Care Quality Commission

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Beech Court Nursing Home

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

We inspected Beech Court Nursing Home on 28 June and 1July 2016. This was an unannounced inspection. Beech Court Nursing Home is registered to provide support and accommodation for up to 26 older people. At the time of the inspection there were eight people living at the service some of whom were living with dementia and required personal or nursing care.

As this service is registered for one person as the registered provider ('the provider') this permits them to also carry out the role of the Registered 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. In addition to this the provider had appointed a manager ('the manager'), however, the manager's role and extent of their responsibilities were not clear.

Risk management procedures were not effective. For example, people at risk of developing pressure ulcers were not always protected from these risks. People's pressure mattresses were not always set to correct settings and staff had limited guidance on how to use this equipment. Repositioning charts were not consistently completed.

Safe recruitment procedures were not always followed before staff were appointed to work at Beech Court Nursing Home. We have made a recommendation on safe recruitment procedures.

People's information was not protected as records in relation to people's care were not always kept confidential. Other records in relation to people's care were not always consistently completed or up to date.

There was on-going maintenance and building work within the home grounds at the time of our inspection. Fire safety notices had been put in place, however, these were not always being followed. This meant people might not have been able to be evacuated safely and effectively. We notified the Fire Service regarding our concerns the same day of our inspection. People's mobility equipment was not always stored in a way which kept it accessible in case of emergencies.

The manager and staff had a basic knowledge but did not have a good understanding of the Mental Capacity Act 2005. 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. Where people were thought to lack capacity to make certain decisions, assessments had not been completed in line with the principles of MCA.

The manager and staff did not fully understand their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety. Under the MCA the provider is required to submit a DoLS application to a 'supervisory body' for

authorisation to deprive someone of their liberty. Where people were deprived of their liberty related assessments and decisions had not been carried out. We have made a recommendation about reviewing and embedding legal safeguards within the MCA.

People's nutritional needs were met. However, people were not always given choices and did not receive their meals in a timely manner.

People had access to limited activities and stimulation opportunities. Activities were not always structured to people's interests. Staff did not always know how to best support people and what activities and changes to the support would suit the needs of people. Staff did not always engage with people in a meaningful way.

Beech Court Nursing Home had suitably qualified and experienced staff to meet people's needs. However, staff were not always deployed effectively as at times, people were left without support. Where required, staff involved a range of other professionals in people's care.

The provider's policies had not been reviewed or updated with current legislation. The leadership structure at Beech Court was not clear because the manager's role and responsibilities were not clear. The provider had quality assurance systems in place, however, some of these systems were not always effective.

Staff had a clear understanding of how to safeguard people and protect their health and well-being. People's medicines were stored and administered safely.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager) and yearly appraisals

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

The provider informed us of all notifiable incidents. Staff spoke positively about the management support and leadership they received from the manager.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. We also made two recommendations about guidance on safe staff recruitment procedures and reviewing and embedding legal safeguards within the MCA. You can see what action we told the provider to take at the back of the full version of this 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

The service was not always safe.

Arrangements for the evacuation of people in the event of an emergency were not safe.

People's care plans did not always identify the risks. The equipment used for prevention of pressure sores was not always set correctly.

There were suitably qualified staff to meet people's needs. However, they were not always deployed effectively. Staff did not always engage with people in a meaningful way.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The manager and staff did not have a clear understanding of their responsibilities relating to the Mental Capacity Act 2005.

The manager and staff did not have a clear understanding of their responsibilities in relation to the application of DoLS.

People were supported to have their nutritional needs met. However, they were not always given choices.

Staff had the knowledge and skills to meet people's needs.

People were supported to access healthcare support when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always understand and respect confidentiality and

records were not always kept securely.

People were treated as individuals and were involved in their care.

People were supported by caring staff that treated them with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received limited activities and stimulation which did not meet their needs or preferences.

People's care plans were not always current and did not reflect their needs.

People's needs were assessed, however, care plans were not always personalised to identify how people's needs would be met.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management structure was not clear.

There were systems in place to monitor the quality and safety of the service and drive improvement. However, these were not always effective.

Some of the provider's policies were outdated.

People and staff told us the management team was open and approachable.

Care Quality Commission

Beech Court Nursing Home

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 June and 1 July 2016 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We contacted two social and health care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We also contacted commissioners of the service to seek their views of the management of the service.

We spoke with five people and five relatives. We looked at five people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the manager and four members of staff which included a nurse, care staff and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments.

Requires Improvement

Is the service safe?

Our findings

At our inspection in December 2014, we issued breaches in relation to people's mattresses not being set according to their weight and fire exits not being safe to use. We re-inspected in June 2015 to check the provider had taken the necessary action. Although the provider had made the required improvements, at this inspection we found these improvements had not been sustained.

People were not always safe. People who were at risk of developing pressure area ulcers had appropriate equipment in place which included pressure relieving mattresses. However, the pressure relieving mattresses were not always set to the correct pressures. For example, one person weighed 58.1kgs but their pressure mattress had been set at a setting suitable for a person weighing 125kgs. We checked two more people's mattresses settings and none were set to the correct pressures for that person's weight. Additionally there were no records in people's care plans that would give a clear instruction on how to ensure people's pressure relieving equipment was set to their assessed needs. We spoke to the manager about these concerns and they could not explain how they were setting pressure mattresses. This meant people were at risk of developing pressure area ulcers due to equipment not being appropriately set for people's individual body weights. Following receipt of our draft inspection report the provider sent us guidance on the use of pressure relieving mattresses and stated this was now available for staff.

People's mobility equipment was not always accessible in case of emergencies. One person was living on the ground floor. They had a personal evacuation plan in place which stated they required a wheelchair during evacuation. However, this person's wheelchair was stored upstairs in a locked room as this person spent time in bed. This meant the person's wheelchair would not be available when required.

On the day of our inspection, there were two care staff and one nurse on duty. Some people required two members of staff to assist them with their care. We saw people spent periods of time in the lounge without staff being present to support them. Three people in the lounge were left without engagement from staff and they were asleep. At one point in the morning, there were no staff in the lounge for 25 minutes and during that time people needed support. One person called another person to 'wake up and eat breakfast' and another called out to another person who was trying to reach a plate of food that had fallen on the floor, "Stop it or you will end up in hospital". This person carried on and almost fell. There were no staff in the lounge and a member of the inspection team rang the call bell and two members of staff came to the person's aid. One person commented, "I don't have a bell now it's broken, so if I wanted help, I couldn't get any at night. I can't get out of bed either so it's frustrating". A call bell had been reported as not working a week before the inspection by one of the nurses to the provider. Nothing had been done to address this. When we raised this with the manager, they told us they had not been made aware of this. The manager then immediately put the person without a call bell on hourly checks.

This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were not always followed before staff were appointed to work at Beech Court

Nursing Home. We looked at recruitment files for six members of staff. Two of these did not have any employment histories, records of identification or appropriate references. In respect of these two staff members we could not ascertain appropriate checks had been undertaken to ensure staff were of good character and suitable for their roles. We discussed this with the provider who told us these two members of staff had been employed as bank staff and their recruitment records had been archived. Following our inspection, the provider sent us copies of these recruitment files. However, we were still unable to ascertain appropriate checks had been undertaken to ensure staff were of good character and suitable for their role.

We recommend the provider seek guidance on safe staff recruitment procedures.

During our visit there was on-going maintenance and building work within the home grounds. Some areas in the home were not being used by people who lived at Beech Court or staff. Fire safety notices had been put in place in these areas, however, these were not always being followed. For example, a temporary fire exit had been put in place so people and staff could leave the building if there was an emergency. This fire exit was not clearly signposted and did not lead to a place of safety. It led through a room full of unused equipment and then out to an area where the building work was taking place. This meant people and staff were exposed to the risk of being trapped as there was no exit to a safe place in an emergency. Following our inspection, we notified the fire service of our concerns. The incorrect signage was immediately rectified following our inspection. The provider undertook regular fire safety checks and fire evacuation practices.

We asked people if they felt safe and comments included; "I suppose I'm safe enough. I can't get out of this chair so I can't do much harm to myself can I?", "I do feel safe. There is always someone about. I kept having falls at home and that's why I'm here so I am safer than at home" and "I have to rely on them (staff) for everything. I'm safe as long as I don't try to move on my own". People's relatives were also complimentary of the home and felt their family members were safe at the service. One person's relative said, "I feel [person] is really safe here. That's why we felt comfortable putting her here".

Staff were aware of the procedures to keep people safe from the risk of abuse. Staff had attended training in safeguarding adults and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, "I would report any safeguarding concerns to the nurse in charge or manager". Another member of staff said, "I would report to CQC".

Staffing levels were determined by people's assessed needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's changing needs. The home used regular bank staff and maintained consistency of care. The provider considered staff sickness and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. One member of staff said, "We have enough staff". Another member of staff told us, "Staffing levels are ok at the moment". However, at our inspection we saw staff were not always deployed to keep people safe.

Medicines were stored in line with manufacturer's guidance and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken, the reason why. Records for stock levels were accurately recorded and regularly checked. Nursing staff who were trained to administer medicine had their competency regularly checked by the manager.

Requires Improvement

Is the service effective?

Our findings

People's involvement in decisions about their care were not always recorded in line with the Mental Capacity Act 2005 (MCA). The 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. Although the manager and staff had basic knowledge of the MCA they did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not always been completed in line with the principles of the MCA. For example, one person was living with dementia and staff told us they made decisions for them. This person had not had a mental capacity assessment completed to determine whether they lacked the capacity to make certain decisions. Some people's records showed family members had signed on people's behalf giving consent for care they received despite not having the relevant lasting power of attorney (LPA) to allow them to do so. For example, one person's relative had a Court of Protection authorised LPA for financial decisions only. However, they had signed the person's care plans to give consent to care on the person's behalf.

This was a breach of Regulation 11 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The manager and staff did not have a clear understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). DoLS provide legal safeguards for people who may be restricted of their liberty. The MCA require providers to submit DoLS applications to a 'supervisory body' for authority to restrict liberty. Where people's liberty had been restricted, related assessments and decisions had not been taken to demonstrate these decisions had been taken in the person's best interest. For example, one person was restricted from leaving the building and was under continuous supervision. However, the best interest assessment had been inconclusive and had not been reviewed when the person's capacity changed. Following our inspection the manager told us they had reassessed this person's capacity and applied for DoLS.

We recommended that the provider consider reviewing and embedding legal safeguards within the MCA.

People had mixed views about their lunch time meal experience. The dining room was not in use due to building and maintenance work. One person said, "I don't like eating in a chair. I prefer eating at a dining table but you don't get a choice". Another person said, "The food is pretty good, it suits me. The cook is brilliant and if you are hungry at any time, she will find you something". We saw two people had a meal in their shared bedroom. However, these two people waited for half an hour before staff came to support them with the meal. A member of staff came to support one person and noticed the other was not eating their food. The member of staff asked if the person did not like the food. The person shook their head. The staff member said, "You have to eat it, it's important you eat it. There is no more food so you must eat that. I will come and help you eat it in a minute". When the staff member left the room the person said, "You see, that's what they do. They make you eat it. It was cold when it came and it's horrible". The person did not have the

meal.

People were not given meal choices, however, the chef told us they knew what each and every person wanted since they were only eight people. However, people's comments did not support this. People told us, "The food is ok. You can have anything for breakfast but the rest you are just given. I don't know what it is today" and "I don't like the food. It's always cold. When I said I don't like it, they [staff] said I had to eat it as there was nothing else" and "They [staff] just bring the food to you, they don't ask what you want. You have to have what you are given. There isn't any choice". One person's relative told us, "We gave them [staff] a list of foods that she [person] likes and she really doesn't like pasta so I am surprised they gave her that to eat. I always thought they were given choices".

Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the team, however these preferences were not always followed. The home had a rolling menu cycle however they did not follow it. The chef told us, "We have a menu but that doesn't always work. I give them what I have".

Where people were at risk of dehydration staff did not always record people's fluid intake. When we spoke with staff they were not always aware of individual requirements of fluid intake for people. There were no guidelines in place for staff to follow to show how much fluid people required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff sought people's permission before any assistance with their care. We saw staff knock on people's doors and sought verbal consent whenever they offered care to people. Staff told us they sought people's permission and explained to the person the care they were about to provide.

Some people had special dietary needs, and preferences. For example, some people needed a diabetic diet, pureed food or thickened fluids where they were at risk of choking. The staff contacted GPs, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns over people's nutritional needs. Snacks were available for people throughout the day, such as fruit and biscuits. People's weight was maintained. For example, three people had been identified as losing weight and had been started on a diet which included fortified drinks and food.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. The induction plan was designed to ensure staff were sufficiently skilled to carry out their roles before working independently. One member of staff commented, "Induction included communication, safeguarding and dementia training. It was good".

Staff had completed the provider's initial and refresher mandatory training in areas such as, manual handling, safeguarding adults and infection control. Staff were supported to attend other training courses to ensure they were suitably skilled to care for people. Staff told us they had the training to meet people's needs. One member of staff said, "We do mandatory training every year".

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. One member of staff told us, "We do supervisions with the manager. It's like every day all the time". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervision meetings. Staff were

also given the opportunity to discuss areas of development and identify training needs. Development and training plans also formed part of the annual appraisal process.

Requires Improvement

Is the service caring?

Our findings

Staff did not always understand and respect confidentiality and records were not always kept securely. Records were kept in cabinets in nurses' station. However, these were not locked. We also found people's records with personal information in the lounge. We discussed this with the manager who assured us they would address this and raise staff awareness in maintaining confidentiality.

People could not move freely around the home as some areas were restricted and people had no access to outside areas due to on-going construction work. The service had a communal sitting room where people also had their lunch because the dining room was out of action due to building work. There were no places, other than the sitting room, where people could sit apart from their bedrooms. People's bedrooms were personalised and contained photographs, pictures and the personal belongings each person wanted in their bedroom.

People were positive about the care they received. Comments included, "I think the staff are caring. They are always busy", "I like most of them [staff]. They look after me and I know I need that" and "No one has ever been nasty to me. They [staff] are very kind". People's relatives were complimentary about the care their family members received. Comments included, "Staff are wonderful. [Person] can get anything he needs, he just asks", "The staff are all absolutely lovely" and "[Person] has been in the home for 11 years. It just goes to show how excellent the care is that he is getting".

During our inspection we observed appropriate interactions between staff and the people they supported. For example, we saw a member of staff taking a person out for a cigarette. They were kind, reassured the person and asked if they were warm enough. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm. One health care professional told us, "Some staff are experienced and know the residents. No concerns about care". One person's relative told us, "Nice homely feel here. Not an institution". Another person's relative said, "Fantastic atmosphere".

Staff were aware of people's individual communication needs. Care plans contained information about how people should be communicated with. For example, people who had sensory impairments or other limitations to their communication. Staff knew how to comfort people who were in distress and unable to communicate their needs verbally. People's care plans specified the facial expressions and body language of people and the signs they would make to express their discomfort if they were unable to explain verbally. Records showed and staff understood the actions required to comfort people. Records guided staff how to respond appropriately, for example by speaking calmly to people, offering reassurance and identifying the source of a person's distress. We observed staff followed this guidance.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. One member of staff told us, "We treat people right, like we would want to be treated". One person's relative also commented, "Absolutely treated with dignity"

Staff told us that people were encouraged to be as independent as possible. One member of staff told us, "We help only with what the residents can't do". One person commented, "I like doing little bits that I can. The girls help me with the rest". Records showed people's independence was promoted. Staff involved people in making day-to-day decisions.

People and relatives were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had an advance care plan and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff told us they understood the importance of keeping people as comfortable as possible as they approached the end of their life. They explained how they would maintain people's dignity and comfort and involve specialist nurses in the person's care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the Beech Court Nursing Home to ensure these could be met. The assessments were used to create a person centred plan of care which included people's preferences, choices and interests.

Care planning was focussed on a person's life, including their skills and abilities. The provider captured people's life histories including past work and social life enabling staff to provide person centred care and respecting people's preferences and interests. People's care records contained detailed information about their health and social care needs. Care plans reflected how each person wished to receive their care and support. For example, people's choice of routine and choice of food. However, people told us this was not always followed. People did not always receive personalised care. For example, one person said, "The nights drag on. They [staff] put you to bed too early at 6:30pm like we are babies. Another person told us, "The biggest problem I have is the nights are too long. They put you to bed so early and I have been told that those are the rules. I don't like that". We had also received two complaints from relatives prior to our inspection raising the same concerns. This meant people were unable to live their life as they wanted to. Staff we spoke with on the day told us people could choose what time they went to bed, but people's and relative's comments did not demonstrate this was happening.

People received minimal activities which were not structured to their needs. For example, one person's records stated they enjoyed gardening. However, they could not do gardening due to on-going building work. This same person had one entry in their records for attending a church service. People commented, "It's boring though. I like to get out in the garden but you can't go if no one can take you and I don't like to bother them", "I don't know what I would do without my family and friends. My husband took me out to dinner but that's the only time I have been out of here in a year. My visitors make the difference because no one talks to you here" and "I have never been asked if I wanted to go to the shops or anything". One person's relative told us, "She seems very happy. I think she gets bored as there is not a lot to do but they [staff] do seem to care". Records showed people attended church services.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were reviewed monthly, however they did not always reflect people's changing needs. Where a person's needs had changed, the care plan had not been updated to reflect these changes. For example, one person's condition had deteriorated and they were nursed in bed. The person was referred to the local authorities Care Home Support Services (CHSS) who gave repositioning advice and support aids. The care plan did not reflect the changes and the daily records did not show staff followed the advice. However, we saw staff following the advice and not recording.

This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives confirmed they were involved in planning their care. One person's relative told us, "I deal with [person's] medication and care plan. I discuss it with the manager. The care plan is up to date and we are all happy".

People had access to healthcare services and on-going healthcare support. One person's relative told us, "[Person] had an infection and was referred immediately. They got antibiotics by the end of the day". Health and social care professionals were complimentary about the service and told us, "Care staff take on board any recommendations we give". People's care records showed details of professional visits with information on changes to treatment if required.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People commented; "I have no complaints and never had any", "My daughter will make a complaint to the manager for me if there is need" and "Never made a complaint, no reason to".

We looked at the formal complaints records and saw these had been dealt with in line with the provider's policy. Records showed formal complaints raised had been responded to appropriately, followed up to ensure actions completed and any lessons learnt recorded. However, informal complaints were not always responded to. People told us they had voiced concerns about going to bed early and this had not been addressed. Since our last inspection there had been some compliments and positive feedback received about the staff and the care people had received.

Requires Improvement

Is the service well-led?

Our findings

Beech Court Nursing Home was not well led. The provider had employed a manager who had been in post for over a year. The manager did not have access to all the records relating to the running of the home and the provider was not present during the inspection. The manager did not have access to staff recruitment files and could not provide us with health and safety records relating to the premises. This could have an effect on the day to day running of the home in the provider's absence. The manager told us they did not have full managerial responsibilities and these were the providers' responsibility. For example, the provider was responsible for allocating the staff rota and most staff recruitment procedures.

Risks to people's safety, such as falls and assistance to move had been assessed and people had plans in place to minimise the risks. However, we identified instances where we could not see and staff could not show us the evidence that the provider was doing all that is reasonably practicable to prevent avoidable harm or risk of harm to people who used the service. For example, one person had bed rails in place and used them. We could not find and staff could not show us records of bed rail risk assessment in place. However, staff knew the risks of using bed rails and acted on those risks. The provider subsequently provided us with a copy of a bed rail risk assessment following the inspection.

Records which showed individual care needs for people were not always completed. For example, people's daily intake was not always recorded consistently. For example, one person had 500mls of fluid recorded for one day and 1050mls another day. Another person had a total fluid of 950mls recorded one day and 200mls another day. Staff did not have a clear understanding of how much fluid each person needed to meet their specific needs and protect them from the risk. However, although records had not been completed, during our inspection we saw staff giving people fluids but did not record when fluid was given.

Records were not maintained accurately to check that safe care was being provided to people. Some people required repositioning to prevent the development of pressure ulcers. On the day of inspection we saw people being attended to as planned. However, people were at risk as the provider and staff had failed to maintain accurate, complete and contemporaneous records of when people were repositioned. The repositioning charts were not always completed consistently. For example, one person's care plan guided staff to change the person's position every three hours. A record showed on 27/06/2016 the person's position was changed at 03:30 and again at 10:00. On 28/06/2016 they were changed at 03:30 and again at 18:00. Additionally two of these people had been assessed as being unable to use call bells and needed to be checked hourly. The hourly check charts were not consistently recorded. For example, one person's check was recorded at 8pm and the next check was recorded at 8am. Another person's checks were recorded at 0315am and again at 0610am. However, during our inspection we saw staff attending to these people and not recording any care interventions. The provider was unable to assure themselves that care was being provided in line with people's care needs.

People's activity records were incomplete. For example, there was no record of any activities for one person for two weeks and again for another week. There were no records of one to one activities for people being

cared for in their rooms and therefore we could not be sure these people were protected from social isolation.

The provider had quality assurance systems and audits in place. However, some of these quality systems had not identified the concerns we found at this inspection. For example, the provider had not identified the incomplete care records that we found as well as the care plans which had not been updated to reflect the changes in people's care needs. In addition, the audits which evaluated people's dining experience had not identified the concerns we found on meal choices and people's poor dining experience.

Some of the provider's policies we saw were incomplete and some needed to be updated. For example, the whistleblowing policy had no contact details and the recruitment policy had not been reviewed as per review date. Policy on controlled drugs was due to be reviewed in 2007 and had not been reviewed and this meant the policy guidelines were not based on current best practice. This could have resulted in people receiving care that was not best practice. We discussed these concerns with the manager who told us they would raise these concerns with the provider. After our inspection the provider sent us completed and updated copies of these policies and procedures

This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where quality assurance systems were operated effectively we found that they had been used to drive improvement in the service. For example, the medicines audit had identified gaps in record keeping and action had been taken to re-train staff and ensure that record keeping in this area had improved.

People and their relatives we spoke with were complimentary of the manager. Comments included; "The manager is a great bloke and does a great job", "The manager seems very nice and he will make you a coffee and bring it to you", "The manager is very good. I can ring and talk to him any time to make sure [person] has everything she needs" and "I see the manager most times and he is very, very nice. He will do anything for you".

Staff told us they enjoyed working at the service. There was an established staff base at Beech Court Nursing Home. Some of the staff members had been with the provider for a number of years. One member of staff said, "I love my job and helping people. I am very well supported and very happy here". Another member of staff said, "It's a good place to work. I would place my own relative here".

Staff spoke highly of the manager. They told us, "The manager is approachable. I can go to him with anything", "Manager is lovely and supportive" and "I feel management would listen to me. We have good team work".

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the chance of further incidents occurring. The manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the manager. The manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

Although the whistle blowing policy did not have contact information, staff were aware of who they could whistle blow to and said that they would have no hesitation in doing this if they saw or suspected anything inappropriate. Staff were confident the management team and organisation would support them if they

used the whistleblowing policy.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care **People did not receive activities, stimulation or engagement which met their needs or preferences.** **Staff did not always engage with people and ensure care was person centred.** **People's choices were not always respected.** **Regulation 9 (1)(a)(b)(c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent **The provider did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments.** **Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of MCA.** **Regulation 11 (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment **People were not always protected from the risk of pressure sores, as equipment was not always**

effectively used.

People's mobility equipment was not always stored in a way which kept it accessible in case of emergencies.

Regulation 12 (2)(b)(d)(e).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always kept confidentially. People's records were not always complete and accurate. The provider's audit systems did not monitor or improve the quality of the service. The provider's audit and governance systems did not remain effective. Regulation 17 (2) (a)(b)(c)(d)(f)

The enforcement action we took:

We have served a warning notice to be met by 08 December 2016.