Mrs Rose Metcalfe

Beechwood House Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Beechwood House Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beechwood House Rest Home accommodates 13 people in one adapted building in a residential area of Bournemouth.

The older people living in Beechwood House Rest Home have care and support needs associated with their physical and mental health.

The inspection visits took place on the 28 September and 2 October 2018. The initial visit was unannounced. We continued to gather evidence form professionals until 11 October 2018.

The service had a registered manager who had been running the home for many years. 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.

We carried out this inspection in response to information of concern we received alleging that people were receiving unsafe and poor care. We planned to undertake a focused inspection to answer the key questions "Is the service safe?", "Is the service effective?" and "Is the service well-led?" Following our visits, we continued to receive information of concern from professionals and whilst analysing our evidence we determined that a comprehensive inspection was necessary.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

At this inspection, we found that risk management was not sufficient to ensure people received safe care and treatment. Risks related to skin damage, mobility and eating and drinking were not being managed effectively and staff did not always have accurate information about these risks. Risks related to the environment had not been picked up and fire safety checks had not been carried out. This was a breach of the regulations.

Allegations of abuse had not been appropriately responded to. Allegations had been brought to the attention of the registered manager but appropriate agencies had not been notified. This was a breach of the regulations.

Staff followed safe procedures and this ensured that people received their medicines as prescribed.

People were supported to have choice and control of their lives. However, the assessment and documentation systems in the home did not support the embedding of the Mental Capacity Act 2005 and we have made a recommendation about this. We have also made a recommendation about the development and documentation of comprehensive assessments of people's needs.

People's communication needs were not assessed, recorded and shared in line with the Accessible Information Standard. We have made a recommendation about this.

Notifications had not been made to the Care Quality Commission where required due to allegations of abuse and people developing pressure areas. This was a breach of the regulations.

Staff had been recruited safely and were able to respond to people when they wanted help. They had received training but this had not been sufficient to ensure people were helped to move safely. This was a breach of the regulations.

The menu offered a variety of main meals and snacks and catered for individual likes, dislikes, allergies and special diets. We have made a recommendation about developing the range of foods available to people on special diets.

Care staff were kind, patient and friendly throughout and people's privacy and dignity were usually respected.

People told us they had access to GP's and dentists when they needed them.

People and staff described the manager and staff as approachable. They knew how to raise concerns and felt they would be listened to and any actions needed would be taken. Complaints were not always investigated in a way that ensured learning and where they included allegations of abuse these were not addressed appropriately.

There were shortfalls in the oversight of the service, risk management, the management of safeguarding, staff training, failure to comply with statutory responsibilities and quality assurance in the home.

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.

People's identified risks relating to pressure area care, mobility and receiving adequate fluid were not fully met. This put people at risk of harm.

Environmental risks were not consistently managed.

People were not protected from abuse by robust systems.

People's medicines were administered safely.

People were supported by staff who had been safely recruited.

Is the service effective?

Requires Improvement

The service was not always effective because care delivery did not always reflect current good practice.

Staff supported people's choices about their day to day care.

People were supported by staff who had not had their competency checked appropriately.

People's rights were protected by the framework of the Mental Capacity Act.

People had a choice of food and drinks available that reflected their likes and dislikes.

Is the service caring?

Good

People were supported by staff who they described as kind and friendly.

People were supported to maintain independence and their privacy was respected.

Is the service responsive?

Requires Improvement

People told us they received their care and support in ways that

suited them.

Care plans were personalised but required some additional information to ensure appropriate care.

People were confident they could raise concerns.

Staff were committed to ensuring people received appropriate care at the end of their lives.

Is the service well-led?

Inadequate

Auditing systems were not effective in identifying areas that required improvements.

Oversight and safety checks had not been carried out.

Statutory notifications had not been made.

The registered manager was respected by staff and they were committed to improving the quality of the home.

Beechwood House Rest 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.

We carried out this unannounced inspection from 28 September 2018 to the 10 October 2018 with visits to the home on the 28 September and 2 October 2018. The inspection team was made up of an inspector and an assistant inspector who visited on both days. The inspection was planned as a focused inspection to look at how people received safe and effective care and treatment and to review the governance of the home. This was carried out in response to information of concern relating to people's experience of care in Beechwood House Rest Home. This was extended to a comprehensive inspection during the course of the inspection. We last inspected the service in April 2018 at this time the service was rated good.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with social care commissioners and health and safeguarding professionals to get information on their experience of the service. The provider had not been asked to complete a Provider Information return (PIR) since their last inspection. 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 were able to get up to date information during our inspection.

During our inspection we spoke with nine people who used the service and three visiting relatives. We also spoke with the registered manager, who is the owner of the home, and four members of staff. We gathered feedback from GPs who visit the home and health professionals who visited during the course of our inspection. We reviewed records related to 10 people's care. We also looked at records related to the running of the home including: three staff files, management audits, accident and incident records, training

records, and policies.

We asked for further information to be provided to us following our inspection. This included information about care plans, training and recruitment information. We received this information. The registered manager told us we would receive an action plan addressing our immediate concerns. We received this two weeks after we visited. This plan needed further work to be effective.

Inadequate

Is the service safe?

Our findings

Whilst people told us they felt safe and made comments such as: "very safe" and "I feel safe here." when we asked them about whether they felt safe, we found a number of concerns related to safe care.

Healthcare professionals had raised concerns about the management of risks associated with people's skin. There were current investigations into whether professional input had been sought for people when their skin deteriorated. During our inspection further concerns were raised regarding people's wounds. This indicated that guidance from the health professionals was not being acted on effectively and that the knowledge was not transferred to the care of other people.

We found that the systems in place were not sufficient to reduce the risk of people developing pressure sores. People who had been identified as being at high risk of developing skin damage, or had wounds when we visited, did not have clear guidance for staff about their nutritional and fluid intake.

Fluid intake is important in maintaining skin integrity. Where people's fluid intake was being recorded there was no clear personalised fluid intake goal recorded and the amount each person drank was not added up to check if additional support or prompting was needed. We asked the registered manager about this and they said that the goal for everyone was 1500ml. We highlighted that it may be appropriate to speak with people's GP's about appropriate targets for fluid intake based on their individual health needs and preferences. We asked that staff start to tally people's drinks after our first visit and found when we returned four days later that this had not been completed. We looked at three people's fluid intake records and noted that when their intake had not been added up, they were not achieving targets and no action was being taken. For example, one person had drunk less than 700mls of fluid with no action identified. Following our inspection the registered manager told us that they had sought guidance around appropriate fluid intake for individuals.

Another person's fluid was added up for three days by staff. The person did not drink their target amount on any of these days and no record had been made of additional drinks offered. The staff stopped adding up the following day despite the person's low intake.

A third person did not have their drinks tallied and did not meet the target the registered manager had detailed. Appropriate action was not always followed, such as, increased offers of drinks or foods with a high fluid content if a person was not achieving their target intake. This meant people were at risk of dehydration.

When people needed help to move safely, the risks associated with this had not been sufficiently assessed. We looked at the care plans for two people who used a piece of equipment to help them move from their chair into a wheelchair. There were no recorded risk assessments associated with this.

Another person was hoisted to be weighed. There was not risk assessment or plan available describing the hoist or sling used to do this safely. We were shown a sling that was over 15 years old and staff told they

used this. Whilst the sling looked intact, no checks had been recorded and the manufacturer's guarantee in relation to load bearing had expired. Feedback from health care professionals included identifying that methods of supporting this person to move in bed and the way a further person was helped to move from their bed to their wheelchair, were not safe. The current care plans for these people did not identify the concerns raised by the health care professionals. The registered manager wrote to us following the inspection and assured us that risk assessments were now in place for people who were assisted to move using a hoist.

Fire safety risks had not been responded to appropriately. Weekly checks on the alarm system had not been completed since June 2018 and information held to give to emergency services about who lives in each room and what their needs are was out of date. This meant an evacuation of the building would be delayed. We also found that staff had differing views of how to respond in the event of a fire and this included some staff not knowing how people with restricted mobility could be evacuated. We shared our concerns with the fire service. The registered manager wrote to us following the inspection and detailed the work they had undertaken regarding evacuation procedures and to assure us that safety checks were being made.

Environmental risks had not all been appropriately identified or actions taken to reduce the risk of harm to people, staff and visitors. For example, a lift that posed potential risks had been considered through risk assessment. However, one person had bare plaster in their room which posed a potential health risk as it could not be cleaned effectively and holes in the lounge and dining room carpets presented a trip hazard that had not been identified or mitigated. The upstairs bathroom held cleaning products and this was left unlocked throughout the first day of our inspection. This meant people could have access to these cleaning products.

We reviewed the oversight of accidents and incidents. This tool had not been used correctly and this meant that it was not picked up that two accidents recorded in one month had involved the same person.

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

Staff were able to explain how they would raise concerns about potential abuse or poor care practice to appropriate agencies. However, safeguarding professionals told us that they had not been informed of an incident which had resulted in the police being called to the property. We also saw that where allegations had been raised by a relative this had not been raised with the local authority and the Care Quality Commission. This meant that people and staff were at risk from a system that did not clearly structure responses to abuse allegations. A transparent approach to safeguarding is necessary to keep people safe. People were not protected by systems designed to keep them safe.

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

Staff had been safely recruited. People and visitors made varied comments about staffing levels. We heard that sometimes staff were very busy. One visitor told us: "There are not always a lot of staff. They are very efficient but the work themselves a bit thin." And two people spoke about staffing levels with each other saying: "They are short staffed aren't they."

We discussed the staffing levels with staff and checked the rota. We heard and saw that there were usually the full deployment of staff but that sometimes it was difficult when staff were sick. Interviews were being held during our visit to increase the capacity of the staff team. At the time of our inspection, the member of

staff doing the sleep in, usually the registered manager, was waking up throughout the night to help people move in line with their care plans to protect their skin. It was acknowledged that this was having an impact on the registered manager's sleep but they felt this was an appropriate response for consistency during what they assessed as being a time limited situation. They told us they were tired but would keep this under review in light of their other responsibilities.

People received their medicines as prescribed. The systems in place largely supported safe administration and storage although we identified that some medicines that had not been in use for a while had not been reviewed by people's GPs. This was addressed during our inspection. The registered manager had assessed staff competency to give medicines.

People were protected from the risk of infection. Staff wore appropriate protective clothing and understood the principles of infection control.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the way their care and support was managed.

Records did not reflect that a comprehensive assessment of their needs had been carried out with the person. However, care plans reflected people's preferences such as the times they liked to get up and go to bed and where they liked to spend their day. The fact that there was not a comprehensive assessment including social needs and any Equalities Act characteristics meant that care plans may not reflect these areas.

We recommend that you seek appropriate advice on completing comprehensive assessments and recording documentation for people.

Staff felt they had the skills, knowledge, experience and support to perform their roles effectively. Staff had access to training when they first started working at the service covering topics such as moving and handling, health and safety, infection control, safeguarding awareness, and dignity.
One member of staff had not kept their training current. The registered manager assured us that this would be booked immediately and explained how they would support this process. The registered manager and staff discussed developing needs and sought training to enhance their knowledge. We saw that staff had undertaken mental health training and dysphagia training in response to changing needs of people in the home. However, this approach had not been effective in ensuring the team kept up to date with best practice around all areas of care.

Due to concerns about how people were supported to move safely, we reviewed this training. Staff told us they received annual refresher training. The organisational policy detailed that this training should be six monthly and should include a practical assessment. This was not in place and no staff had their competence to use equipment recorded. Competency was determined by the registered manager who had not had their competency formally assessed. People were not being assisted to move safely and there were no robust checks on staff knowledge application.

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

We found that three people who had lost weight had not had their risk assessments related to nutrition completed correctly and because of this incorrect calculation there were not clear pathways in place to ensure that their calorie intake was increased, that health professionals were informed and that appropriate diets were made available to them. We checked with GP's who told us that these people had received input in relation to their weight and eating. We discussed this with the registered manager who acknowledged the initial calculation errors and told us they would review this system with the staff team. They also made information available to the cook during our inspection identifying people who needed their diets fortified.

People told us that the food was good and we spoke with a member of staff who cooked for people and they

knew people's tastes and preferences well. Whilst staff had undertaken training in relation to nutrition and hydration their management of this aspect of care was not reflective of current good practice. Where people ate their food pureed this was presented as one single colour mixed meal. It is often more appetising for people to have their food presented as different tastes and flavours and this can increase people's food intake.

We recommend you seek appropriate guidance about research based good practice for people with special diets.

People told us that the doctor was called if they were unwell and that they could see a dentist if needed. GP's who visited the home regularly were positive about their communication with the home and confident in the decisions staff made about seeking their input.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The staff and registered manager told us that everyone in the home could make decisions about their care and no one needed a Deprivation of Liberty Safeguard to be applied for. It was apparent due to the nature of some people's health and wellbeing, such as short term memory deterioration, that this may change imminently and that some complex decisions may already need an MCA assessment.

Staff understood the function of the Mental Capacity Act 2005 when people could no longer make decisions for themselves and our observations indicated that people's consent was always agreed about day to day care and staff discussion reflected this.

Whilst staff had received training, we recommend you seek appropriate advice and guidance to ensure that the MCA and its processes are embedded. This will enable staff to identify when MCA assessments and Best Interests decisions are needed.

Individual bedrooms were furnished according to people's preferences.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. All the interactions we observed throughout the inspection demonstrated this. People responded as if this was normal and natural, in line with their usual experience. On person told us: "It is very friendly here." Another person told us "The atmosphere is friendly. Staff are nice." There was a calm atmosphere in the home with enough space for people to engage with each other in the communal lounge or to spend time in their individual rooms.

The evidence of failings identified during our inspection does not reflect a caring provider. However we found that this was a sudden and dramatic change in the service and the registered manager, who also owned the service, identified that issues had 'snowballed'. Staff and people were consistent in their reflection that the registered manager cared deeply about the people, the staff team and the service a whole.

The respectful and compassionate approach was echoed when staff spoke about people with each other and with us. People recognised and felt comfortable with staff. They told us the staff who worked in the day time and at night were kind and caring. We saw people sought out staff by ringing their bells or calling out. Many of the staff had worked at the service for a number of years. They had built up strong relationships and had a good understanding of people, their personal backgrounds and histories, their interests and preferences. Information about people's histories was also referenced within people's care records.

Relatives and friends could visit when they wished without notice. Relatives told us that they were made welcome when the visited. One relative told us how they were able to bring their pet into visit and another relative told us how the staff looked after their loved one's pet. They both appreciated the staffs understanding of the importance of these relationships.

People's privacy and dignity was upheld. Assistance with personal care was offered discreetly where needed and usually took place behind closed doors. On one occasion a door had not been closed completely. This was rectified immediately.

Requires Improvement

Is the service responsive?

Our findings

People were asked about their care and support throughout our visits. For example, one person was asked on a number of occasions by staff whether they wished to get up yet. When they asked for help to get up it was provided in a timely manner.

The service was not meeting the Accessible Information Standard, which became law in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand. People's communication needs were not highlighted sufficiently in their support plans and this information was not made available to visiting professionals. One person no longer used speech reliably as their means of communication. Their care plan indicated that this was a matter of choice and that they would use head movements to communicate when this was the case. We did not always observe this to be the case and health professionals told us they had visited this person without staff support at times and not been given information on their communication.

We recommend you seek appropriate guidance about the assessment, recording and sharing of people's communication needs.

People, and relatives, told us they were able to raise concerns with the registered manager or staff. However, we also heard from one relative who had raised a complaint about care that had not been responded to in line home's policy. We asked the registered manager about this and they acknowledged they had not responded to the complainant in accordance with their time frames.

House meetings were not held formally and the registered manager told us that they gathered people's views informally. Peoples' views were also gathered through regular quality assurance discussions which included questions about their experience of the care they received.

Support plans were individualised to the person according to their needs and preferences. They included information about people's life histories and reflected their preferences. Support plans described the help people needed and what they could do for themselves. They covered areas including, personal care, eating and drinking, health conditions and staying safe. The registered manager and staff had consistent views about the support that they were providing to people.

Care plans did not sufficiently cover what activities people found meaningful activity or the support they would need to follow their hobbies and interests. Whilst feedback on activities was recorded, there is a risk that if this information about people's preferences is not recorded or appropriately monitored that opportunities for people to engage in activities will be missed. People who were able to go out without staff support did so during the inspection visits. Staff also provided support for people to go out. One person told us that they usually went to the Air Show with staff. Records showed that activities included regular animal visits to the home and musical entertainment. The staff also provided this support and spent time in chatting with people, painting their nails and ensuring they had audio books to listen to. Events such as birthdays and the Royal Wedding were celebrated with parties.

We spoke with the registered manager about end of life care provision in the home. They explained that people had decisions about their wishes for the end of their lives respected. Where people had made plans these were recorded and where people chose not to, this was revisited with them sensitively from time to time. When people had died in the home staff had been able to stay with the person and provide support for them and their families to ensure a dignified death. We saw cards from relatives reflecting their appreciation for this compassion and care.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service in April 2018 we judged the home to be good in all areas. At this inspection we found that oversight of the quality and safety of the service had deteriorated substantially.

The provider organisation was made up of the owner who was also the registered manager. There were delays in providing us with all the information requested at the end of our inspection visit or afterwards. They told us that they were finding it difficult to locate things after other statutory agencies had also asked to see documents. Whilst there were competing demands on their time this indicated a lack of robust systems and structures to ensure suitable oversight of the home.

Some functions of oversight and safety checks had been carried out by a member of staff who had left. For example, fire alarm checks. These had not been picked up by another member of the team and the registered manager had not identified this omission. Records of reviews had also not been completed and this meant it was not possible to understand when changes to care plans had been made.

During our inspection there was a failure of the computer system that held people's care plans. This risk had not been assessed and this meant there was no back up to provide for this eventuality. Whilst paper copies of care plans were held in files these were not up to date. This meant staff did not have access to accurate up to date information on how to care for people.

Daily records made by staff were not complete with substantial periods of times including records of meals eaten were missing from two people's records that we reviewed. Other documentation relating to the running of the home such as references were also not available in a timely manner. The documentation systems did not support the running of the home or the monitoring and improvement of the care provided.

Audits had also not been effective in identifying the environmental issues that we highlighted during the inspection.

Other management functions including policy review had also not been completed during this time.

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

There was a lack of clarity around leadership roles with varying views on the seniority of one member of staff. This had led to some communication difficulties for the local authority whilst responding to a potential safeguarding allegation. We discussed this with the registered manager and they explained they had become aware of this miscommunication and rectified it.

The understanding amongst the registered manager and senior team in relation to statutory notifications had led to failure to notify the CQC. This meant that CQC had not received information to support their monitoring of the service. We had previously found this to be the case when we inspected in November

2016. At this inspection the registered manager who told us they would review the regulations as a matter of urgency in relation to statutory notifications. This had not been embedded into working practice.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010.

We spoke with the registered manger and they acknowledged that there had been a deterioration in oversight and that focussed work was needed to get back to the standard they wanted. They told us they were committed to achieving this and there was a marked positive change in their efficient provision of information. They started to develop a service improvement plan to respond to concerns identified and agreed to receive support from the local authority. They told us they would send us a copy of this service improvement plan. We received this two weeks after our inspection. The plan required further work to be effective. Professionals also reflected that the standard of the home had previously always been good. One professional told us: "We thought of it as one of the good homes." Staff also felt supported and respected, and were committed to ensuring that high quality care was delivered.

People and relatives were comfortable with the registered manager. They also told us they liked the "friendly feel of the home". This ethos of ensuring people felt at home and relaxed with each other and staff was apparent in staff interactions and the way people described their experience.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory Notifications had not been made to CQC. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not assessed effectively and care and support did not reduce the risks people faced. Regulation 12 (1) (2) (a) (b) (c) (d) (e)

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 People were not protected by systems that operated effectively to investigate abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not established or operated effectively to ensure compliance with the regulations. Records were not available or

complete.

Regulation 17 (1) (2) (a) (b) (c) (d)