Skolak Healthcare Limited

Beechill Nursing Home

Inspection report

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Date of inspection visit:
23 October 2017

Date of publication:
20 November 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 23 October 2017 and was unannounced. When we last inspected Beechill Nursing Home on the 29 and 30 August 2017 we found breaches of seven of the Regulations of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014, including concerns that placed people at serious risk of harm. We identified breaches in relation to: cleanliness, maintenance, fire safety, security of the building, managing risks and servicing of equipment, wound care, medicines, recruitment, supervision and training, Deprivation of Liberty Safeguards, activities and governance.

We rated all domains of our inspection report as 'inadequate' and the overall rating for the home was 'inadequate'. This meant the home was put in 'special measures'. Services in special measures will be kept under review. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

At this focussed inspection we looked specifically at the areas of concern that posed significant risk to people using the service. These were concerns around fire safety, wound care, bedrail risk assessments, monitoring of legionella, servicing of the passenger lift, and the window restrictors. Following our inspection on 29 and 30 August we asked the provider to send us an action plan stating how they would address our concerns, which they did. We used information contained in their action plan to inform this inspection. Not all the risks and concerns identified at our comprehensive inspection of 29 and 30 August have been reviewed during this inspection. We reviewed the risks which had caused us to take urgent action against the provider. This means that the ratings for individual domains in our inspection report for our 29 and 30 August inspection will remain unchanged. They will be reassessed at our next comprehensive inspection which will look at all aspects of the service again.

Beechill Nursing Home provides accommodation, personal care and nursing care for up to 31 people who have a variety of needs including substance misuse and other complex needs. It is situated in the Cheetham Hill area of Manchester. Facilities include 23 single bedrooms and four double bedrooms, a large lounge area, dining room, a conservatory and a smoke room. There is a small garden area at the back of the property and car parking at the front and rear of the premises.

We found that fire safety had improved and people were no longer exposed to serious risk in this area. The provider had addressed the concerns we raised around fire safety and the majority of those identified by the Greater Manchester Fire and Rescue Service (GMFRS). GMFRS had carried out their own inspection of the service at our request.

There was new wound care documentation in place and we found this was being completed correctly. Wounds were being monitored and evaluated correctly.

Following our last inspection a new, more comprehensive bed rail risk assessment had been identified by the provider. However, this had not been implemented at the time of this inspection. This meant people

living at the home who had bed rails in place still did not have the appropriate risk assessment. We asked for this to be rectified immediately and during our inspection risk assessments were carried out on all people using bed rails to check that they were safe to be used.

At our last inspection we found that the provider was not aware of their responsibilities to ensure people living at the home were protected from the risk of exposure to legionella bacteria. Since our last inspection a legionella risk assessment had been carried out and the provider had taken some steps towards ensuring people were protected from the risk of legionella. We identified that some work had not been carried out, such as ensuring the water temperatures were correct and sampling of the water for legionella. We asked for this work to be carried out.

At our last inspection we identified that the window restrictors were not robust. At this inspection we saw that all but one of the window restrictors had been replaced with a more robust type that could not be disengaged without the use of a specialist tool. One chain style window restrictor remained. This has since been replaced with a more robust type. Regular checks on the window restrictors were being carried out to ensure they were working correctly and that they protected people from the risk of falling from the windows.

Following our last inspection we asked for the passenger lift to be serviced. This has since been carried out and the lift passed as safe to use. However, the service report identified that some maintenance work and cleaning was required. We have since been provided with the maintenance report which shows that this work has been completed.

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

We found that action had been taken to improve safety.

New window restrictors had been fitted. The passenger lift had been serviced and passed as safe.

New wound care documentation was in place. A bed rail risk assessment had been identified for use. However, this had not been implemented for those people living at the home who were using bed rails.

Fire safety had improved, although some work remained to ensure the fire doors were free from paint and closed correctly. A legionella risk assessment had been carried out.

Is the service well-led?

Inadequate

We found that the registered manager had taken some action to address our concerns around the safety of the service.

Where risk assessments had indicated further work was needed, the registered manager had not ensured this work was carried out.

The registered manager was not up-to-date on guidance documents and legislation which was required in order to keep people in the service safe.

Beechill Nursing 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 review the actions the provider had taken following serious concerns we identified at our previous inspection on 29 and 30 August 2017.

This inspection took place on the 23 October 2017 and was unannounced. It was carried out by three adult social care inspectors.

Prior to the inspection we reviewed the action plan the provider had sent us in response to the concerns we identified at our inspection on 29 and 30 August. We used this information to inform this inspection.

During the inspection we spoke with the deputy manager, a registered nurse, the registered manager, the maintenance person and visiting fire officers from Greater Manchester Fire and Rescue Service. We also spoke on the 'phone to the person who carried out the Legionella risk assessment in order to clarify some information.

We undertook a tour of the premises to assess how our concerns around the safety of the building had been addressed. We reviewed a range of documentation including the fire records, legionella risk assessment and window restrictor checklist. We also discussed the implementation of the new wound care documentation and bed rail risk assessments with the deputy manager.

Inadequate

Is the service safe?

Our findings

At our inspection on the 29 and 30 August 2017 we found that all the window restrictors were inadequate, as they were constructed from a thin piece of chain screwed to the window casings and could be easily broken under any type of exertion. At that inspection two of the window restrictors were found to be broken and the windows could be opened wide enough for a person either to climb or fall out of.

At this inspection we found that all but one of the window restrictors had been replaced with a more robust type that could not be disengaged without the use of a specialist tool. One chain style window restrictor remained. This was on in the kitchen window. However, this room was on the ground floor and was kept locked to prevent people who used the service from entering. Therefore this did not pose a risk to people living at the home. We have since received evidence that this window restrictor has also been replaced.

We found one of the new window restrictors was broken. This was on a window in a bedroom on the first floor. The part of the restrictor that was attached to the opening section of the window frame had become detached. This meant the window could be opened wide and there was a risk a person could either climb out or fall out of the window. We immediately reported this to the maintenance person who repaired it. However, we later checked it and found that with minimal force it became detached again from the window frame. It was repaired for a second time and appeared to be in working order.

We saw evidence that there was now a recorded daily check of the window restrictors to ensure they were functioning correctly. The check consisted of a signature each day, with any issues noted in a comments box. From reviewing the records of the daily check we saw that the window restrictor we found broken had also been found to be broken on a previous occasion. We brought this to the attention of the registered manager so that this window restrictor could be monitored closely and further remedial action taken if necessary.

At our last inspection we identified serious concerns around fire safety and referred the service to Greater Manchester Fire and Rescue Service (GMFRS) who carried out their own inspection of the home and issued an enforcement notice. GMFRS will be carrying out their own follow-up review of their enforcement notice. At this inspection we found that improvements had been made in relation to fire safety.

We looked around the building and saw that the fire escapes were free from any obstructions. At our last inspection we found that the fire escape from the room adjacent to the smoking room was locked and staff were unsure of the location of the keys. Since then the locks had been replaced with a type that could be easily opened in the case of an emergency. Weekly tests of the fire alarm, emergency lighting, fire escapes and fire doors had been carried out. At our last inspection we found that the fire extinguishers had not been serviced and no check on the electrical installation had been carried out to ensure it was not a fire risk. At this inspection we found that both of these checks had been carried out and were satisfactory.

Since our last inspection a more comprehensive fire risk assessment had been carried out by an external company. An action indicated from this risk assessment was for the provider to carry out a daily check on

the ashtray, which had been found to be overflowing. We saw that although checks had been started, they were not being carried out on a regular basis. We brought this to the attention of the registered manager.

During our inspection we spoke with officers from GMFRS who were carrying out their own inspection of the building and evaluating the progress the provider had made since their enforcement notice. They indicated they were satisfied with the overall progress the provider had made in relation to fire safety, although there were still several outstanding actions to be completed.

At our inspection on 29 and 30 August 2017 we looked at how the service managed wound care and found this to be inadequate. There was no evidence to show that people with wounds had them evaluated on a regular basis. Wound evaluation, which includes measuring and photographing the wound, monitoring pain level, descriptions of the wound bed and level of exudate are important tools in wound management, as they enable staff to monitor the improvement or deterioration of wounds and identify signs of wound infection.

At this inspection we found that wound management had improved. The provider had introduced new wound care documentation and this was in use for the two people living at Beechill Nursing Home who had wounds. A wound care dressing plan was used to describe the nature of the wound, the type of dressing to be used and the frequency of the dressing change. In addition there was a wound assessment chart which enabled staff to record the on-going monitoring of a wound. This included details of the wound dimensions, description of the wound bed, condition of the surrounding skin and level of pain at the wound site. At our last inspection we found that staff were unable to measure wounds as the dressing packs they used did not include a sterile tape measure. Since then the provider had ensured that staff were supplied with dressing packs which contained sterile tape measures. Since our last inspection some staff had undertaken wound care training.

At our inspection on 29 and 30 August 2017 we found that there were no adequate bedrail risk assessments in place to ensure that bedrails were the most appropriate equipment to use and were safe to use for each individual person. Inappropriate use of bed rails or use of bed rails which are broken can put people at risk of injury or fatality from entrapment or asphyxiation. The Health and Safety Executive (HSE) suggests that 'a risk assessment is carried out by a competent person taking into account the bed occupant, the bed, mattresses, bed rails and all associated equipment'.

Since that inspection we had been provided with a copy of a more comprehensive bed rail risk assessment that the provider intended to use. However, we found that this had not yet been implemented and people at the service who were using bed rails still did not have the appropriate risk assessment in place. We asked for this to be rectified immediately and during our inspection risk assessments were carried out on all people using bed rails.

At our last inspection on 29 and 30 August 2017 we found that the provider was not aware of their responsibilities to ensure people living at the home were protected from the risk of exposure to legionella bacteria. Since our last inspection a legionella risk assessment had been carried out. This had identified that several of the hot water temperatures were too low and did not reach the temperature necessary to destroy legionella bacteria. The risk assessment recommended that the boiler temperature be increased. From discussion with the registered manager and the maintenance person it was identified that this had not been done. We asked the registered manager to arrange for the gas boiler to be checked by an external company and subsequent to this inspection we were provided with evidence to show that the boiler and been checked and the water temperature increased.

The legionella risk assessment had not identified the need for a bacterial water sample to test for the presence of legionella bacteria. However we discussed with the registered manager that this test was good practice, particularly in view that the water temperatures were not always reaching the required temperature. The registered manager arranged for a testing kit to be delivered. These precautions would help to minimize the risk of people living at the home being exposed to legionella.

At our inspection on 20 and 30 August 2017 there was no evidence to show that the servicing of the passenger lift was up-to-date. We asked for this to be carried out and were provided with the service report. On reviewing the service report it showed that although the lift had been passed as safe some maintenance work and cleaning of the lift shaft and lift pit was required. We have since been provided with evidence to show that this work has been completed.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager who had registered with the Care Quality Commission (CQC) in January 2011. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection on 29 and 30 August 2017 we identified concerns that posed significant risk to people using the service. These six concerns were around fire safety, wound care, bedrail risk assessments, monitoring of legionella, servicing of the passenger lift, and the window restrictors. Following that inspection we requested the registered manager provide us with an action plan detailing how they were going to address our concerns and the timescale for implementation of their remedial actions. At this inspection on 23 October 2017 we looked specifically at what improvements the registered manager had made in relation to the six specific areas.

We found that the registered manager had taken steps to address the areas of concern and had provided us with evidence detailing their remedial actions. However, although some action had been taken there were still areas where further improvements were required and further action was only undertaken by the registered manager at the insistence of the CQC inspectors.

For example, we were shown a blank copy of the new bed rail risk assessment which we were told was going to be used. However, we found that this had not yet been implemented and people at the service who were using bed rails still did not have the appropriate risk assessment in place. The registered manager had not taken the required steps to ensure people using bed rails were safe to do so.

Although a legionella risk assessment had been carried out, we found that action recommended to ensure the water was at the correct temperature had not been undertaken. We were informed by the registered manager that the maintenance person had increased the boiler temperature. However, when asked, the maintenance person told us they had not been asked to carry out this work. We asked the registered manager to arrange for the gas boiler to be checked by an external gas engineer to ensure water was reaching the required temperature, which he did.

Since our inspection the registered manager had taken steps to improve fire safety at the home. However, officers from GMFRS told us that although they were satisfied with the improvement made, there was still some action required, such as ensuring paint was removed from the fire door seals. We found that an action indicated from the fire risk assessment had not been fully implemented. This was in relation to daily checks on the astray in the smoking room. The registered manager had not ensured that these checks were being carried out and recorded.

Through our discussions with the registered manager at this inspection we found that he was not always aware of guidance documents, such as the 'Health and Safety in Care Homes' guidance produced by the

Health and Safety Executive. Guidance documents provide registered persons with valuable information about how to maintain peoples' safety, and comply with the law.