want mashed (food). Give gravy, sauces etc and give mashed if unwell'. The person's At a Glance' care plan stated, 'I required a pureed diet and my fluids thickened'. Staff were not sure about how the person's food and drinks should be provided to them. There was a risk the person would not receive their food and drink as they wanted and that staff would not know how to minimise risks associated with their choices.

People who were able, told staff what support they required and how they would like things to be done. Other people who had difficulty communicating their needs and preferences were not involved in planning their care. People were not always happy with the support they received from staff. Most people accepted what staff did for them; however others refused the care and support offered to them. Systems were not in place to make sure people were offered support again after they had refused it.

People using the service and the person who is lawfully acting on their behalf, were not involved in an assessment of their needs and preferences. Assessments had not been reviewed regularly and whenever needed throughout the person's care. Care plans were not updated with any changes in people's needs. This was a breach of Regulation 9(1)(a)(b)(c)(3)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had very little opportunity to follow their interests or to take part in social or physical activities. People and their relatives told us that people 'needed more stimulation and engagement from staff'.

No activities or social interactions were available for some people and there was a risk that they were isolated or lonely. People told us, "There is nothing to do" and "I just

Inadequate

# Is the service responsive?

sit here staring into space". People did not have the opportunity to go out unless they had family or friends to support them. Activities were not available for people to participate in when they wanted to. People relied completely on staff to keep them occupied and stimulated. Staff did not have time to spend with people. The majority of people spent their time in the lounge with the television on or in their bedrooms. People had not been asked what they wanted to watch on the television and told us that it did not interest them. Many people spent their time doing very little.

No activities were offered to people on the first day of our inspection. On the second day we observed a staff member sitting next to a person colouring in pictures. The person was not colouring their picture and was trying to engage with the staff member. The staff member pointed to the person's picture and showed them what they wanted them to do and then continued to colour their own picture. The staff member did not speak with the person or other people in the room whilst they did this. Other people in the room continued to sleep or look around the room. On several occasions we observed staff sitting in the lounge with people, completing records. None of the staff spoke to the people, everyone sat in silence.

Participation in meaningful activities during the day promotes people's health and mental wellbeing but this was limited at Beacon Hill Lodge. The registered provider had not supported people to be involved in their community as much or as little as they wished and to take part in meaningful activities. The provider had not ensured that people were not isolated. This was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A process to respond to complaints was in place, this had not been followed. Staff did not know how to receive a complaint and gave different descriptions of how they would manage a complaint made to them. One staff member told us they would refer the person to the manager. They said if the manager was not present they would ask the person to return to make the complaint when they were. The provider had not recognised that staff at the service were not following the policy or that people's complaints had not been addressed.

Information about how to make a complaint was on display. This information was out of date and was not easy for some people to read and understand. Action had not been taken to encourage and support people and their families to raise concerns, make complaints and give feedback about the service. People's relatives had made complaints to staff at the service. These had been recorded but action had not been taken to address people's complaints to their satisfaction. Following the inspection, the provider told us they had taken action to make sure that all complaints were acted on and resolved.

The registered provider had not established an effective system for identifying, receiving, recording, handling and responding to complaints by service users and others. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

Staff were concerned about the quality of the service being provided to people and the action that the local authority safeguarding team and CQC may take to keep people safe. One staff member said, "We know things are not right here, but we will do our best to help the new manager turn it around".

A manager had been managing the service since June 2015. They had replaced the registered manager who had not been working at the service since April 2015. The manager had visited the service before they began work and had met with senior managers in the provider's organisation. They had not received a hand over and had not been informed that the local authority was investigating several allegations of abuse and poor practice at the service. Following the inspection, the provider told us they had taken action to make sure that the service was managed effectively.

The manager had introduced herself to some people and their relatives. Other people were not aware of the new manager. One person and their relative told us, "We are quite impressed that she will make a difference to the home". Another person told us, "The manager seems to be getting it together". A staff member told us, "I am very hopeful that things will improve with the new manager".

Values such as involvement, independence and respect were not central to everything the staff did. Staff did not know what the provider and manager's vision for the service was, and had not been asked for feedback about the service or made suggestions in ways that it could be improved. The manager had made a small number of changes to the way the service operated. The manager told us that changes were communicated to staff in the diary and from verbal instructions from the manager. Staff told us that there was a lack of communication between the management team and staff, and they received contradictory information from senior managers. One staff member told us, "Staff aren't told what's going on. Things start to happen and we're not told what is happening. I feel a bit left out sometimes". Another staff member said, "One person says one thing and one person says another, it's very confusing".

The provider and manager were not leading the staff team or managing the service. The manager had given additional leadership responsibilities to one staff member. This staff member did not have a job description and were not clear what their role was. The staff team had not been told about the person's new role and some staff were not following the instructions they were being given. This put the staff member under additional pressure and they told us they felt 'stressed' at times.

Staff did not work together as a team to support each other and provide a good standard of care to people. They did not have the confidence to question the practice of their colleagues. The nurse on duty worked in isolation and did not communicate with other staff, including care staff. Nursing staff were responsible for planning the care people received but did not lead the team to ensure care was delivered to meet people's needs. One staff member told us, "Staff don't listen to what they are being asked to do and the reasons for that." This lack of communication put additional pressure on staff and at times meant that people did not receive the care and support they needed. Following the inspection, the provider told us they had taken action to make sure that staff worked more effectively together.

Shifts were not planned to make sure that people had the support they needed when the wanted it. At lunchtime, people waited for a long time for their meals as some staff were still getting people up. Staff were not held accountable for the care and support they provided, such as supporting people to change their position regularly, as they were not monitored or directed. Nurses had not signed and dated hand written MARs and were not be held accountable for any mistakes they made when recording this important information.

Staff did not feel supported and appreciated by the provider and told us they were never thanked for the work they did. The provider and manager had not taken action to motivate staff to deliver a good quality service to people, and the poor standard of care provided by staff had gone relatively unchallenged. Staff told us that they were not motivated by the provider or manager. All the staff we spoke with said the staff morale was very low. One staff member told us, "I love caring but I cannot cope with the low morale because of all the changes and the shortage of staff". Another staff member told us they were considering leaving the service as they did not feel valued. Some staff

# Is the service well-led?

told us they did feel supported by the new manager and could ask for support and guidance when they needed it. The manager was on call when they were not at the service and their contact details were available to staff.

The provider and manager did not have the required oversight and scrutiny to support the service. Staff told us they were not confident that the provider knew what was happening at the service. The provider had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. The manager told us they had spent their time at the service, "digging around" to find the level the service was operating at and needed new staff to move the service forward. They told us they did not have a plan in place to address the shortfalls in the quality of the service, and had been concentrating on high risk areas, such as wound management and making sure people had call bells in their bedrooms.

People and their relatives were not involved in the day to day running of the service. Systems were not in place to obtain the views of people, their relatives or staff to improve the quality of the service. People had not been asked for their views about the service they received or for suggestions about how the service could be improved.

Staff had not been given an opportunity to tell the provider or manager their views about the quality of the service they delivered or make suggestions about changes and developments. One staff member told us they would not want their own mother to receive a service at Beacon Hill Lodge, as the quality of the service was not high enough. Staff did not feel involved in the development of the service and felt that their views were not valued.

Systems and processes were not in place to ensure that the service was of a consistently good quality. The provider and manager had not made it clear to staff what good quality care looked like and how it would be provided. They were not aware of most of the shortfalls in the quality of the service found at the inspection. Checks on the quality of the care people received had not been completed. Following the inspection, the provider told us they had taken action to address these issues.

Medicine checks had not been completed to identify any shortfalls in the way medicines were managed at the service and risks this posed to people. There was no process in place for the provider or manager to check for patterns in any errors or issues and to learn from this. The manager had not completed a medicines audit since they began working at the service in June 2015. Following the inspection, the provider told us they had taken action to make sure that the quality of the service provided was checked regularly including the completion of medicines audits.

Some paper policies and guidelines were available to support staff. These had previously been stored on the computer but had been deleted. Staff told us that they had not read the provider's policies and guidelines and did not use them to deliver the service.

The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service. This was a breach of Regulation 17(2)(a)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and senior manager's told us that important records such as policies, guidelines and assessments of people's wounds had gone missing from the service. No action had been taken to keep people's personal private information safe and to retrieve the missing documents. Checks had not been completed to ensure that staff had access to the information they needed to provide the service safely. Staff records were stored in a locked cupboard.

Accurate and complete records in respect of each person's care had not been maintained. Records of the care people received were limited. One person's care records stated, 'personal care given'. It was not clear what care the person had received. Other records were not dated or did not have the person's name on them. Some hand written records were difficult to read and staff were unable to tell us what they said. People were at risk because decisions about their care were made based on inaccurate or incomplete information.

Medicines administration records (MAR) contained gaps where staff had not signed to confirm that people had received their medicines. These records should be signed at the time the medicine is given. There was a risk that the MAR charts were not correct and health care professionals, such as doctors, would make care and treatment decisions based on inaccurate information.

Inadequate

# Is the service well-led?

The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including decisions taken in relation to their care. Records in relation to the care people received were not held securely. This was a breach of Regulation 17(2)(d)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that notifications were sent to CQC as required. Notifications are information we receive from the service when significant events have happened at the service, like a death or a serious injury. We had not been informed that people were the subject of DoLS authorisations. Following the inspection the provider told us that they had taken action to improve the service.

The registered provider had not notified the Care Quality Commission of significant events that occurred at the service. This was a breach of Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The provider had failed to deploy sufficient numbers of suitably competent, skilled and experienced staff to keep people safe and meet their needs.**<br>**Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

| 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<br>**The provider had failed to establish systems and processes to protect people from the risks of abuse.**<br>**Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The provider did not have plans in operation to respond and manage major incidents and emergency situations such as fires and make sure people were safe and any risks to their care were minimised.**<br>**Regulation 12(2)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

This section is primarily information for the provider

# Action we have told the provider to take

The provider had failed to assessed and mitigate risks to people. Plans for managing risks were not available to staff and staff did not follow them.

Regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>Moving and handling equipment had not been properly maintained to make sure it was safe for people to use. Equipment suitable to meet people's health care needs, including catheters, was not available at the service. Security of the building was not maintained. Some areas of the premises and pieces of equipment were not clean.<br><br>Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to make sure that staff they employed were of good character and had the skills they required. Satisfactory evidence about staff's conduct in previous employment concerned with the provision of health or social care, detailed on Schedule 3 had not been obtained.<br><br>Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider failed to operate safe systems to protect people from the risks associated with medicines. |

This section is primarily information for the provider

# Action we have told the provider to take

Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>The provider did not have processes in place to make sure that care was only provided with the consent of the relevant person.<br><br>Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| 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<br><br>The provider had failed to act in accordance with the Mental Capacity Act 2005. The risk of people being unlawfully deprived of their liberty had not been assessed. Where people had a Deprivation of Liberty Safeguard authorisation in place the provider had not planned their care to manage the risks of excessive restrictions on their liberty.<br><br>Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Staff were not supported, skilled and assessed as competent to carry out their roles. Staff had not received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform.<br><br>Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider had failed to make sure that people received appropriate care and treatment to meet their needs.<br><br>Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>People's nutrition and hydration needs had not been regularly assessed and reviewed and action had not been taken to respond to people's changing needs.<br><br>Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>The provider did had not taken action to give people and their relatives opportunities and support to be involved in making decisions about their care and treatment.<br><br>Regulation 9(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>People were not treated with dignity and respect at all times.<br><br>Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>People using the service and the person who is lawfully acting on their behalf, were not involved in an assessment of their needs and preferences. Assessments had not been reviewed regularly and whenever needed throughout the person's care. Care plans were not updated with any changes in people's needs.<br><br>Regulation 9(1)(a)(b)(c)(3)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>Participation in meaningful activities during the day promotes people's health and mental wellbeing but this was limited at Beacon Hill Lodge. The registered provider had not supported people to be involved in their community as much or as little as they wished and to take part in meaningful activities. The provider had not ensured that people were not isolated.<br><br>Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>The registered provider had not established an effective system for identifying, receiving, recording, handling and responding to complaints by service users and others.<br><br>Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have systems and processes in operation to assess, monitor and improve the quality and safety of the service. Feedback on the service provided from relevant persons had not been obtained by the provider so they could use it to continually evaluate and improve the service.<br><br>Regulation 17(2)(a)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of each service user, including decisions taken in relation to their care. Records in relation to the care people received were not held securely.<br><br>Regulation 17(2)(d)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>The registered provider had not notified the Care Quality Commission of significant events that occurred at the service.<br><br>Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009. |