Beachlands Care Limited

Beachlands Residential Care Home

Inspection report

Marine Parade
Seaford
East Sussex
BN25 2PY

Tel: 01323891004

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 February 2018. The first day was unannounced. At the last inspection of Beachlands Residential Care Home (Beachlands) in December 2016 and January 2017, the overall rating was requires improvement. At that inspection, we found breaches in Regulations 9, 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not reflective of people's individual health and social needs and there were not enough meaningful activities for people to participate in. Mental capacity assessments for people who had limited capacity were not always followed or reflective of individual needs. Systems for monitoring quality were not always effective.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key questions effective, responsive and well led to at least good. We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan. This inspection showed improvements had not been made and the service remained in breach of Regulations 9, 11 and 17. Additionally this inspection found the service was in breach of Regulation 12. The overall rating for Beachlands has been rated as Inadequate.

Beachlands 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. Beachlands provides accommodation and care for up to 29 people. There were 26 people living at the service when we inspected. People cared for were mainly older people who were living with a range of care needs, including arthritis, diabetes and heart conditions. Some people needed support with their personal care and mobility. Some of the people were also living with dementia.

Accommodation was provided mainly on the ground floor, with a few rooms on the first floor. The service was situated in a quiet residential street in the East Sussex town of Seaford.

The service had a registered manager in place. 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. The provider for the service is Beachlands Care Limited and Beachlands is their only registered premises.

As at the last inspection, the provider did not to identify a range of areas to ensure safety and quality of care for people. The provider told us that, due to difficulties with the recruitment of permanent staff, the service had been using agency care workers to provide much of the care to people for an extended period of time. Agency care workers were not given the information they needed to enable them to care for people safely. The provider had not identified that agency care workers were not always being supervised in their roles to

ensure they provided people with safe and quality care. The provider had not ensured that their audits covered all areas of care delivery or ensured that all other audits were completed to the same standard. This included medicines audits and the accurate and full completion of people's records.

As at the last inspection, the provider had not ensured all people had assessments and care plans to outline how their needs were to be met. This included assessments and care plans relating to people's mobility, communication needs, continence care and for people who were living with dementia. Some activities provision had been started since the last inspection but these did not take place every day and they were aimed at people who were able to come to the main lounge. People who were not able to leave their own rooms were not supported by individual assessments of their needs to ensure their social needs were met, and risk of isolation reduced.

Although records showed staff had been trained in the Mental Capacity Act (2005), people who needed support with decision-making continued not to have mental capacity assessments completed to ensure they were appropriately supported.

Where people had individual risks, these were not consistently supported by clear assessments and care plans to reduce their risk. Staff were unclear about actions to take to ensure certain people's risks were reduced. This included where people were at risk of pressure damage and infection. Relevant professionals were not always contacted to support people to reduce risk, including where they had difficulty in swallowing. The provider had also not developed a training plan so staff were supported in developing skills in relation to people's more complex needs. For example, supporting people who had catheters or specific nutritional needs.

Although the provider assured us they provided adequate staffing levels and kept this under review, depending on people's needs, they had not actively reviewed if they had sufficient staff deployed to meet people's current needs. This related particularly to assessment of staffing levels in relation to people's dependency and a review of staffing levels at night and. The provider had not been successful in recruiting any staff since the last inspection, where they were found to have safe systems for staff recruitment.

The provider had not identified they were not making sure people's privacy and dignity was respected. This included ensuring there was no risk of communal use of certain underclothing. Although people had some of their individual preferences documented, staff were not respecting these. For example, staff were not always ensuring people could watch their preferred television channels in their own rooms.

People told us they felt safe at the service. Staff had an understanding of how to safeguard people from risk of abuse and were confident the registered manager would ensure any allegations of abuse were appropriately managed.

Other risks were effectively managed, including fire safety and supporting people with their medicines. Staff were trained in relevant areas, including health and safety and moving and handling. Staff said they were supervised and felt supported in their roles. They said there was a good rapport between them and management.

People made very favourable comments about the meals. They also said they were supported to access external healthcare supports when they needed. People told us they were supported by kindly, caring staff and they could spend their days as they wanted to. Staff showed people a friendly supportive approach. People's visitors and relatives were welcomed into the home.

The provider had developed action plans in some relevant areas, including a major plan to improve and develop the building and home environment. People said they were confident action would be taken if they raised concerns.

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.

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 always safe.

Some people's risks were not appropriately assessed. Where people had risks identified, relevant steps were not always being take to reduce their risk.

The provider had not assessed if there were sufficient staff deployed. No staff had been recruited since the last inspection.

People said they felt safe. Staff were aware of how to ensure people were safeguarded.

People were supported in taking their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the MCA were not always being followed.

Some people did not receive the support they needed where they had additional healthcare or nutritional needs.

Staff were not trained in all relevant areas, particularly in relation to supporting people with their healthcare needs. There were training and supervision systems for other areas of care provision.

People said how much they liked their meals and commented favourably on their quality.

The provider was aware parts of the home environment needed improvements and had a plan to address this.

Is the service caring?

Requires Improvement

The service was not always caring.

Some systems did not fully support people's privacy and dignity.

Some people's individual wishes were not always followed by

staff.

Staff showed a kindly and caring approach to people.

People commented on how much they liked the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care plans did not clearly set out how they needed to be cared for. Some staff did not follow people's care plans.

Recreational activities had been developed, but these were not accessible to all of the people.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Inadequate

The service was not well-led.

People continued to be put at risk because systems for monitoring quality and safety were not effective.

Some records were not accurately completed.

People and staff spoke favourably about the inclusive nature of the provider and registered manager, and the homely service provided.

Beachlands Residential Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 19 and 20 February 2018. The first day of the inspection was unannounced. The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service, including the previous inspection report. This included details of its registration, previous inspection reports, action plans any safeguarding alerts and any notifications they had sent us. Notifications are information about significant events that the provider is legally obliged to send to the Care Quality Commission. We also reviewed the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

We met with 15 people who lived at the service and observed their care, including at lunchtime, and support with medicines. We spoke with two people's relatives and two external professionals. We inspected the service, including the laundry, bathrooms and some people's bedrooms. We spoke with two of the permanent care workers (one of whom who was also the activities worker), four agency care workers, a chef, a kitchen worker, the laundry worker, the registered manager and the provider.

We 'pathway tracked' five of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service and made observations of the support they were given. It is an important part of our inspection, as it allowed us to

capture information about a sample of people receiving care.

During the inspection we reviewed records. These included the service's training and supervision records, medicines records, risk assessments, accident and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

At the last inspection, this key question was judged to be good. However at this inspection, we found risks to people were not always assessed and people's safety was not always ensured. Where things went wrong, lessons were not always learnt from what had happened.

The National Institute for Health and Clinical Excellence (NICE) issued guidelines in 2014 which outlined that because pressure wounds, once developed take an extended period to heal, can be very painful and may be a source of infection, the emphasis must always be on their prevention, before they occur. The importance of accurate assessment of risk and consistent care provision is outlined as a key area. The service was not doing this.

We met with a person who had sustained a pressure wound while in the service. The person's current risk assessment documented they were at high risk of pressure damage. Their care plan documented the person's skin was to be inspected 'daily/weekly'; it did not document which. The person's care plan did not document if the person could move independently when in their bed or sitting in their chair. The person spent all of their day sitting out of bed in a chair; they were sitting on a pressure relieving cushion. NICE guidelines state while the use of equipment is a key area in reducing people's risk, a person also needs to be supported to move regularly, to ensure their risk is reduced. We asked staff how they supported the person. One agency care worker told us they did not know. Another agency care worker told us incorrect information about where the person's wound was; they told us the person was stood up when they went to the toilet. The only permanent care worker on duty told us they did not know how long the person had the pressure wound. They told us the person was to be moved "regularly," and was to be helped to stand up "at least once a day." Neither of the two permanent care workers or four agency care workers on either day of inspection knew if the person was able to move themselves independently in bed at night. The person had no repositioning chart to show how often they were supported to move or change their position. The person's records showed they had first sustained the wound in January 2018, about a month before the inspection. Before the person's wound developed, there were records of them having a sore area, however equipment to reduce the person's risk was not introduced until after the person had sustained a pressure wound. This does not follow NICE guidelines and had not protected the person from harm

The service had not learned from this person's pressure wound, to ensure other people who may be at risk of pressure damage had relevant assessments of their risk. One person told us they preferred to remain in their room all day, sitting in their chair. Their records showed they had a low weight and dietary needs, both of which can indicate risk of pressure damage. This person had no assessment for risk of pressure damage. The person also had no care plan to reduce their risk. Another person who staff told us sat in a chair most of their time and needed support to move, had been admitted to the service in September 2017. This person also had no assessment or care plan about how their risk of pressure damage was to be reduced, five months after their admission to the service.
The service was also not ensuring they reduced other risks for people. At the last inspection, in December 2016 and January 2017, we had identified issues relating to risks to people from tripping and scalding from the use of portable heaters. This had not been addressed by this inspection. Two of the people with had

free-standing portable heaters in their rooms. Neither person had the risk to them of having a portable heater included in their room risk assessment, although one of the people's records showed they had difficulties with their vision and the other person's records showed they had 'limited awareness of their current surroundings ' and difficulties with their balance. The lack of appropriate action by the provider had the potential to put these people at risk of scalding

The service was not ensuring risk of infection was reduced for some people. Two of the people used urinary catheters. NICE guidelines (2012) outline that urinary catheters have the potential to cause risk of infection to people. One of the key areas in reducing risk is a clear regime for the changing of catheter drainage bags, which manufacturer's guidelines outline should take place every five to seven days. We asked staff about when one of these people's catheter drainage bags were changed. One agency care worker told us they did not know, another said the person's catheter drainage bag was changed on a Saturday and a permanent carer worker told us it was changed every Thursday. We saw the person's catheter drainage bag was changed on the second day of the inspection, a Tuesday. The person had a current care plan about their catheter. It only stated they had a catheter, with no information about its type, how personal hygiene for the person was to be performed in the light of their catheter, the use of overnight bags or when their catheter drainage bag was to be changed. The person had a record of when their catheter bag had been changed. This showed their catheter drainage bag was not always being changed regularly. One record showed it was changed on a Saturday, with the next change on a Thursday, 10 days later. This lack of clear systems to ensure the person's catheter drainage bag was changed, in accordance with guidelines, had the potential to put them as risk of infection.

The provider was not ensuring safe care was being provided in all relevant areas. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments about if there were enough staff on duty to meet people's needs. One person told us, "Things could be better" about staffing, another, "They're all far too busy" and another, "They're short of staff – we've lost so many." This was not echoed by other people. One person told us, "From my point of view, there's enough staff," another, "I can walk with my frame but I have to have someone walking behind to make sure I'm safe, which I always do," and another "I haven't had to wait when I've needed staff." The provider told us, "We change staffing levels according to need." The registered manager told us they worked a rota with three care workers in the morning, two in the afternoon and one care worker awake and one sleeping at night. In addition, they employed domestic workers, a laundry worker, chef and kitchen worker. Although some of the people had higher dependency needs, the provider had not reviewed their current staffing levels, to assess if people's increased needs were met and to ensure their safety. This was particularly at night where there was only one waking care worker to support 26 people.

On both days of the inspection, two of the staff on duty were agency care workers, with different agency care workers on duty on Monday 19 February from Tuesday 20 February 2018. On the first day, one of these agency care workers had not worked in the service before. The registered manager told us they had a contract with the agency so generally they had similar agency workers on duty but they did not have the same ones every day. The registered manager said this situation had been on-going for a period of time and although they had advertised, they had difficulty in recruiting more permanent staff. At the time of this inspection, they had not been able to employ any new care workers since before the last inspection. Although the service were using high levels of agency care workers, the provider had not assessed the risk to people from not receiving continuity of care from agency care workers who were not familiar with their needs.

The lack of appropriate assessment of staffing levels is a breach of Regulation 17 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found comprehensive staff recruitment procedures were being followed. The registered manager told us they had a person who had recently approached them for employment, so they hoped, if this person was suitable, to be able to reduce their reliance on agency staff in the future, so staff could feel more confident in the support they received from staff.

People told us they felt safe in the service. The provider had systems to ensure people were protected from risk of abuse. One person told us, "Oh yes I'm safe here, that's a really good thing," another, "When we are able to use the lounge there is always staff there, and when I'm in my room I feel safe because there are staff around." A person's relative told us, "He's safe because staff are on duty at night." We asked staff about a range of areas which could indicate a person might be at risk of abuse. All staff confirmed they would report any such matter to the registered manager or care worker in charge of the service. One member of staff told us, "Pretty much anything I'd tell the manager," and another, "I have to tell." One agency care worker emphasised the importance of reporting such matters. They told us, "It's better to be safe than sorry." The local authority safeguarding policy was available in the service for staff to refer to if necessary. The service had not needed to refer an allegation of abuse to the local authority since the last inspection. The registered manager told us they were aware of their responsibilities to alert the local authority, should they need to.

The provider did ensure the safety of people in a range of areas. The temperature of baths was regularly monitored and records showed they were within safe levels, to ensure people's safety from risk of scalding. The service had several hoists available to support people with moving. All had been regularly serviced to ensure the safety of people and staff should a person need to use a hoist. The fire prevention systems were regularly checked to ensure safety in the event of a fire, this included checking of the fire alarms and ensuring exit routes were not blocked. The fire safety systems were checked annually, as required, by an approved external contractor.

The provider ensured people's risk of infection was reduced in other areas. The provider told us there had recently been a small outbreak of an infection in the service, when some people experienced diarrhoea and had felt unwell. To stop risk of spread they had emphasised hygiene in the environment, and had instigated increased cleaning such as the full use of detergent on door handles. They had also requested people to remain in their rooms until the incidence across the service had stopped. This follows good practice guidelines. People were aware of this outbreak and the steps being taken. One person told us, "We've been kept very well informed about the sickness outbreak; I don't like not being able to go and meet everyone in the lounge, but I think it's right for them to put safety first." People also commented positively on the general standards of cleanliness across the service. One person told us, "My room is kept clean, usually every day," another said, "I've no issues about the laundry, all seems very efficient. My room is clean enough." We looked at difficult to reach areas like the undersides of bath hoists. They were all clean. The laundry worker told us all staff were very good at separating different categories of laundry, and they received all potentially infected laundry in appropriately colour-coded laundry bags. They confirmed one of the washing machines had a sluice wash programme.

People told us they received their medicines safely and in the way they wanted. One person told us, "Staff bring my medicines every day" and another, "I have paracetamol if I ask for it, as I get pain from [a medical condition]." A care worker told us they had recently started to use a new pharmacist who had introduced new systems and equipment which, "Makes things so much easier." All permanent care workers had received recent training in medicines from the new supplying pharmacist. The registered manager confirmed agency care workers did not give people their medicines.

We watched a care worker supporting people to take their medicines. They did this in a safe way, checking both the prescription and label on the medicines container before going to people. They always locked the medicines trolley when they were not with it. They checked with each person who was prescribed 'as required' (PRN) medicines, for example for pain, if they needed their medicine and listened carefully to their response. Medicines needing cold storage were locked away and regular checks made on the medicines fridge to check it remained within the correct levels to keep cold-storage medicines safe. All people had a medicines administration records (MAR). These were all completed to show people had been supported in taking the medicines they were prescribed. Medicines records also included significant details for people about how they liked to take their medicines, such as if they wanted a full glass of water with their medicines and if they took tablets all together or individually.

Requires Improvement

Is the service effective?

Our findings

We inspected this key question to follow up the concerns found during our previous inspection in December 2016 and January 2017. At that inspection we found a breach of the legal requirements and areas to improve. This was because staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not always followed or reflective of individual needs. We identified this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider remained in breach of this Regulation.

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. 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.

We met with a person whose current records showed they had been diagnosed as living with dementia. Their current care plan documented they had 'limited awareness of current surroundings'. Staff confirmed the person did not always know where they were and had limited sense of time and place. The person had no mental capacity assessment to ensure they could continue to consent to areas such as what they would like to eat, while being supported with more complex areas in their life. This was also the case for another person who was living with dementia. Another person's records documented they lived with short-term memory loss and their family member had a power of attorney. Despite this, the person did not have a mental capacity assessment. A person who had been admitted at the beginning of February had a note in their records which documented a doctor had assessed that they did not have mental capacity. This person did not have a mental capacity assessment completed by either the service or their doctor.

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

People did not consistently have assessments completed when they needed and healthcare support was not always requested when relevant. When people had difficulties with eating and drinking, care plans had not always been developed.

We met with a person who told us they had difficulty in swallowing, so always ate a soft diet. This was confirmed by staff and we saw the person was given a soft diet at mealtimes. The person also had biscuits in their room, which some staff told us the person ate without difficulty. The person had no swallowing risk assessment in relation to risk of choking. We asked care workers about referral to an external healthcare

professional such as a speech and language therapist to assess if the person was at risk of choking. Care workers told us they did not know if such a referral had taken place. We discussed this with the registered manager who said they would contact the person's GP so an appropriate assessment of the person's swallowing risk could take place.

When we met with a person, we saw they were sucking on a marmalade sandwich, rather than eating it. The person did not have their dentures in. We told an agency care worker who went to fetch the person's dentures. The person had a dietary assessment which assessed them as being at high nutritional risk. Their current care plan stated they were to be assisted every day with putting in their dentures. We told an agency care worker that the person had not had their dentures put in that morning. They told us the person no longer wore their dentures because they no longer fitted. We asked if the person had been referred to a dentist about this. The care worker said they did not know. The person's care plan evaluations had not considered this matter to ensure the person had dentures which fitted, to enable them to eat their meals without difficulty.

We met with a person who had been admitted to the service in early February 2018. They told us they were concerned because they had been losing weight recently. Their records showed they had a low body weight. The service had not completed a dietary risk assessment for the person to enable assessment of whether plans needed to be put in place to support the person's nutritional intake.

People's care plans had not ensured they were supported with eating in the way they needed. One person had requested an omelette for lunch, but was having difficulty in cutting it up. We told the registered manager who reported the person was unable to do this independently and staff cut up their meals. This was not documented in their records. Other people's preference and supports with their meals were not documented. We met with a person who said they didn't feel like eating their main course because they were always given too much and a large amount, "Puts me off eating." They said they had told staff about this. This matter was not documented in their records. Another person left much of their breakfast. They also said this was because they were given too much every day. This was also not documented in their care plan. The person told us, "I can't get through to them about it." The lack of appropriate information about people's dietary needs and preferences had the potential to put people at nutritional risk.

The provider had not consistently ensured staff had the skills, knowledge and experience to deliver effective care and support. On both days of the inspection, there was one permanent care worker and two agency care workers on duty. For one of the agency care workers it was their first day working at the service. We asked them about how they had been inducted on their first day. They told us they had been shown where equipment like gloves and aprons were stored. They had been allocated to the other agency care worker, who had worked in the service before, and they had told them which people they were to support that day. This agency care worker said they knew about fire safety because of their training from the agency and they had noted where the fire exits were when they came on duty. They said they had been given, "No written information" about safety or people's specific needs. We asked two different permanent care workers how they inducted agency staff. They told us about different matters. We asked the registered manager if they had a written agency care worker induction to ensure all new agency care workers were effectively inducted into their role in the service, and informed about key matters. They said they did not have any agency induction programme. This meant they could not ensure all agency care workers had the skills or knowledge to deliver effective care and support.

We asked permanent care workers about how they supported people who had more complex needs, such as people who were at risk of pressure damage, needed catheter care, nutritional support or swallowing difficulties. Neither of the two care workers knew about NICE guidelines on prevention of pressure damage.

One care worker was not aware people who were provided with pressure relieving equipment still needed to be support to move at regular intervals, to reduce their risk. We discussed with the registered manager that they did not have a plan to ensure staff had been trained in these more complex areas so they had the knowledge and skills to meet people's needs.

The provider had not ensured care was provided in an effective way. This was because they had not assessed risk to people in relation to swallowing difficulties and nutrition and ensured they were doing all that was possible to reduce such risks, including by working with other healthcare professionals. They had not ensured staff had the skills and knowledge to meet people's needs and reduce their risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also not ensured people received the nutritional support they needed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat and drink in other areas. People gave us very favourable comments about the meals. One person told us, "The food is excellent, we're really lucky with the chefs," another, "There's always a choice" and a person's relative told us, "They bend over backwards about food here." One person told us, "If we want something else, it's no trouble, they will make anything we want, such as an omelette; they welcome requests for different things and for additions to the menu." We saw one person requested an omelette, it was promptly prepared for them when they asked; it smelt very good. A person told us they chose to eat a specific diet. They told us, "It was a real worry before admission but the food choices and preparation have been excellent so far and there has been full consultation." A person told us they particularly liked the way, "I can see they buy good fresh ingredients. The service is first rate." Due to restrictions because of the infectious disease outbreak, people were eating in their rooms when we inspected. Meals were taken to people individually, nicely presented on trays. People said they liked eating in the dining room. One person told us, "There's company there and I like the views from the windows."

The registered manager had a system to ensure staff were trained in key areas such as moving and handling, fire safety, infection control and safeguarding. One person told us about staff training, "The staff seem competent." One care worker, when asked about training said, "Regular training? Oh yes we do get it." A kitchen worker told us about their training, particularly their training in health and safety. All of the staff we spoke with told us they had been trained in supporting people who lived with dementia. The registered manager maintained a record so they could see at a glance which members of staff had been trained in these key areas, and who was due. Staff also said they were supervised and supported in their roles. One care worker told us, "We get good support from the manager." We saw one member of staff had requested first aid training during supervision and the registered manager showed us how this was being actioned. The registered manager also maintained records of staff supervision, however they said sometimes they provided staff with supervision on an 'ad hoc' basis, when required. They did not currently keep records of such supervisions, but would do so in future.

People were supported to access healthcare professionals in other areas. One person told us, "They call in the doctors if I'm poorly," another about when they weren't well recently, "The staff recognised I wasn't myself and got the doctor in" and another, "I believe they would quickly get additional help from outside if I needed it." During the inspection we met with two external professionals. They commented on the good working relationships with the service. The registered manager told us they called in emergency services when needed, however they tried to avoid people being admitted to hospital, unless strictly necessary. This was because they had found people became distressed if they spent long periods in accident and emergency or hospital, both of which were unfamiliar to them.

The premises was built some time ago. The provider was aware of this and had plans for a major

refurbishment, including provision of facilities such as wet rooms. The refurbishment would include re-building parts of the building. Most of the rooms were on the ground floor and there was a lift for the people who lived on the first floor. People were positive about the home environment. One person told us, "I like the location and layout of the home." Another person described their room as, "Warm and comfortable" and a person's relative told us the person's room was, "Lovely and really nice." One person commented about the bathrooms, "To have a bath, they had a bath chair and I manage fine." People commented about the outside spaces. One person told us, "The pond and patio are lovely."

Requires Improvement

Is the service caring?

Our findings

At the last inspection, this key question was judged to be good. However at this inspection we found some areas which required improvement. This was because people's privacy and dignity was not consistently respected and promoted. When we went into the laundry, we saw there was a container in which there was a pile of un-named net underwear. Beside the container were several knee-high female socks, also un-named. We asked the laundry worker whose clothing this was. They told us this clothing did not belong to any specific person and they were, "Used generally," if needed by people. The provider was not ensuring people's privacy and dignity by preventing the communal use of underwear.

On the first floor, a toilet and a bathroom each had a glass panel in the door. The glass in them was ridged, there was no blind or curtain over the glass. What a person was doing in the toilet or bathroom was clearly visible from outside. This had not been identified by the provider as a potential risk to people's privacy and dignity when using these facilities.

People were not consistently supported when they made decisions about their care and support, this was particularly for people who were frail and living with dementia. We met with a frail person who was not able to turn their television on or change channels independently. Although their 'this is me' plan documented they liked to watch the news, they did not have their television on during the first day of the inspection. On the second day, when we visited them, they had a programme about animals on their television. They told us, "I don't like that," gesturing at the television. We turned their television on to a 24 hour news channel and they gave us a big smile of thanks. Another person who told us they did not go to the lounge, had a 'this is me' care plan which stated they liked listening to the radio. They did not have their radio playing either day of the inspection. The person told us they were, "Bored." We told the registered manager about this. They told us they had found the person no longer enjoyed listening to the radio. They had not actively involved the person in making decisions about what they wanted to do, now they no longer wanted to listen to the radio. One person's records documented they had moved to this country from another when they were an adult. They had no information in their records about which part of the other country (which was quite large) they had moved from, or other factors in their cultural background which would support them. We met with a person who staff told us was living with dementia. There was little source of stimulation in their room such as a clock or calendar. They had some magazines, but they did not identify the magazines as being theirs.

The provider had ensured people were supported in other ways. People told us they could spend their days as they wanted. One person told us, "Sometimes I stay up quite late, this is not seen as a problem" another, "I go to bed late and get up early - that's what suits me" and another, "I choose every day when I want to be in my own room and when I'll go to the lounge." People told us staff supported their independence. One person told us, "They are very good staff, not interfering," another, "I choose how to use each day, I think that's important and I feel I still have my own life" and another, "I feel quite independent in my room. I've got my books and things." Throughout both days of inspection, people went in and out of the home as they wanted to, simply telling staff they were going out or coming back. No restrictions of any sort were placed on these people coming and going.

People told us their privacy and dignity was respected. One person told us, "I still feel I am living my own life. This is my room and staff respect that," another, "Staff treat my room as private," and another, " I like way I can get to the WC on my own." We observed care workers consistently knocking on people's bedrooms doors before they went in. Staff were cheerful towards people when they did this, calling them by their own preferred name. We met with a person who lived with dementia, who frequently repeated what they said. Staff treated the person with respect, they did not try to correct the person. Because of their friendly approach, the person was relaxed and calm.

People said they were treated with kindness, respect and compassion, and were given emotional support when needed. One person told us, "Staff are good fun here," another said, "Staff come in to me and we have a laugh," and a third person, "I'm pleased with what they do for me." People said staff knew them well. One person told us, "The staff know me very well and I know them, so I feel very much at home," another, "The girls all know me" and another, "It's such a home here." One person's relative told us they liked the way, "Staff will stop and listen, they explain things." Staff showed a sensitive understanding of how people might feel. One agency care worker said they were aware that because they were quite tall, some people might find them "threatening." They described the importance of putting a person at their ease and being friendly to them, to ensure they felt comfortable with them, before giving them care.

People told us they had felt involved in making decisions about their care from when they were admitted to the service. One person told us, "When I came in they asked me all about myself, my family, what I like to read. I was involved deciding what should be in my care plan and my daughter helped." Another person told us, "Some of the furniture is mine, they wanted me to feel at home when I was admitted." One person's relative told us, "We felt we had good information and were able to say what [the person's] needs were when they came into the home."

People were supported to maintain links with their family, friends and local community. One person told us, "I have a lot of family visits and we just get on with it, so it's like having a flat really." Another person told us how they still went out to their own hairdresser. People's family and friends visited as and when they wanted, staying for as long or short a period as suited themselves and the person they were visiting. Staff were always polite and friendly towards people's visitors.

People's records were kept confidentially in the office. When staff wrote records in the lounge areas, they always returned them to the office once they had finished completing them.

Requires Improvement

Is the service responsive?

Our findings

We inspected this key question to follow up the concerns found during our previous inspection in December 2016 and January 2017. At that inspection we found a breach of the legal requirements and areas to improve. This was because the service was not consistently responsive, as care plans were not reflective of people's individual health and social needs. There were also not enough meaningful activities for people to participate in to meet their social and welfare needs. We identified this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider remained in breach of this Regulation.

Some people did not have care plans to direct staff on how their individual needs were to be met. This was of particular concern because the service was using agency care workers who did not work in the service every day and so would always not be aware of how each person needed and wanted to be supported. The lack of effective care planning meant agency care workers would not have clear directions about responding to each person's care needs.

One person been admitted in September 2017, over four months before the inspection. The person told us they had a range of needs, including needing support with their mobility and their continence. The person told us about the equipment they used to stand up, move about their room and move about the service. There was no plan of care about this to ensure staff supported the person in the way they wanted and used the person's equipment safely and in the way that suited them. There was also no plan about how the person's mobility was to be maintained or improved. The person also told us about the support they needed with their continence. They had no assessment of their continence care needs to ensure their individual reasons for their continence difficulties were identified. Staff gave us different responses about the person's continence care needs. There was no evidence of an active programme to support the person with maintaining their continence.

Staff told us about another person who had continence care needs. The person also had no assessment of their continence care needs and no records of the frequency of their difficulties. When we asked staff about this, they gave us differing responses about how often the person needed support. The person had no care plan about how their individual needs were to be met in relation to their continence care. This person also had needs in relation to their mobility. They had a walking frame placed by them in their room. The person looked frail. They told us they needed help to get to the toilet. Their care plan was not specific and documented they walked with sticks. We asked staff about how the person walked about their room. Staff gave us a range of responses, including that the person did not use an aid, they used sticks and they used a frame. The person's care plan did not include any information on steps to be taken by staff to ensure the person continued to be able to move about in the way they wanted, and which was safe for them. The lack of care plan about people's mobility and continence, particularly as the service were using staff who were not familiar with their care needs meant the service was not designing care to ensure the person's needs were met.

This was not also not happening in other areas relating to responding to people's care needs. One of the

people we met with had records which showed they lived with dementia. When we met with them, they were not aware they were living in a care home and what they told us about how long they had been living in the service was not accurate. On one occasion what they told us about indicated they may have been hearing or seeing things which were not happening. What they felt they had heard or seen was clearly of concern to them. We asked staff about this. They told us the person had told them similar matters and could also show some signs of agitation at times. No records were made of such matters to monitor how often they occurred or what interventions supported the person. The person's care plan made no mention of how they were to be supported, apart from that staff were to remind them of where they were.

Where people had short term care needs, care plans were not developed to ensure their needs were met, and care workers made aware of how to meet such needs. One of the people who was living with dementia told us they were not feeling very well. The registered manager told us the person had recently developed a urine infection. The person had no short-term care plan to ensure staff were aware of this, that the person might need additional support, particularly with encouragement to drink additional fluids. None of the four agency care workers knew about the person's urine infection, and because they did not work regularly in the service, they also were not aware the person's current needs were different from how they usually were.

We asked the registered manager about the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The Registered Manager told us they did not know about this Standard and would research it, so they were aware of their responsibilities. We met with a person who had difficulties with both their vision and hearing. These difficulties were noted in their care plan but there was no information about how they were to be supported in the light of these difficulties or how information was to be made accessible to them. The activities programme and menus were not presented in a range of forms, such as pictorial or large print. The registered manager had not developed plans about how the activities programme and menus could be made more accessible to people who had visual or memory difficulties.

Several people explained that, due to the infections disease outbreak, they were spending time in their rooms, which they usually did not. When we asked about the activities provided, we received a mixed response. One person told us, "Now I can't see to read and write, time seems so long, another," "There are no activities here, I just sit around and do nothing" and another, "All I do here is eating and sleeping, I get so bored." This was not echoed by other people. One person told us, "I go into the lounge every day and meet my friends; I've got to know people here," another, "They try to keep our interest in the lounge with quizzes and games, I enjoy the company anyway," and another, "My days here go very quick."

Activities were led by a designated member of staff, for two hours during the afternoons, three days a week. They all took place in the main sitting room. The designated member of staff told us they had not received any training in the area and had designed a programme together with the registered manager. Activities included reading local papers, arm chair exercises, quizzes and bingo. Activities programmes were not provided to people who chose or who were unable to leave their rooms. One person who said they did not go to the lounge told us, "I don't see anyone to talk to when I'm in my room, staff don't come into my room" and another told us they did not like sitting with others so there were, "No activities for me here." One person who lived with dementia remained in their room all day and had very few personal contacts, such as having a cup of tea with a member of staff.

The care worker who led on activities kept a record of who had been offered and who attended activities. They told us it seemed to be the same people who joined in and some people weren't interested. Some people did not have any information about their past interests and preferences in their care plans, while

others did. When such information was documented it was limited and there was no evidence it was used to develop or maintain people's social and recreational interests. One person's care plan documented they liked opera. It had no further information on the operas they enjoyed. They had no music playing in their room on either of the days. Another person told us they had enjoyed a particular arts-based activity in the past. They told us one activity of this type had taken place in the past but no more had been organised after that. One newly admitted person told us about their enjoyment of Scrabble. This was not documented in their care plan and there were no plans to support them in progressing this interest.

People's care plans continued not to be reflective of people's individual health and social needs, and there were also not enough meaningful activities for people to participate in to meet their social and welfare needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people told us they felt the service was responsive to their needs. They particularly mentioned how they could go out of the service easily to meet friends and family in Seaford. One person told us they liked the way friends and family were able to support them in going to their preferred place of worship every Sunday. People told us about how much they enjoyed meeting other people living in the home. They also said they liked the main lounge, or garden in the nice weather. One person told us, "I enjoy the company," and another "In the summer I like to sit outside the dining room, I love being by the sea. My son takes me shopping." One person commented on how much they liked the trips out in the service's own minibus, telling us, "Quite a few of us go out on trips in the summer, in the minibus. It's just a ride around the countryside but it's lovely." A person described a recent pub visit organised by the registered manager where they met some old colleagues. They said they had "A wonderful time" there. Family members and visitors came in and out of the service as they wanted to. One person's relative told us because of where the service was, they were able to just pop in to visit whenever they were passing.

People told us they were confident if they had any concerns or complaints, they could go to the registered manager. One person told us, "If I'd a problem, I know she'd deal with it fairly" and another, "I've no complaints here." A person's relative told us they had "No issues" and were sure the manager would listen if they raised concerns about their loved one's care. The provider had a complaints procedure which was displayed in the main entrance area. The registered manager showed us their complaints records. This showed no formal complaints had been received for several years. We asked them how they reviewed smaller concerns which people might raise. They told us they were dealt with at the time and they did not keep a record of such matters.

The service has not recently cared for people at the end of their lives. The registered manager told us if this should happen in the future, a key area would be working closely with the district nurses, the person's GP and other supports from the community, including local churches, if that was what the person wanted.

Inadequate

Is the service well-led?

Our findings

We inspected this key question to follow up the concerns found during our previous inspection in December 2016 and January 2017. At that inspection we found a breach of the legal requirements. This was because Beachlands was not consistently well-led. People were put at risk because systems for monitoring quality were not always effective. We identified this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider remained in breach of the Regulation.

The provider sent us an action plan after the last inspection. This outlined the three breaches in Regulations would be met by 16 September 2017. The provider had not identified during their quality audits that they had not met their action plan and remained in breach of Regulations 9, 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Additionally they had not identified they were now in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection, the provider had invested in a computerised care planning system. Once developed, care plans were printed and put in people's individual care folders. These folders were kept in the office. The four agency care workers we met with told us they were given a verbal handover about how to meet people's needs when they came on duty. They said they did not read people's individual care plan folders because they needed to support people as soon as they came on duty and because people's care folders were all kept in the office. Agency staff were not given any written information about people's needs, to outline key areas where people needed support. One agency care worker told us some people could tell them about their needs, but this was not the case for all people. They said they had been given no written information about how to support people. We saw one person's relative raise a query about their loved one's care with an agency care worker. This agency care worker referred the matter to another agency care worker, who also did not know the answer. One of the agency care workers said to us, "How can we answer if we aren't given any information?" One agency care worker who was providing care to a person who had a catheter did not know which day the person's catheter bag was due to be changed. The provider had not identified the lack of clear information for agency care workers as a potential risk to people

Agency care workers wrote up the care they had given to people at the end of their shift, in a daily records folder. This folder was separate from people's individual care plan folders. As agency care workers, who provided most of the care to people, only had verbal information about how to meet people's care needs, this system did not ensure people's care plans were being followed. Because only verbal information was used, agency care workers were not always aware of key areas they needed to report on about people. For example, we saw a person who was not feeling well that day did not eat their meal. This was not documented in their records by the agency care worker. The condition of another person's toilet in their ensuite indicated they had on-going issues in relation to continence. The number of times the person had continence needs that day was not documented in their records. We told the registered manager about both these matters. We discussed with the registered manager that if agency staff are not provided with key information about people's changing conditions, they would not be aware of significant areas to report on. The lack of such information meant people's care plan reviews may not be accurate and relevant

information about people's on-going care would not be available to permanent staff and external professionals.

During the inspection, we observed two people's overnight catheter drainage bags had been left in a condition which could have put the person at risk of infection. We also observed a range of areas relating to cleanliness, including two unclean toilets and a soiled tissue by bath which remained on the side of a bath for all of one inspection day. We reported on these matters to the registered manager and they were dealt with at once. We asked the two permanent staff how they supervised agency care workers when they were the only permanent care worker on duty, to ensure they performed their roles in a safe and effective way. They told us they would tell agency care workers what to do at the beginning of their shifts, but for the first part of the morning shift, as the only permanent member of staff, they needed to concentrate on safely supporting people with their medicines, so could not supervise agency staff. On the first day of the inspection, one of the agency care workers had not worked in the service before. This agency care worker was inducted and supervised by another agency care worker. This second agency care worker did not work in the service every day. The provider had not identified that lack of appropriate induction and support to agency care workers could mean there was a risk people would not receive safe and appropriate care which met their needs.

The provider had not identified other matters during their audits. People told us they had concerns about response times when they used their call bells. One person told us, "If I ring my bell, sometimes I wait a long time or they say we'll be back in a minute and are back an hour later" and another, "They keep me waiting such a long time." The service had a call bell alarm system which enabled assessment of how long it took staff to respond when people used their call bells. We asked the registered manager if response times to call bells were regularly audited. They told us they did not do this. They said they would investigate any individual concerns raised by people about response time to call bells.

The provider had not identified other matters. A person's relative told us their loved one would like to use the service's minibus, so they could go out on the monthly trips. They said "Unfortunately there is no ramp, just steps, so some people can't go." One member of staff told us, "Really it needs a lift on the bus, then more would be able to go, it's quite difficult getting people on and off, and some can't manage." There was no risk assessment about this and no action plan about how people who lived with physical difficulties might be supported in going out of the home on minibus trips. In one of the upstairs toilets, there was no wash hand basin in the toilet room, so people could be supported in safely washing their hands after using the toilet. There was no risk assessment or action plan about this.

Where the provider performed audits, they did not assess all relevant areas. The audit of accidents to people included relevant matters like the person's name and where it had occurred in the service, but it did not include time of day. This meant the registered manager could not assess if accidents to people occurred more at certain times, such as at night when there was only one waking staff on duty or during staff handover. The audits also were not consistently completed because some of the audits documented if the accident had been witnessed, but others did not.

Other audits did not identify all relevant matters. The last medicines audit had taken place on 21 January 2018. It stated that no issues were identified. However when we reviewed people's MARs, this statement was not correct. For six MARs where PRN medicines were prescribed for people, four stated only they were to be given 'as directed' and did not include any relevant information such as a PRN protocol about when and how often they were to be given or the reasons the person needed to take them. Of six people's MAR charts where they were prescribed skin creams, only one had a body chart completed to show where the prescribed cream was to be applied to the person's body. Two people had skin creams in their rooms of the

type which are usually advised if people have dry skin or eczema. Neither of the people had any information about how they were to be supported with these creams.

The provider's audits had not identified that relevant information relating to people's care was not being clearly and accurately completed. One person had reference in their records to a 'small' wound. We asked several staff about the actual size of this wound. Staff either said they did not know or gave us differing sizes in their responses. We discussed with the registered manager that descriptions should be clear and measurable. One person had their fluid and food intake recorded. Their food intake chart showed a gap of three days where no records were completed. The person's fluid intake record was also not consistent, with some records being documented as 'cups' and in others as millilitres. None of the records were totalled every 24 hours to assess if the person's fluid intake was sufficient. This person's record documented they had eaten all of their breakfast and drunk all of their tea on one of the inspection days. We saw this was not the case. We discussed with the registered manager that records needed to be consistently completed and accurate to fully support people's needs assessments.

People continued to be put at risk because systems for monitoring quality were not always effective. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had performed effective quality audits in other areas and had developed action plans to address matters. Much of the home showed old, threadbare carpets, the laundry was cramped and the walls could not be easily wiped down, bathrooms and toilets did not fully support people who lived with disability needs. To address these and other matters, the provider had made plans to fully refurbish the building. This would involve considerable building works. The provider told us the programme would be starting in the spring of 2018. People told us they had been informed about these proposed changes. One person told us, "The owner told us about how they intend to alter the building at the Christmas party."

People made positive comments about the management. One person told us the registered manager was, "Always around the home; you can go and ask her anything," another, "I know [the registered manager's first name] quite well and see her around the home regularly. She asks if I'm happy and honestly I am," and another said about the registered manager, "She's straight, she's a good person to be in charge here." People told us how they were informed about matters they needed to know about. The registered manager went to see everyone when they came on duty to remind them about the infectious disease outbreak and explain why they could not go into the lounge that day. They listened to people's questions, gave reassurance and answered questions when people wanted to know more. The last residents' meeting had been held on in August 2017. The minutes showed the meals had been discussed. They also showed all people had said they were happy with the service provided. The provider had left questionnaires out for anyone coming into the home to comment on the quality of the service.

The provider explained this was a small family-run service. Beachlands was the only care home they owned. Staff said they appreciated this. One member of staff told us, "The owner's here every day and we talk to him." The registered manager had worked in the service for a long period of time, as had most of the permanent staff; several staff told us they had worked in the service for over 10 years. Staff said they felt involved by management. One member of staff told us, "I like it here," another, "The people are nice to work for" and another, "I like the job, it's very rewarding." Some of the agency staff also said how much they liked working in the service. One of them told us, "We're made to feel part of the team."

Staff told us about being part of the local community. The registered manager described the support they received from one external company which included providing additional trips out for people at times.

Some people regularly went out to the local shops, so they could maintain links with parts of the community which were important to them. One of the external professionals told us they had only recently started supporting the service. They said staff had been supportive of them, were keen to develop their practice and contacted them when they needed further support. The provider told us they did not currently have a web site but were planning to develop one for the service, when the refurbishment took place.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring people had person-centred care, which was appropriate and met their needs and reflected their preferences. This was because they were not carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care. They were also not designing care or treatment with a view to achieving people's preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring people were provided with safe care. This was because they were not assessing the risks to the health and safety of people receiving care. They were also not doing all that was reasonably practicable to mitigate any such risks. They were not ensuring that persons providing care or treatment to people had the qualifications, competence, skills and experience to do so safely. They were not assessing the risk of, and preventing, the

spread of infections. They were also not working with other appropriate persons to ensure that timely care planning took place to ensure people's health, safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of people. The provider had not maintained an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care provided.