Akari Care Limited

Beech House - Salford

Inspection report

Radcliffe Park Crescent
Salford
Greater Manchester
M6 7WQ

Date of inspection visit:
13 February 2018
14 February 2018
20 February 2018

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17 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Beech House provides residential care for up to 36 older people. The home is situated in Salford, Greater Manchester and is located near to local transport routes. Car parking is available at the front of the home or in nearby side streets a short distance away. The home is owned by Akari Care Limited.

Beech House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the last comprehensive inspection of Beech House in January 2017, we rated the service as 'Requires Improvement' overall and in four of the five key questions we inspected against (Safe, Effective, Responsive and Well-led). The Caring domain was rated as Good. During that inspection, we identified breaches of the regulations with regards to person centred care, safe care and treatment, nutrition/hydration and good governance. We also issued two warning notices regarding nutrition/hydration and good governance following the inspection telling the home they must improve. The provider then sent us an action plan, informing us of the planned improvements they intended to make. We also held meetings with the provider to discuss the concerns, with the local authority also in attendance.

To follow up on these concerns and due to receiving a number of safeguarding alerts about the home, we undertook a further comprehensive inspection on 13, 14 and 20 February 2018. The first day of the inspection was unannounced, however we informed staff at the home we would be returning for a second and third day to complete the inspection. At this inspection, we identified multiple breaches of the regulations regarding person centred care, safe care and treatment, safeguarding people from abuse and improper treatment, nutrition/hydration, good governance and staffing. You can see what action we have asked the provider to take at the back of the full version of this report.

Medication was not being administered to people safely. We identified multiple instances where people did not receive their medication because it was not available in the home to be given to them by staff as prescribed.

People's skin integrity was not always being well managed and we found guidance from district nursing staff was not being followed. We also observed one person sat in a chair without appropriate pressure relieving equipment in place which could have placed their skin at risk.

We found people were being placed at risk because they were not always receiving food and drink of correct consistency which could place them at risk of choking/aspiration.

We found several environmental risks around the home such as the kitchen area not being secure and people's thickened drinks left unattended in the lounge area.

People were not always referred through to the falls service for further assessment when necessary. The deputy manager told us people were referred once they suffered two falls or more, however we found this had not been done for one person living at the home in a timely manner. The deputy manager made this referral during the second day of the inspection.

Staff did not always receive the appropriate training, supervision and appraisal to support them in their role.

We identified concerns relating to people's nutrition and hydration needs with advice and guidance from other health care professionals not being followed. Drinks were not easily accessible for people in communal areas who were at risk of dehydration and one person had run out of their nutritional supplements, despite needing them following weight loss.

The home did not have a system in place to monitor which people were currently subject to deprivation of liberty safeguards (DoLS) authorisations. We found instances where mental capacity assessments had not been undertaken, despite their being concerns about people's capacity during social work assessments. Applications for DoLS for these people had therefore not been made at the time of the inspection by staff. Staff said these people wouldn't be able to leave the home freely as it would not be deemed safe for them and would be a restriction.

People living at the home spoke favourably about the staff and the care they received. However we observed several missed opportunities for interaction between staff and people living at the home, such as staff leaning over the barrier near the entrance to the lounge area and watching people who were up early in the morning as opposed to interacting and speaking with them.

People's dignity was not always preserved and at times we heard staff talking loudly about taking people to the toilet and on one occasion, how one person living at the home had suffered continence issues during the night.

We observed there to be a lack of activities and things for people to do during the inspection. We were informed the activities co-ordinator had recently left the home, which was the reason why none were taking place.

Not all people living at the home had an appropriate care plan in place which meant staff did not have access to information about the care people required.

Confidential information was not being stored securely, with care plans left on the top of cabinets in a room which was not locked and could be accessed by unauthorised personnel.

Quality assurance systems were in place, however were not robust and had not identified the concerns we found during this inspection. There had also been a failure to improve standards despite two warning notices being issued following our last inspection in January 2017.

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, we will be inspecting 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 in 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medication was not managed safely.

People were provided with foods which could place them at risk of choking/aspiration.

Appropriate systems were not in place with regards to people's skin integrity.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the necessary training, supervision and appraisal to support them in their roles.

People's nutrition and hydration needs were not being met.

Mental capacity assessments were not undertaken when concerns about people's capacity arose. DoLS applications were not always made in a timely manner to the local authority.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People living at the home spoke positively about the care they received.

We observed missed opportunities for interaction between staff and people living at the home.

We observed instances where people's dignity was not always preserved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care did not always meet people's needs and reflect their

preferences.

Accurate records were not always maintained by staff with regards to people's care.

There was a lack of activities and stimulation for people living at the home during the inspection.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of our inspection there was no registered manager at the home. The previous home manager had applied to register with CQC, although had since left the service.

Systems for audit and quality assurance were not operated effectively and did not highlight the concerns we found during our inspection.

Appropriate action had not been taken to ensure the passenger lift was in good working order, with concerns from the previous service check not acted upon in a timely way.

Warning notices served at the last inspection had not been met.

Beech House - Salford

Detailed findings

Background to this inspection

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

This inspection took place on 13,14 and 20 February 2018. The inspection team consisted of two inspectors and a pharmacist inspector from the Care Quality Commission and an expert by experience. An expert by experience is a person that has personal experience of caring for people with needs similar to those at Beech House.

Prior to the inspection we reviewed all of the information we held about the home in the form of enforcement notices, notifications, previous inspection reports, expected/unexpected deaths and safeguarding incidents. We also contacted any relevant stakeholders from Salford city council which included the safeguarding team, healthwatch, infection control and environmental health. This was to establish if there were any particular areas we needed to focus on during the inspection.

During the inspection we spoke with a wide range of people and viewed records in order to help inform our inspection judgements. This included the deputy manager, area manager, temporary home manager, nine people who lived at the home, three visiting relatives, six members of care staff, the chef and three visiting health care professionals.

Records looked at included 10 care plans, five staff personnel files, 35 Medication Administration Records (MARs), training records, building/maintenance checks and any relevant quality assurance documentation. This helped inform our inspection judgements.

We had not requested the home complete a provider information (PIR) prior to the inspection. A PIR is a document the home completes in advance of the inspection, where they are given the opportunity to detail how they will meet the regulations and key lines of enquiry (KLOE).

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017, this key question was rated as Requires Improvement. This was because we identified concerns regarding risk assessments, missing window restrictors, fire doors being wedged open and pressure relieving equipment not always being in place for people who needed it. At this inspection we found the majority of these concerns had been addressed, however found there had been a deteriation in other areas.

We asked people living at Beech House and their visiting relatives if they felt the home was a safe place to live. One person said, "Yes I think so." Another person said, "If I ring for someone they come to me." A third person added, "I feel safe because staff come to me when I ask them."

At this inspection a pharmacist inspector looked at medicines and associated records for 35 people who were living in the home between 5 and 13 February 2018. We found that medicines were not handled safely for 32 of those people. This meant that those people's health had been placed at risk of harm during that period. We found that no audits or checks on the safe handling of medicines had been made since December 2017 and that the deputy manager and regional manager were unaware of the concerns we discovered during the inspection.

At the previous inspection the inspectors were told that an electronic medication system had been introduced with the intent of reducing medicines errors, called well-pad. During the inspection the deputy manager told us the system "was not working well and it was not possible to do significant checks on medicines.." We spoke with the regional manager and she told us she was aware there were concerns with the electronic system used by the homes in the Akari group. However the regional manager did not tell us of any additional systems they had put in place to ensure that medicines were able to be handled safely.

We saw that 17 people had run out of one or more of their medicines for between one and 13 days between 1 and 13 February. Additionally the print out of the electronic records showed that people had run out of medicines during that period for odd days or odd doses. The deputy manager told us that the medicines were in stock on those days and when we looked at the stock and date of dispensing it appeared those medicines may have been available to administer. However we also saw that for at least one person the well pad informed staff there was no stock available of a pain relief medicine; however the controlled drug register showed there was sufficient stock to administer the pain relief. We asked the deputy manager why the out of stock codes had been used when medicines were in stock. She told us that the staff "don't always put in the right codes because they don't care." People missed being given doses of their medicines because either there was no stock or the staff perceived there was no stock. This meant that at least 17 people did not have their medicines as prescribed and this placed their health at risk of harm.

We asked the deputy manager about the medicines being out of stock and why no action had been taken. She told us that an email was sent via the electronic medicines system to the manager to alert them about medicines that were running low but she had not taken any action because, "I am not the manager." We asked why the staff who administered medicines did not take any actions to order stock and we were told

that staff "don't care, well they do care but they don't do anything."

We saw that two people were given the wrong dose of their medicines. One person was given a double dose of antibiotics on two occasions and another person was given a double dose of their medicine to treat cholesterol, the label on the box stated it should be given once daily but was given twice a day. We saw that the "well pad" told the staff to administer the double dose of the cholesterol medication for nine days. This showed that staff did not check the label on the box of medicine before administering it.

The records about the administration of medicines showed that a lot of people either refused their medicines at the time they were offered or they were asleep. We asked the deputy manager why so many people were missing their medicines and she told us it was because "staff didn't care enough to go back" to give medicines. This placed those people's health at risk of harm.

The records about the stock of medicines were poorly maintained and did not give an accurate reflection of the actual stock in the home. The deputy manager told us this was because the electronic system did not allow them to carry stock over from previous months. However some stock levels were accurate and when we checked the stock against the records we found some medicines had not been given as prescribed. These medicines included a controlled drug which was not given but had been signed for. This potentially meant that person was in pain causing a risk to their health.

We found that medicines which were prescribed "when required" or with a choice of dose did not have any personalised information for them to be given safely and consistently. Out of 35 people whose medicines records we looked at 17 people were prescribed some medicines to be given as and when it was needed or with a variable dose. The home had been asked to keep records about one person's pain, behaviour and sleep patterns since January 2018 because they were unable to communicate their pain verbally. However there were no such documents available. On the first day of the inspection a strong pain killer was received for this person but the staff had no way of assessing if they should administer it as they were unsure if they were in pain. They decided to give this person pain medicine without any rationale for doing so.

We also saw that when people were prescribed creams there was no information available to tell staff where the creams should be applied. If this information is not available then creams cannot be given safely or consistently, placing people's health at risk. We also found that no records were made by care staff about the application of creams and the electronic medicines records failed to show that all creams had been applied as prescribed. We found that creams were not stored safely as they were found in communal bathrooms. If creams are not kept securely they could be misused or used by more than one person which means there is a risk of cross infection.

We saw that one person was given their medicine covertly, hidden in food. There were no records that could be found during the inspection to show that the mental capacity act had been followed or that a best interest meeting had been held to show it was appropriate to hide this person's medicine in their food. There was no information from a pharmacist as to how to give medicines safely. There was no guidance for staff to follow to explain how to hide medication in food. The deputy manager told us that they would give medicines hidden in a chocolate covered marshmallow several times each day or sometimes in chips. No risk assessment or advice had been taken to check this was safe as the person was diabetic. We were also told that this person would usually take medicines in liquid form but that they had not requested liquids for them as the doctor had not "got back to them." This person's health was at risk due to unsafe medicines management.

Staff also failed to contact other health care professionals in a timely manner. One person was prescribed a

pessary that needed to be administered by a district nurse; they had failed to do so and the person did not have their pessary for two weeks because they had not contacted the district nurses.

We looked at systems in place to ensure people maintained good skin integrity. We reviewed the care file of one person who had a wound plan in place because of an old skin tear to their left elbow. One of the actions for staff to follow was to ensure their left elbow was kept elevated when sat in their chair. However we observed this was not followed during the inspection. For instance, on the first day of the inspection, their right arm was elevated and their left arm was resting on the chair arm. On the second day of the inspection, neither arm was elevated and on the third day of the inspection, both arms were elevated with cushions. We contacted the district nursing team following the inspection who stated this could compromise the healing of the skin tear if the guidance was not followed.

This person had a waterlow risk assessment in place which indicated they were at high risk of skin breakdown. The reasons for this included being doubly incontinent, chair bound and being unable to walk/move independently. They therefore required the use of a pressure relieving cushion when seated in their chair. However on the second day of the inspection we observed this person being transferred from a wheelchair into a dining room chair by two members of staff and left for approximately one hour before returning to their lounge chair after lunch. These actions could place this person's skin at risk of further break down.

We checked to see that people were being protected from the risks associated with choking and aspiration. One person at the home required a pureed diet which meant they required their food to be blended because they were at risk of choking and aspiration. This had been recommended by the speech and language therapy (SALT) team, however the documentation containing their recommendations could not be located during the inspection. When checking this person's previous food and fluid charts we saw they had consumed or been offered foods which could place them at risk. This included sausage roll, chicken bites, hot dog and sandwiches. We spoke with two members of staff working in the kitchen who said as far as they were aware, this person's food was always blended, however some of these food options could have placed them at risk due to not being the correct texture.

This person had also been prescribed thickened fluids, however there was no written guidance for staff making drinks for this person to follow. We asked two members of staff how they thickened this persons drinks; one staff member said they used two scoops to thicken drinks and another told the first member of staff they should use four scoops of thickening powder. The first member of staff then said they should use "two to four scoops" but more in a cup of tea. It is unsafe that staff did not know how to correctly thicken fluids for a person who had swallowing problems and could be placed at risk of aspiration pneumonia. Staff told us they made no records of thickening fluids. We observed staff assisting this person with drinking during the inspection. However we saw the thickened drink was left unattened on a side unit, on two occasions, which increased the risk of another person wrongfully drinking it and placing themselves at risk.

We looked at the systems in place to assess and mitigate risks within the home and protect people who were deemed to be at high risk of falls. The deputy manager told us that if a person suffered two falls at the home then they would be referred through to the falls service for further assessment. We looked at the accident and incident records and noted one person had suffered an unwitnessed fall in the dining room in November 2017 and the follow up action to be completed was a referral to the falls service. This person had then gone on to have two further falls from their chair to the floor, which could have resulted in an injury such as a fractured hip. The deputy manager confirmed this referral had not yet been done, however completed this referral during the second day of our inspection.

During the inspection we observed the kitchen area was not secure, despite the door being fitted with a key coded lock to restrict access. Despite the lock being in place, the door was being left a jar whenever staff entered the area. The kitchen contained items such as sharp knives and broken glass which could place people at risk if they entered without a staff presence. On one occasion we observed a person who lived at the home attempt to access the kitchen area, however a member of staff was walking by and re-directed them towards the lounge area. We asked the deputy manager if a risk assessment was in place regarding access to the kitchen area, and this was not produced.

These issues meant there had been a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

We looked at the systems in place to ensure people were safeguarded from abuse and improper treatment. The home maintained a log of all safeguarding concerns that had taken place within the home including details about the incident and any internal investigation processes that were taking place. We spoke with staff about how they recognised potential abuse and what action they would take if they felt people were placed at risk of harm. One member of staff said, "Some of the types of abuse that can occur include mental, physical and financial. Changes in behaviour, weight loss, becoming violent could be signs that abuse has taken place." Another member of staff said, "If I see something I don't like I will report it. Bruising could be a sign of physical abuse and a person's facial expressions could inform us if they were unhappy or scared."

Prior to our inspection, various safeguarding alerts had been submitted to the local authority for further investigation. We also asked the provider to raise multiple safeguarding alerts following the inspection due to the concerns we had identified regarding the safe management of people's medication. We raised several other safeguarding alerts due to some of the concerns we had identified regarding the management of people's skin integrity, providing the correct consistency of diets and people not receiving appropriate nutrition and hydration. This meant people were not being protected from abuse and improper treatment in accordance with this regulation.

This meant there had been a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding service users from abuse and improper treatment.

We looked at the systems in place regarding recruitment of staff and reviewed five staff personnel files during the inspection. Each file we looked at contained evidence of job application forms, interview questions/responses, photographic identification, references from previous employers and disclosure barring service (DBS) checks. These checks would ensure staff were of good character and suitable to work with vulnerable people.

We checked to see if equipment and the building were being well maintained. We found appropriate checks and work had been undertaken regarding gas safety, the fire alarm system, electrical installation, legionella and hoists. The certificates of work completed were available and held within an organised file. This would ensure they were safe for people to use.

We checked to see that there were sufficient staff working at the home. Over each day of the inspection, the staffing levels consisted of three members of staff at night (with one being a senior carer), six care staff in the morning and five in the afternoon (including a senior carer on each shift). This was based on people's care needs and was reflected on the homes dependency tool. During the inspection we were made aware of several people who had been admitted to Beech House, despite the home not being able to meet their care needs. We were informed staffing levels had been increased further based on this so that there were enough staff to care for people safely.

We asked staff working at the home for their views and opinions about current staffing levels and received a mixed response. One member of staff said, "When we have six on the numbers are fine. We have been promised we will always have six on now." Another member of staff said, "95% of the time it is absolutely fine. Staff has gone up recently because of some of the new residents and when we are fully staffed it works well." Another member of staff said, "Current staffing levels are enough and we can get by with that." A fourth member of staff added, "We have three on at night and we are okay for now."

Inadequate

Is the service effective?

Our findings

At the previous inspection in January 2017, this key question was rated as requires improvement. This was because we identified concerns regarding people's nutrition and hydration requirements and we issued a warning notice for regulation 14 due to people being placed at risk of harm. At this inspection we found the quality of service had declined in other areas and the home was still not meeting the requirements of this regulation.

We checked to see if improvements had been made regarding people's nutrition and hydration, however found similar concerns to our last inspection. We looked at the nutritional care plan of one person who had had poor communication and often forgot to inform staff when they were thirsty. As a result, their care plan said they needed to have a jug of water/juice accessible to them so they could pour themselves a drink independently. However we observed this guidance was not being followed and saw this person seated in the lounge without access to drinks during the inspection on several occasions. This could place this person at risk of dehydration.

We looked at the care plan of a second person who had lost weight since living at Beech House. They had been appropriately referred to the dietician service, who then implemented an action plan for staff to follow, which included providing this person with a fortified diet and to offer them high calorie milkshakes. We found this guidance was not being followed and staff working in the kitchen had not been provided with any information about the actions that needed to be taken to prevent this person losing more weight. They told us all food was fortified as a batch and not people's individual portions in line with guidance from other health care professionals. The deputy manager told us the high calorie milkshakes were given at 3pm each day, however we observed these were not provided and were not documented on previous food/fluid charts as being given. We spoke with this person during the inspection who reported that they did not always receive them consistently and that it was dependant on 'which staff were on that day.'

A third person required ensure supplements due to also losing weight. Ensure supplements are prescribed by a GP when people may be at risk of weight loss. These had been advised on their action plan implemented by the dietician service. When conducting a stock check of medicines, we found the ensure supplements had been out of stock for several days prior to the inspection meaning this person was not receiving them as prescribed, which could place them at risk of further weight loss.

These issues meant there had been a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Nutrition/Hydration. This was because nutrition and hydration needs of service users were not being met.

We looked at the induction, training, supervision and appraisal staff received to support them in their role. The staff we spoke with told us they completed an induction when they first started working at the home, which provided them with a good introduction into working in a care setting. We looked at the induction programme which covered areas such as, being introduced to people living at the home, first aid arrangements, accidents/incidents, training and development, supervision/appraisal, confidentiality and

record keeping. Staff said there were opportunities to shadow existing members of staff and observe how things needed to be done within the home.

There was a training matrix in place, detailing the training undertaken by staff which we were told was up to date and was an accurate reflection of courses completed. The training matrix however, identified that staff had not received appropriate training to support them in their role. This included areas such as moving and handling, safeguarding, health and safety, dementia awareness, infection control and fire safety. The regional manager said these training courses had not been undertaken because the previous home manager had cancelled them and not informed them about it (the cancellation). We were then shown a training plan of courses that were planned throughout the year (2018), when this training would be completed.

We were told no staff appraisals had taken place since the last inspection in January 2017. The regional manager said this was because the previous home manager had not yet been in post long enough to undertake these sessions with staff. We found six members of staff had received supervision in September 2017 and five staff in August 2017 but there were no other records of staff supervision available at the time of the inspection. There were also several documents titled 'Significant discussion record' which were typed and the contents of each document was exactly the same for each member of staff concerned. The deputy manager said this was the wrong form and should not have been used for individual supervision.

These issues meant there had been a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Staffing. This was because staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home was not consistently working within the requirements of DoLS/MCA.

The home did not have a system in place to monitor which people were currently subject to deprivation of liberty safeguards (DoLS) authorisations and we found instances where mental capacity assessments had not been undertaken, despite their being concerns about people's capacity prior to living at Beech House via social work assessments. Applications for DoLS for these people had therefore not been made at the time of the inspection. Staff said these people wouldn't be able to leave the home freely as it would not be deemed safe for them which would be a restriction. The deputy manager informed us these would be submitted following the inspection.

This was a a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safeguarding service users from abuse and improper treatment. This was because appropriate systems were not in place to ensure people received care or treatment without lawful authority.

The deputy manager told us approximately two thirds of people using the service were living with dementia. We looked around the premises and found some bedrooms did not have a photograph of the person on their door or any other item that would assist with recognition/orientation or help them to understand where their room was and some bedroom doors just had a door number. People living with dementia may not always have the ability to recognise time and place or understand where they are and items that would assist with helping a person understand where they are, such as a photograph or a 'memory box' placed on or near their bedroom door are helpful in assisting with orientation.

We recommend the home seeks appropriate guidance about making the home more 'Dementia friendly'.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2017, this key question was rated as good.

We asked people living at the home for their views and opinions about the care they received at Beech House and if staff were kind and caring. One person said, "Staff are smashing, really helpful." Another person said, "Yes they are very nice to me." Another person commented, "Yes staff are kind and caring." A fourth person added, "Nothing is too much trouble."

The visiting friends and relatives we spoke with during the inspection informed us they were happy with the care provided at the home. One relative said, "Very satisfied, the girls are great." Another relative said, "When I come I don't see anything that would concern me." Another relative said, "I've seen staff speaking to people, they are lovely. People are very cared for here. Yes no issues with staff, I like them and the care is good."

We checked to see if people living at the home were treated with dignity and respect by staff. During the inspection we observed staff knocking on doors before entry and asking people if they would like to be taken to their bedrooms for personal care. However we also observed instances where people were not treated in a respectful way for instance, when stating loudly in the lounge area that they were going to take people to the toilet. On another occasion, a member of staff described how one person had been to the toilet approximately '15 times' in the night and was experiencing continence difficulties. This was whilst other people were seated in the lounge area. Another member of staff close by noticed this and indicated to them to lower their voice. This demonstrated people were not always being treated in a dignified manner.

We saw instances where staff took the time to speak to people and enquire about their welfare or inform them of what was going on. Despite this, we observed people remained in the communal lounges with little engagement as staff were engaged in other duties around the home. For instance, on two of the mornings (first and third day) of the inspection, we observed staff both leaning over the barrier near the entrance to the lounge area and also sitting down, watching people who had gotten up early in the morning as opposed to sitting down and interacting with them. This meant there had been missed opportunities for interaction between staff and people who lived at the home.

On other occasions we saw staff interacting pleasantly with people. We saw staff greeted people as they got up in the morning and asked what they wanted for breakfast when they came into the lounge area. Staff offered people a hot drink whilst waiting for breakfast. On another occasion we observed a staff member greeted one person and said, "Good morning [person name] would you like a cup of tea? Do you want me to use your hairbrush after having your shower ?" This demonstrated a positive attitude regarding the person's well-being.

We observed staff speaking with people and explaining any care interventions that were taking place. Staff took their time to explain the procedure to the person concerned and did not rush the manoeuvre. Domestic staff were attentive to any spillages that might have presented a slip risk to people, for example a spilled

drink, and ensured areas were cleaned immediately.

People's independence was promoted by staff where possible. During the inspection we observed people being able to mobilise and eat their own meals without requiring assistance from staff. On another occasion we observed a member of staff giving a person a drink and stating they would 'leave the drink with them' so they could drink it on their own and at their own pace.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection carried out in January 2017 this domain was rated as requires improvement and there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care, because the provider was not effectively assessing, monitoring and reviewing care plans. 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 rating of this domain to at least 'good'. At this comprehensive inspection we found a continued breach of this regulation.

We checked to see if people living at the home received care that was responsive to their needs and in line with their preferences and choices. We observed several people remaining in the same seated position in the lounge for long periods, largely unengaged in meaningful activities. We saw the care plan for one person stated they were mobile and liked to walk about and should not be made to 'sit down aimlessly' but they remained seated during the inspection.

We checked to see how people were supported with interests and social activities. There was an activities notice board in place that identified trips out, hand made crafts, lunch out, and exercises but we did not see any evidence of these activities being carried out. However there was no activities coordinator in post and this was the case at the last inspection, which meant opportunities for people to take part in activities was limited as staff were engaged in providing care tasks.

We asked people what they thought about activities. One person said, "Yes sometimes there is something on, not always. Bingo if anything but that's it." Another person said, "Nothing much happening." A third person added, "Nothing much to do. We sleep." A fourth person also commented, "Here, no." We did not observe any activities taking place on either day of our inspection which meant people were being placed at risk of social isolation.

We saw some people were receiving care that was personalised and responsive to their individual needs. Some people had a pre-admission assessment and their care and support needs had been identified with involvement from the person and their relatives. However some assessments had not been signed by a family member (where it was appropriate to do so because the person lacked capacity) and we saw not all people received care that was personalised and responsive to their individual needs.

One person's care plan stated they 'liked to have a beard' but we observed staff had attempted to shave the person. We spoke with the relative of this person who said, "I think staff think they're doing the best thing by shaving [person name] but he's always had a beard." This meant people's preferred choices and needs were not being upheld.

We observed one person had visibly dirty clothing on the first day of the inspection. Their left foot was bare and they did not have a protective 'boot' on as required causing their bare foot be be open to the environment, increasing the risk of injuries and infection. This was provided on the second day of the inspection. The deputy manager told us this person often took their own clothes off but until we raised this

issue with staff, no-one had taken any action to intervene and provide the required protective footwear.

We observed one person who was sitting in the lounge had excessive saliva running down their chin and onto their clothes, which was a part of their current condition. A night staff member was stood nearby and could see this person's situation but did nothing to comfort, support or reassure this person or offer assistance. We intervened and offered a tissue to the person who wiped their mouth. The night staff member said, "We have quite a lot of difficult people and we don't get time to read care plans; permanent staff do that." This demonstrated a lack of knowledge about individual people and an approach that was not in keeping with responding to individual needs.

We found two pairs of glasses left on the side cupboard in the lounge. We asked staff why these were not being worn by people and they said, "They must have been there from the night before." Staff had not noticed this and people were therefore left without their glasses for an undetermined length of time. One person's pre-admission assessment stated they wore glasses but their admission assessment stated they did not wear glasses, which was confusing and contradictory.

These issues meant there had been a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care, because care and treatment did not always meet people's needs and reflect their preferences.

We looked at how the home supported people who were at the end of life. We were told there was no-one currently living at the home with end of life needs. We found not all care files we looked at contained people's end of life care wishes. We spoke with a visiting end of life care nurse who told us, "The service has had their six steps to success accreditation removed and they are no longer accredited. I have tried to get them to attend training but have got no response." The six steps programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care.

We looked at how complaints were handled. There was a complaints policy and procedure in place and details of how to make a complaint were posted in the building. The complaints procedure identified details for the Local Government Ombudsman (LGO) the local
authority or CQC. We looked at the complaints file and saw one complaint was recorded for December 2017, which had been resolved.

Inadequate

Is the service well-led?

Our findings

At our previous inspection carried out in January 2017 this domain was rated as requires improvement and there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance, because the provider was not effectively assessing, monitoring and improving the quality of services provided. Additional breaches of regulations were also identified in relation to Regulations 9, 12 and 14. The overall rating for the service was Requires Improvement. We issued Warning Notices for Regulations 14 and 17 and sent a concerns letter to the provider asking for an urgent action plan detailing how the issues were to be rectified. A meeting with the provider and local authority was also held.

At this comprehensive inspection of Beech House on 13, 14 and 20 February 2018 we found breaches of regulations in respect of : Regulation 9 - Person centred care; Regulation 12 – Safe care and treatment; Regulation 13 – Safeguarding service users from abuse and improper treatment; Regulation 14 – Meeting nutritional and hydration needs; Regulation 15 – Premises and equipment; Regulation 17 – Good governance; Regulation 18 – Staffing. This meant the provider had failed to improve the overall rating of the home from 'Requires Improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the quality of care received had deteriorated, which meant the quality of service provided to people living at the home was not continuously improving over time.

At the time of the inspection there was no registered manager in post and the last home manager had left the organisation in February 2016. They had commenced their registration with CQC, however this had not been completed. 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. A deputy manager was in post.

During our inspection we found a lack of co-ordinated leadership, which was impacting on the quality of care provided. This lack of management oversight had further deteriorated since the last registered manager left the service.

Day-to-day operational leadership of staff was inadequate and the provider, Akari Care Limited, had failed to provide sufficient oversight to recognise and respond to emerging issues identified at this inspection.

Following the inspection the home agreed a voluntary suspension on admissions with immediate effect from 14 February 2018. The home also entered the local authority 'concerns process', with the first meeting held on 20 February 2018 and a follow up meeting held with the provider on 01 March 2018. Safeguarding alerts were also made for people deemed to be at risk.

We asked about formal satisfaction surveys undertaken with people who used the service and their relatives. However we were told no surveys had been undertaken during 2017 and people and their relatives had not

been provided with the opportunity to provide formal feedback about the overall service. We were also unable to determine when the last meeting with residents and their family members had taken place. We saw a 'residents and family meeting' file which contained an invite letter for meetings scheduled for March and April 2017 but there was no minutes of these meetings in the file (in the form of notes taken) and no other records were made available to us on the days of the inspection. The deputy manager told us they thought the April meeting was the last meeting held.

We looked for records of staff meetings and were provided with a 'staff meetings' file. This contained records of meetings taking place in March and April 2017 when discussions included, group supervisions, activities, job descriptions, mealtimes, food/fluid charts, rumours/gossip, health and safety, roles and responsibilities, housekeeping, training, respect for residents. No other records of staff meetings were provided to us which meant we could not determine if any other meetings had taken place.

We looked at the provider's CQC notifications file and saw there were three notifications recorded for February 18. There were no other records in the file for period January to July 2017 despite CQC receiving several on-line notifications during this time period. Oversight of notifications sent to CQC was therefore insufficient.

We looked at audits the location and provider had undertaken of key areas of care and record keeping and found these were not always up to date or were not effective. The last infection control audit was undertaken on 31 December 2017 but there was no overall score or percentage of standards achieved score identified, and the last staff observation was May 2017 with a further hand hygiene audit carried out in August 2017 for 12 staff. This meant we cound not determine if all staff had been regularly observed to ensure they followed safe infection control practices.

We looked at audits of care files and found five care plans had been audited in December 2017, nine in November 2017and 12 in October 2017 but there were no other records in the audit file we were given. This meant we could not determine if people had their care files audited regularly.

We asked for documentation regarding the auditing of medicines. We found the last audit of medicines had been carried out in December 2017 but this did not identify the audit result or if the service had passed or failed the audit. No other audits of medicines were provided to us and audits that had been undertaken had not identified the issues we found with medicines. The deputy manager told us no medicines audit had been undertaken in January 2018.

The last audit of mattresses and pressure relieving equipment had been completed in July 2017 for 11 people and no other records were available in the audit file supplied to us. This meant we could not determine if mattresses and pressure relieving equipment being used at the time of the inspection were fit for purpose.

We looked at the 'Internal Quality Assurance' file and saw a 'Quality Assurance action plan review' had been undertaken on 09 and 10 January 2018 by the provider's quality and compliance manager. This action plan identified a large number of issues requiring remedial action such as care plan audits not being completed, care plans not being person-centred, the lack of risk assessments, staffing issues, lack of activities, infection control audits not taking place, nutrition and hydration plans not being maintained as required, weights not being monitored regularly, a lack of governance and quality assurance systems, managers reports being completed at irregular intervals. However the action plan linked to this audit only had the 'action required' box completed and the 'responsible person/target date/sign and date on completion/sign and date on review home manager/sign and date on review regional manager' boxes were empty. This meant the

person(s) responsible for taking remedial action had not been identified and there was no update on progress recorded or if identified actions had been achieved.

There was no DoLS tracker in place and the deputy manager could not tell us the present status of applications previously submitted. The last health and safety audit document provided to us was dated 14 July 2017 and had achieved a score of 95% compliance. No other audits of health and safety were available in the file.

We looked at how accidents and incidents were managed. A monthly log of incidents was kept. The log included the date/time of the incident, the reference number, the name of the person concerned, the nature of the incident, details of any injuries sustained, the immediate action taken and the outcome, if reported to CQC and RIDDOR. However we found one incident that had taken place in December 2017 did not clearly identify the action taken regarding pain in the left leg of the the person involved following a fall from a chair.

During the inspection we found six people admitted in 2018 did not have a care plan in place. This meant there was a risk staff would not have appropriate information about their care needs. Care file information that was available was not being stored confidentially and securely; they were stored in an unlocked room that was accessible by anyone in the vicinity and left in confusing piles on top of a filing cabinet.

Despite the audits and quality management systems in place, the provider had failed to ensure that there were effective systems to allow them to monitor and assess the delivery of the service and were not aware of the majority of our concerns until raised during feedback. This included the concerns regarding medication, nutrition hydration, choking/aspiration risks and DoLS.

Prior to our inspection we received information of concern that the lift had broken down, causing several people to sleep in the lounge over night. We looked at the previous lift service records from October 2017 which stated the 'lift shoes' required further attention. The lift shoes had been identified as the reason for the lift breaking down in February 2018, meaning there had been a failure to mitigate a known risk within the service.

These issues meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

We saw the ratings from the last inspection were displayed in the home for people to see. In addition to a CQC provider certificate of registration, a certificate of employers liability insurance and the statement of purpose.