Beeches Care Homes Limited

Beeches Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service responsive?	Inadequate

Overall summary

We inspected the service on 22, 24 February and 2 March 2015. The inspection was unannounced. Beeches Care Home provides accommodation for 43 people who require personal care. On the day of our inspection 33 people were using the service.

We carried out an unannounced comprehensive inspection of this service on 7 October 2014. Breaches of legal requirements were found in relation to the quality of the care and support people were receiving and how they were protected from harm. We took action against the provider and told them they must make improvements. After our unannounced comprehensive inspection we received concerns in relation to the care and support being given to people who used the service, including people being not being supported to change their clothing when they had been incontinent and a high number of falls occurring in the service.

We undertook this focused inspection to confirm that the provider now met legal requirements and to look at the concerns we had received. This report only covers our findings in relation to those requirements and what we found in relation to the concerns raised. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beeches Care Home on our website at www.cqc.org.uk

The service did not have a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from abuse or the risk of harm and the acting manager did not share information with the local authority when needed. People were not protected from the risk of falling and there were not enough staff to meet the needs of people.

People were not protected by The Deprivation of Liberty Safeguards and had restrictions placed upon them without staff having the authorisation to do so.

People were not supported to eat and drink enough to keep them healthy and they were not cared for appropriately.

People were not given care and support that was responsive to their needs and this placed them at risk. Complaints were not listened to or acted on and this led to a failure to use this information to improve the quality of care received.

We alerted the local authorities to our concerns and we shared information about seven people we had observed had suffered neglect.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

We found that action had not been taken to improve the service in relation to responding to incidents and people were still not protected from the risk of abuse or harm.

People were at risk of frequent falls as there was a lack of appropriate planning of care and information was not always shared with the local authority.

There were not enough staff to provide care and support to people when they needed it.

Inadequate

Is the service effective?
The service was not effective.

People were not supported to eat and drink enough and they were not protected under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Inadequate

Is the service responsive?
The service was not responsive.

We found that action had not been taken to improve the service in relation to responding to providing people with care and support that was responsive to their needs. We had to share information with the local authority as we found people had been subject to neglect in relation to their care.

People who used the service and their relatives did not feel able to raise concerns with the acting manager as when they had done so previously these had not been acted on.

Inadequate

Beeches Care Home

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection of this service on 07 October 2014. Breaches of legal requirements were found. We took action against the provider and told them they must make improvements to ensure people were safe from harm and were being given appropriate care that met their needs. After our unannounced comprehensive inspection we also received concerns in relation to the care and support being given to people who used the service, including people being left in soiled clothing and not being assisted to change. We also received concerns about a high number of falls occurring in the service.

We undertook an unannounced focused inspection of Beeches Care Home on 22 February, 24 February and 02 March 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 07 October 2014 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, effective and responsive. This is because the service was not meeting some legal requirements. We had also received information of concerns from four separate sources. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We looked at the information of concern we received in the two weeks prior to our visit, and we contacted the local authority safeguarding team to ask for their views.

During the visit we spoke with five people who used the service, six relatives, seven members of care staff, the deputy manager and the acting manager. We observed care and support in communal areas. We looked at the care records of seven people who used the service.

Inadequate

Is the service safe?

Our findings

At our inspection on 07 October 2014 there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risk of abuse because information about incidents had not been shared with the local authority when required. We took action against the registered provider and told them they must make improvements to protect people from abuse and harm.

We saw that the required improvements had not been made to prevent similar incidents happening again and therefore the provider remained in breach and people were not protected from abuse and harm.

The acting manager had created a small unit in the service and we saw consideration had not been given to how this unit would be monitored by staff nor had they assessed the risk to people living on this unit. In the four weeks prior to our visit there had been two serious incidents where one person had sustained a significant injury and another person had got their arm trapped in a fire door. Discussions with the acting manager confirmed to us that the risk to people in this unit had not been recognised. Plans for staff to monitor the people in the unit had not been put in place. We looked at the care plans for the people living in this unit, two of whom were at high risk of falls and one of whom had a history of hitting other people due to their dementia related illness, and we saw these risks had not been taken into account when creating the unit. This meant people on this unit were not protected from harm or the risk of harm.

Information about these two incidents had not been shared with the local authority safeguarding adults' team, by the acting manager or staff, in line with local protocol. When we discussed this with the acting manager they showed a lack of awareness of why they should have shared the information. We spoke with staff and although they understood the process of reporting safeguarding incidents outside of the service, they did not recognise that these two incidents should have been reported to the local authority. A lack of awareness and sharing information with the local authority placed people at risk of further harm.

The local authority shared information with us that related to a recent incident of aggression between two people who lived with a dementia related illness. The local authority investigation into this incident had been concluded and it had been found that there was a lack of appropriate care planning in place to alert staff to the potential risk of an incident of this nature.

We found that there was a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we were told by relatives that they had concerns about the levels of staff in the service. Two relatives told us it was difficult to find a member of staff when they needed them and that they regularly had to look for staff as people needed assistance and had been waiting for a long time. Another relative told us staff did not seem to spend individual time with people. They told us there were long periods of time where there were no staff present in communal areas. We observed and experienced this to be the case during our visit.

On the first morning of our visit staff told us one member of staff had called in sick and so they were short staffed. We looked at the staff rota and saw this happened frequently. Staff were working long hours, often without a break and they were working up to 14 days without having a day off. This was because there were insufficient numbers of staff employed at the service. A relative said, "I don't see how you can run a home well when you do not have the staff, if something happens there is no one to cover."

We saw there was not enough staff to give care and support to people in a timely way and people were left waiting for help to get up in the morning and to go to the toilet. We were told by two different sources that people were often left in bed until late morning due to a lack of staff to assist them. We saw this to be the case during our visit and when we spoke with staff about the amount of people waiting for assistance to get out of bed they told us they were working as fast as they could but they had a large number of people to assist.

We saw that at lunchtime two people had to wait for 30 minutes in the dining area for staff to support them to eat as staff were busy supporting other people. One person was given a meal on a small table beside their armchair and they could not reach this and so did not attempt to eat

Is the service safe?

it. The person called out three times for help from staff, at one point calling out, "Please help me, I can't see. "Staff were busy supporting other people and this person did not get assistance with their meal for 20 minutes.

The provider had increased staffing levels when we visited on the third day of our inspection by engaging staff from an agency. However we had concerns about the staff that had been sourced from the agency as they did not have any knowledge of the people they were supporting. We spoke with one agency member of staff and they did not even know the name of the person they were supporting with a meal. Information about the needs of people was not being communicated to the agency staff and this presented a risk that people would receive care that was unsafe. For example one person, who was at risk of choking and should have been given a meal that was softened, was given a meal which had not been softened. This placed them at risk of choking.

We found that the provider was not deploying enough skilled and qualified staff in the service. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The atmosphere in the service was chaotic and the communication between staff was wholly inadequate and this presented risks to people in relation to what level of monitoring and support they were given. We saw there had been a high number of falls in the service and there were 93 falls recorded in the four months prior to our visit.

We saw that where people had been assessed as being at 'high risk' of falling, staff did not always know about this risk and evaluations of the risk were ineffective with staff recording, 'No falls this month' when in fact the person had fallen that month. We looked at the records of four people who had been assessed as being at 'high risk' of falling. Discussions with staff showed there was a lack of knowledge of if these people were at risk of falls and following the falls, preventative measures had not been put in place to minimise the risk of people falling again. Records showed that all four people had sustained further recent falls as a result of a lack of knowledge, communication and appropriate assessment and care planning.

We raised concerns to the acting manager and the registered provider about the amount of falls in the service. We raised the lack of staff knowledge of the risks and lack of communication when people did fall, which resulted in people being placed at risk of further falls. They assured us they would make immediate improvements. We returned to the service two days later to assess if the immediate improvements had been made but despite the assurances from the registered provider, this had not happened. We continued to have significant concerns about the risk of people falling and indeed witnessed two of these falls.

We observed one person, who was at risk of falling walking in the service with a member of staff and the member of staff was not paying close attention to the movement of the person. The person turned and fell to the floor and when we spoke with the member of staff they told us the person was not at risk of falling and did not usually fall. This was not the case and records showed the person was at high risk of falling and had a long history of falls.

On our third visit we witnessed a person who was assessed to be a high risk of falls fall in a communal room. Another person who used the service had tried to alert staff when the person stood up. The person told us, "They are always falling." The person had a history of falling previously and had fallen twice in the previous week, yet no review of their care had been carried out to identify how to protect the person from any further falls.

We also found that staff, including senior staff, were unaware the person had fallen on both those occasions. A senior staff member said they had completed an incident form when the person had fallen recently, but they were unaware that there was a second incident form about another fall the person had. A staff member told us there had not been anyone that had fallen over the last week that they were aware of. Again the lack of communication in relation to this person and their risk of falls led to them being placed at risk of further falls and may have contributed to the fall we witnessed as steps had not been put in place to reduce the risk.

Another person had been assessed as being at 'high risk' of falls and had fallen several times. We had found their sensor mat, which was in place to alert staff if the person got out of bed, was unplugged on the first day of our inspection. On the second day the sensor mat had been removed completely and when we discussed this with the acting manager she was not aware of the ongoing falls this

Inadequate

Is the service safe?

person had. The acting manager arranged for the sensor mat to be returned, however the person's relative told us on our third visit that they were concerned about their relative's safety due to their history of falling. We found the sensor mat had once again been removed and none of the staff could give a reason for this. The lack of communication in relation to this person's risk of falls led to the sensor mat not being in place and left them exposed to the risk of more falls as staff would not be aware they were out of bed.

We found that the provider was not protecting people from the risk of unsafe care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We looked at the weight records of all of the people who used the service and we saw that a high number of people had been losing weight over the previous four months. We had concerns about the nutritional intake of four of these people during our visits.

These four people were dependent on staff to support them to eat and drink enough. We saw that all four were not given the assistance they needed to get up and dressed until late morning. Whilst they were waiting they were not given anything to eat and drink and records showed food and drink had not been given to them since teatime the previous day. For example one of these people had a meal and a drink at 4pm hours on the day prior to our visit and did not receive any food or drink until 1130 the next morning. This person was then offered lunch at 1pm, one hour after finishing their breakfast. This infrequent meal regime could be a contributing factor to these four people losing weight.

One relative told us they often assisted people who needed help to eat their meal when they saw they were struggling to get food in their mouths and staff were not available. Another relative told us they had to ask staff to get one person a drink as they had been waiting for so long. We saw evidence of this on the first day of our visit with one person struggling to eat their meal and spilling a lot of it on themselves and the floor and people having to wait for assistance with their meal.

We raised concerns to the acting manager and the registered provider about weight loss and people not being supported to eat or drink enough. They assured us they would make immediate improvements. We returned to the service two days later to assess if the immediate improvements had been made but despite the assurances from the registered provider, this had not happened and we continued to have concerns about how people were being supported to eat.

When we returned to the service two days later we saw a chart had been implemented by the acting manager and staff recorded on the chart when people had been given a meal. People who were waiting for staff to assist them to get up had been given breakfast in their room. This gave us some assurances that people had been supported to eat enough during this visit.

However we found this had deteriorated again when we returned for the third visit. We observed tea being served in the dining room. There was no organisation as to how food was served to people in the two dining areas and in bedrooms and it was difficult for us to tell who had been given a meal and who hadn't. We observed some people given three courses and other people sitting without any food in front of them. We asked a staff member how they knew everyone had been given something to eat and they admitted they would not as they had not completed the chart to show who had been served a meal. Another staff member said, "It's not working, we need to structure mealtimes."

We saw some people who were in their rooms were brought their evening meal but were not provided with the support they needed to eat these. We saw one staff member leave a meal for one person on a bedside chest of drawers which was not easy for the person to reach and unpractical for them to eat. The staff member said, "Are you going to eat? I'll leave it with you." Another person had their meal on a very wobbly table. As a result the person had food on the floor, bed and over their clothes and so did not actually eat much of the meal.

We did not see the people who had tea in their rooms taken a pudding, and their dinner plates had not been cleared away. The acting manager told us people had been offered pudding but refused; however one person who ate in their room who was able to talk with us told us they had not been offered one. This showed the staff did not have a clear idea of who had been provided with their evening meal and presented a risk that people would not receive enough food to keep them healthy.

We found that the provider was not protecting people from the risk inadequate nutrition and hydration. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured staff were suitably trained to carry out their duties. We observed staff using methods of moving and handling which was not safe and we also observed staff not using protective clothing to protect people from the risk of the spread of infection. Staff spoke of not having had training since being employed at the service.

Inadequate

Is the service effective?

One staff member said they had been trained to use the equipment such as the hoist in a previous job but had not been at this service. We observed staff assisting a person to transfer from chair to chair using a stand aid. The person was not able to stand and so the stand aid was not safe and a hoist should have been used. Staff placed this person at risk of harm due to their lack of knowledge of which equipment to use. The acting manager agreed this person could not be safely assisted using a stand aid.

We found that the provider was not deploying enough skilled and qualified staff in the service. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We saw one person had assessments in their care plan which informed staff that the person was resistive to personal care but to continue with the care as it was in the person's best interests. An application had not been made to the DoLS team to authorise this method of care delivery and to ensure staff were delivering the care in the least restrictive way.

The acting manager had placed a keypad on a door in one area of the service to create a small unit. This restricted people from leaving the unit if they chose to and three of these people lacked capacity to understand that they were being prevented from leaving the unit. An application had not been made to the DoLS team to give staff authorisation to place such restrictions on these people and so the restrictions were unauthorised. The acting manager had stopped the keypad being used following an incident where a person had been injured and a representative from the local authority had informed them they were concerned appropriate steps had not been taken prior to creating a secure unit. The acting manager and staff we spoke with had a lack of understanding of the need for a DoLS application being made.

We found that the provider was not deploying enough skilled and qualified staff in the service. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medical advice and treatments were not followed or implemented in good time. One person had been set some daily exercises to undertake several months previously to assist with their mobility, but staff were unaware of these and the person had not been supported to complete these. We also found there had been an unnecessary delay in commencing some treatment for another person to boost their nutritional intake. Some people who were losing weight or having frequent falls had not been referred to external professionals for guidance on managing these risks. This had resulted in further weight loss and falls and so people's health, safety and well-being was not being maintained.

A relative told us their relation had needed to undergo some tests in hospital. They told us they had experienced considerable frustration trying to get staff to pursue making the appointment and then chasing up the results afterwards, so had done so themselves.

We found that the provider was not protecting people from the risk of unsafe care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our inspection on 07 October 2014 we found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not receiving care which was safe and responsive to their needs. We took action against the registered provider and told them they must make improvements to make sure people received safe and appropriate care. We saw that the required improvements had not been made to improve the care and support people were getting and therefore the provider remained in breach of Regulation 9.

Three people who were more independent told us they were happy with the support staff gave them with one of them saying, "I do most things for myself but the staff treat me very well." The relatives of one person also commented positively on the care their relation was receiving.

However we found that where people were dependent on staff to give care and support, they were not always given the care they needed. We received information of concern from various sources prior to our visit relating to people being left for long periods of time in soiled beds and clothing. During the first day of our visit staff had reported that when they had assisted two people to get up they had been laying in soiled beds. We found a further two people in bed late morning waiting for staff to assist them and one had vomited and this was still on their clothing, they had no access to a call bell to alert staff and they did not have access to a drink. We found a further person who was lying on soiled bed linen.

Relatives gave us examples of how their relations and other people who used the service did not have the support they needed to meet their continence needs. One relative told us they had asked for assistance for their relation over half an hour previously and they were still waiting. They said they had seen another person left waiting to be changed for two hours.

One person had fallen prior to our visit and we saw that staff had not sought any medical advice for this person until the person fell again on the same day some eight hours later. After the second fall staff had noticed the person had sustained a significant injury during the first fall and emergency medical attention was arranged. During this delay in getting medical attention the person would have been in significant pain and staff had recorded after the first fall that the person had complained of being in pain. Despite this medical attention had not been sought and staff had left the person in pain and discomfort for eight hours.

We found other examples of how people did not get their needs met. We were present when a person who spent their time in their room told a staff member in the morning they had not been feeling well. The person told us at lunchtime no one had been back to see them. They told us later, "Staff don't come to see me unless I buzz." We saw another person ask a staff member for an item and was told they would get them one in a minute. We saw the person had to wait over 20 minutes for this.

We raised these concerns to the acting manager and the registered provider and they assured us they would make immediate improvements. We returned to the service two days later to assess if the immediate improvements had been made but despite the assurances from the registered provider, this had not happened. We continued to have significant concerns about the care and support people were receiving from staff.

Two relatives had arrived to visit that day and found their relation sitting in soiled clothing and we found one person in bed in the afternoon also in soiled clothing. We found a further person was poorly in their bedroom and staff had opened the window which had caused the room to be icy cold due to the time of year and the outside temperature. The person told us they were cold and they were wearing only a thin undergarment. We asked staff to close the window and provide the person with warmer clothing.

We found that the provider was not protecting people from the risk of unsafe care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to and during our inspection relatives raised concerns with us about the quality of care delivered. One relative told us they had raised concerns with the acting manager but had not had their concerns addressed. A provider information return was send to us in September 2014 and we were told in this that there had been four complaints made in the previous 12 months. However when we asked the acting manager for a record of complaints made she

Inadequate

Is the service responsive?

told us there had not been any concerns raised and there was not a complaints log available. This meant we could not be assured that complaints were responded to or acted on.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected from the risks of unsafe or inappropriate care. Regulation 9 (1)(a) and (b)(I)(iii)

The enforcement action we took:
We cancelled the registration of this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not protected from abuse or the risk of abuse. Regulation 11 (1)(a)(b)

The enforcement action we took:
We cancelled the registration of this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risk of inadequate nutrition and hydration. Regulation 14 (1)(a)(c)

The enforcement action we took:
We cancelled the registration of this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were supported by staff who were not supported in relation to their responsibilities, to enable them to deliver care and treatment safely. Regulation 23 (1)(a)

The enforcement action we took:
We cancelled the registration of this provider.