Tamaris (England) Limited

Bebington Care Home

Inspection report

165 Heath Road
Bebington
Wirral
Merseyside
CH63 2HB

Tel: 01516091100
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Bebington Care Home is a purpose-built care home providing residential and nursing care for up to 87 people with varying needs. These include specialist nursing support, respite care, end of life and general assistance with everyday living for people living with dementia. At the time of inspection 74 people were living in the home.

People's experience of using this service: The quality of care had deteriorated since the last inspection. The provider and manager had not assessed and managed risk, which placed people at risk of harm. People's emergency evacuation plans had not improved and there were continuing issues with people not having access to their call bells.

There was an insufficient number of permanent staff to meet people's needs and a high use of agency staff. Staff had not been appropriately inducted into the home and the issues we identified during the inspection made us question the effectiveness of staff training.

There were concerns with staff practices regarding monitoring of people's health and not acting on identified concerns. Medicines had not been managed safely.

Complaints were inadequately managed and accidents and incidents were not adequately reported by staff. People had assessments and plans regarding their care and support needs. However, the care plans lacked important information and were not always kept up-to-date. Quality assurance processes were inadequate.

The service was not well-led and there was a lack of effective governance and oversight by the provider and manager. Records were not always accurate and up to date.

Rating at last inspection: At the last inspection the service was rated requires improvement (January 2018)

Why we inspected: This inspection brought forward due to information of concern from the local authority.

Enforcement: The service met the characteristics of Inadequate in four key questions of safe, effective, responsive and well-led and Requires Improvement in caring. We are taking enforcement action and will report on this when it is completed.

Follow up: Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The overall rating for Bebington Care Home 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.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Bebington Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notifications of concerns from the local authority regarding pressure area care and health monitoring of people living in the home. These concerns were looked at during the inspection.

Inspection team: This inspection was carried out by one adult social care inspector, one adult social care inspection manager, one assistant inspector, one medicines inspector, one specialist professional advisor (SPA). The SPA was a registered nurse with experience of the care of people with dementia. An expert by experience also attended the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Bebington Care 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.

The service did not have a manager registered with the Care Quality Commission. A manager was going through the processes to register with CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did: The provider did not complete the required Provider Information Return. This is information providers must send us to give us key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection we spoke with seven people using the service and eight relatives to ask about their experience of the care provided. We spoke with five staff, resident support supervisors and managing director. We also received feedback from other social care professionals.

We reviewed a range of records. This included 10 people's care records and medicine records. We also looked at five staff files around staff recruitment. Various records in relation to training and supervision of staff, records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- The majority of people we spoke with said they felt they or their relative was safe with staff members, however further comments we received suggested some concerns about safety overall.
- Monitoring information such as charts for pressure area care, nutrition and fluids were not always completed fully. We also saw hourly observation and bedrails checks had not been completed.
- During the inspection we identified people who had pressure area concerns that had not been recognised. This was brought to the providers attention. We asked for this to be acted on immediately. The provider also identified additional people with pressure area issues during the inspection.
- During our last inspection we had identified that personal emergency evacuation plans (PEEP's) had not been updated. At this inspection we found that this had not improved. There were no adequate PEEP grab file and the PEEP and care plan information did not match. We saw that the PEEP's had not been updated since our last inspection.
- During our last inspection we had identified that call bells had not been made available for people in their rooms. At this inspection we saw that this had not improved. This was also commented on by a relative who told us their family member's call bell was routinely tied up out of reach.
- We identified that the system in place for staff to report accidents and incidents was not being used appropriately by staff. This meant there was no way identifying trends. Due to the inadequacy of the reporting of accidents and incidents we could not be certain that each person who had had an accident/fall/incident had been treated appropriately or monitored.
- We found that appropriate action had not been taken in response to people's falls and that the failure to respond had resulted in people being placed at serious risk of further injury.
- Evaluation entries were in many cases repetitive, brief and on the same date. Dependency levels referred to one person as a low risk regarding their dementia, however we observed that they were very agitated and confused so we did not consider this to be accurate.

The provider did not manage risk safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- During our last inspection we found medication documentation was not always correct. At this inspection we found this had had deteriorated.
- Records for adding thickening powder to drinks, for people who have difficulty swallowing, were insufficient to keep people safe.
- Records to show topical preparations such as creams were being applied were not always completed and

accurate; therefore, we were not assured people's skin was cared for properly
● Correct documented evidence of authorisation to administer medicines covertly, hidden in food or drink, were not always in place.
● Variable doses of medicines i.e. one or two, administered to people were not documented so staff were unable to assess the effectiveness of the medicine.
● The actual time a medicine was administered was not documented for time sensitive medicines, so, for example staff could not be assured that the four-hour time interval between paracetamol doses had been observed.
● Information to support staff to administer medicines was not always available; for example, directions for eye drops did not stipulate which eye
● Medicines with a short-dated expiry once opened, were not dated when opened. Therefore, there is a risk they would be used beyond their expiry dates.
● Quantities of remaining medicines did not match the records of doses administered to the person so we could not be assured medicines were administered as prescribed.
●The temperature of the medicines fridge was not always monitored; therefore, efficacy of the medicines stored within the fridge could not assured.

Medicines were not managed safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There had been a consistent high use of agency staff for several months which meant there was no continuity of care.
● The provider used a dependency tool that was meant to indicate how many staff were to be used depending on the needs of the people living in the home. We looked at rotas for two months previously and identified shifts that had not had sufficient staffing.
● The provider had followed appropriate recruitment processes and made. Checks such as criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out.
● One relative told us "The staff are see are very pleasant [towards my relative], although obviously over-stretched." Another relative said "Permanent nurses not around currently and agency nurses say they don't know what's going on."

Preventing and controlling infection
● Risk assessments were not sufficient for preventing or controlling infection. Examples included those with pressure area issues were not monitored surrounding elimination. This meant that people were at risk of having their pressure areas infected.
● We saw that personal protective equipment such as gloves and aprons were freely available for staff.

Learning lessons when things go wrong
● Due to the lack of effectively kept records we could not be certain that mistakes that had happened had been identified and acted on. This meant lessons would not have been learnt to remove the risk of repeating mistakes.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

- Induction of staff was inadequate. For example, some permanent and some agency staff had not been given any kind of induction to the service.
- Staff had received minimal supervisions or appraisals within the last twelve months.
- Due to the issues we identified during the inspection this had brought into question the validity and effectiveness of the training being provided to the staff.
- There was no evidence of the providers disciplinary processes being followed following a complaint that had been made about staff. This meant we could not be certain staff practice was being monitored appropriately.

The provider did not manage staff support and induction adequately. This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service was not working within this framework.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Mental Capacity assessments and best interest meetings had not always been carried out with or for people surrounding the administration of covert medications. Medicines should not be administered covertly until after a best interests meeting has been held.
- We identified that some care files had no evidence of consent documented in them.
- Staff lacked understanding of best interest and mental capacity assessment principles and documentation was not always completed. This meant inappropriate decisions could be made on a

person's behalf if they lacked capacity to make the decision for themselves. (insert spiritual needs example here). One person whose relevant person's representative (RPR), who is a person's advocate requested spiritual support (priest visit) for the person. When we queried if this had taken place we were told by staff a 'best interests' meeting had taken place and it had been decided that this was not in the persons interest. There was no evidence of this. We did not consider withholding spiritual support was in the persons best interest. This was immediately brought to the providers attention for action.

The provider did not ensure consent to care and treatment was in line with law and guidance. This demonstrates a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- The initial assessments carried out when people were first introduced to the home recorded the allergies of a person however these were not reflected in appropriate care plans.
- We identified that staff did not work with agencies effectively and this had impacted on the care that people received.
- Monitoring information surrounding food and drink intake was incomplete and at times not completed at all. An example of this was where one person was referred to a dietician December 2018 due to poor compliance with diet. This person's weight was not monitored effectively and we could not locate a recording that the dietician has visited the person, this had not been followed up by the staff.
- We identified that there had been significant weight loss of one person and this had not been actioned until January 2019 when a permanent staff nurse was on duty.
- We saw that information had not been passed on regarding speech and language therapist directions following the referral. This meant that the person had not been supported safely.

The provider did not ensure safe care and treatment of people using the service. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The home had four units. One dementia residential, two general nursing and one dementia nursing unit.
- The general presentation of the home was obviously in the process of re-decoration on the days of inspection, so it was therefore difficult to accurately assess the suitability of the environment for people living with dementia. Doors to people's rooms were shabby and did not all have name tags, however some had bright signs on them.
- Door numbers were not clearly visible and some were faded.
- We were told that due to staff shortages one unit had to shut a door in the middle of the corridor if two people living with dementia had an altercation. This reduced the ability for people to move freely.
- Each bedroom was en-suite and was able to be personalised by the people living in the home.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always respected. For instance, we saw bed rail signs up over doors, this was removed by inspection team.
- We saw one person sitting alone in the lounge with the door closed. We asked them if they would like it left open and we were told yes. If we had not asked what was wanted, this person would have stayed isolated.
- People's personal information was not always stored securely, therefore their privacy was not maintained.
- We asked people how they were treated and the response was mostly positive. Comments included "[The staff] are very pleasant" and "They seem lovely with [relative]."
- Each person we spoke with was happy that their privacy and dignity was respected, for example when carers were giving personal care. Comments included "[The staff] close the curtains and the door for privacy", "The staff always knock; always shut the curtains if they need to change [relative]" and "Oh yes staff are careful about privacy; they shut the door and everything."
- During the course of the inspection, we were aware of a number of incidences that were not recorded or potentially responded to safely and appropriately. We identified times that people's privacy and dignity was not respected. This meant that staff working at the home did not always recognise people's diversity. There were occasions where staff had omitted to respond to people's needs or provided information or support and this potentially impacted on the wellbeing of people living in the home.

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

- We saw that people were able to make their own decisions about aspects of their personal care. For instance, if they preferred a bath or a shower.
- The provider used an electronic form for people to give feedback on the service, this was available at all times by using an electronic tablet that was positioned at the entrance of the home. However, on speaking to people we were told that they did not feel that feedback was acted on. We identified complaints had not been acted on.
- People we spoke to did not appear to know about any other form of consultation.
- We observed and heard care staff supporting people with a kind and respectful manner in their approach, they responded people's differing needs

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- There were no dedicated activities for people so this had fallen to staff. Due to staff shortages the feedback had shown this had not been happening.
- A relevant person's representative (RPR), who is a person's advocate originally requested spiritual support for a person in October 2018, again in December 2018 and again March 2019. The inspector identified this had not been acted on. This was immediately brought to the managing director's attention who and then acted on it. It should not have taken an inspection to have highlighted this.
- We saw that there was a lack of communication within the home. In one instance this resulted in a person missing an important appointment.
- Some of the people and family we spoke with told us that they were not involved in care plans. This meant some people did not have choice and control.
- Care plans did not match with relevant risk assessments. This meant that staff did not have appropriate guidance on how to support an individual appropriately. With the large use of agency staff this meant that there was a high risk of people not receiving person centred, responsive and safe care.
- We saw evidence of discussions with palliative care occupational therapists. One discussion had resulted in a person safely being able to sit out of bed for short periods however the person told us they did not wish to do this as ''there is no point.'' This had not been flagged by staff and so we alerted staff to explore this further.
- During the inspection we asked if anyone was on end of life care and we were told no. However, one person's care plan stated they were on end of life care. This was immediately brought to the managing directors attention.

This demonstrates breaches of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- During the inspection we identified a significant complaint identified had been made to the manager and had not been dealt with appropriately. There had been no outcome and no record from Human Resources to show that this had been dealt with at all. Following on from this there had been no safeguarding notification to either CQC or the local authority.
- Several relatives told us they were not supported to raise concerns, their concerns were not addressed by the provider and they had lost faith in the service's complaint process. One person said, "I'm reluctant to submit a formal complaint because I'm not convinced it would lead to anything."
- There was no record of any of the concerns that had been raised by each of the families we spoke with.

The provider did not manage complaints adequately. This demonstrates 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

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

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

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Notifications surrounding abuse, pressure area problems/accidents incidents not being submitted to CQC.
- The numerous issues we identified during our inspection demonstrated that audits were ineffective and failed to monitor the safety and quality of service being provided
- Staff were meant to do a daily walk round to identify problems and then fill in the tracker on the iPad provided. This is also the responsibility of the home manager and should be done by two staff. The information recorded then goes onto the providers electronic system for action and is used to complete audits we were informed that the agency nurses should also partake in this but 'do not bother to do it.'' This was passed on to the managing director.
- This was supported with the lack of reporting of accidents and incidents, complaints and pressure area issues that was found during the inspection.
- There was a lack of other audits, for instance monitoring information such as turn charts or nutrition charts
- There was no oversight of the induction and supervision process and we could not be certain people's practice was otherwise monitored.

The provider did not notify the Commission of significant incidents. This is a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009
The lack of robust quality assurance meant people were at risk of receiving poor quality care. This demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- We received significant feedback from staff and relatives regarding the lack of communication within the home. This was fed back to the managing director.
- We saw some meetings had been held with staff.
- We identified throughout the inspection instances where information had not been passed on to families and other professionals.
- There were instances when other professionals had given directions for the care of people living in the home that had not been followed.
- We identified instances where people had had changing needs that had not been acted on, for example

referrals to falls teams or tissue viability nurses. We also found when initial referrals had not been followed up. This meant the home did not effectively work in partnership with others to ensure care was safe, responsive and effective.

Continuous learning and improving care

● As the audits were ineffectual there was no evidence that any mistakes had resulted in any learning and so care was not improved. Complaints had not been acted on and relatives told us they did not feel supported to give feedback.