Beechfields Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beechfields Nursing Home is a nursing home providing personal and nursing care to up to 35 people. The service provides support to older people some of whom are living with dementia, physical disabilities, and sensory impairments. At the time of our inspection there were 30 people using the service. The care home accommodates people in 1 adapted building across 2 floors.

People's experience of using this service and what we found
People were not protected from incidents of harm and abuse. The provider failed to submit safeguarding referrals to the local authority safeguarding team in accordance with their regulatory responsibility. Incidents involving distressed behaviours were not investigated and action to reduce incidents of distressed behaviour was not taken. Risk assessments were not always completed, and medicines were not always safely managed or stored. Clinical and environmental risks were not always monitored safely. Staff were not competently trained to understand people's health conditions.

The provider failed to ensure governance systems were robust and quality systems did not safely monitor risks to people. Lessons were not learnt from the last inspection to ensure people remained safe from harm.

People were not always treated with dignity and respect. However, people told us they were happy living in the home and felt supported by the staff team. People told us they felt included in decision making in the home and staff told us they felt able to raise concerns or make suggestions with the registered manager.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager understood the duty of candour and was receptive to all concerns raised in the inspection. New systems and processes were introduced to monitor the care and support people received.

The provider worked in partnership with other health and social care agencies, including the local authority quality team who were supporting the provider to make improvements regarding their overall governance.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 May 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about neglect and failure to escalate concerns to health professionals. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We inspected and found there was a concern regarding people's dignity, so we widened the scope of the inspection and reviewed the key question of caring.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this full report.

The provider responded to all concerns raised in this inspection and implemented new systems and processes to improve the overall governance and support provided to people. We will review the success of these systems at the next inspection.

You can read the report from our last comprehensive inspection, by selecting the 'All inspection reports and timeline' link for Beechfields Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, risk management, respecting people's dignity and the governance of the home at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Beechfields Nursing Home Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors.

Service and service type
Beechfields Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Beechfields Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 18 January 2024 and ended on 14 February 2024. We visited the location's service on 18 January 2024.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with 6 people who lived at the home and 6 relatives. We also spoke with the nominated individual, registered manager, 8 staff members including nurses and care staff. We looked at 5 people's care records and 3 people's medicine administration records (MARs). We also viewed 2 staff files and documentation related to the governance of the service. We received feedback from 2 visiting professionals and reviewed direct feedback to the service from another visiting professional.

The provider sent us further documentation following the site visit including risk assessments and evidence of action they had taken following our feedback.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse. Where incidents of abuse had occurred and staff had logged them in people's records, the provider failed to make safeguarding referrals. This placed people at risk of harm.
- We reviewed 16 behavioural incident reports completed by staff. These involved incidents of distressed behaviour where people demonstrated physically aggressive, self-injurious and sexualised behaviour to others. These had not been investigated by the management team or reported to the safeguarding team. This meant people were at risk of harm because strategies could not be developed to support people when they were distressed, and the incidents were not subject to independent review by the safeguarding team.
- One incident report referred to a person being restrained. Staff were not trained in physical intervention. This incident had not been investigated by the staff team or reported to the local authority safeguarding team. The provider failed to investigate this incident which placed people at risk of receiving unsafe responses from staff.

Systems had not been established to ensure people were safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff received safeguarding training and told us how they would report concerns to the management team. However, we were concerned incidents of distressed behaviours were not handed over to the management team.
- Despite incidents not being investigated, people told us they felt safe living in the home with the staff who supported them. One person said, "I am happy here, I feel safe. The staff are smashing, they are very good."

Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating medicine management. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12 (safe care and treatment)

- Medicines were not always managed safely. During the last inspection, we raised concerns over the monitoring of medicine refrigerator temperatures and the safe monitoring of pain relief skin patches. During this inspection we found ongoing concerns within each of these areas.
- Medicine fridge temperatures were being recorded daily. However, the provider was not monitoring the

minimum and maximum temperatures in accordance with national guidance. Temperature recordings at times exceeded the maximum temperature, but there were no follow-on actions recorded in response to this. At the time of inspection, there were no medicines stored in the fridge. However, people were at risk of potential harm should they need their medicine refrigerated.
● During the last inspection we raised concerns over the administration of pain relief skin patches. These were not rotated correctly on a person's skin. During this inspection we found skin patches were being rotated correctly. However, skin patches were not checked daily to ensure they were still secure against the skin. This is important because some skin patches are applied on a weekly basis and can become dislodged from the skin. Skin patches require daily monitoring to ensure people continue to receive their prescribed pain relief medicine.
● One person's pain relief medicine had been changed from being regularly prescribed to when required. However, a protocol for administering this had not been completed. This meant the person was at risk of not receiving their pain medicines when required.

Systems had not been improved to ensure medicines were managed and stored safely. This was a continued breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People received their medicines in a dignified way and quantities of medicines matched the documentation.

Assessing risk, safety monitoring and management
● Risk assessments were not always in place to guide staff how to manage and mitigate risks to people. This placed people at risk of harm. One person with limited mobility required a call bell risk assessment due to choosing not to have a call bell within reach. This had not been completed which placed the person at risk of harm because staff may be unaware the person could not notify them if assistance or support was required.
● Where people experienced health conditions such as epilepsy or diabetes, risk assessments were not always in place. This meant the provider could not be assured people were protected from harm through having their health conditions thoroughly assessed and be assured staff were supporting people safely in accordance with health professional guidance.
● One person had a diagnosis of diabetes and needed their blood sugars monitored regularly. The care plan did not describe how often their blood sugars needed to be monitored. We reviewed the blood sugar readings and could see these were being monitored weekly. However, 1 recent reading exceeded the safe levels identified in the care plan. There was no follow up information recorded. This meant the provider could not be assured staff were taking the appropriate steps to support people when their blood sugars were elevated.
● The provider failed to ensure staff received training in diabetes and epilepsy, despite people having a diagnosis of these health conditions. This meant people were at risk of harm because staff providing care or treatment to people did not have the competence, skills, and experience to do so safely.
● Where people experienced distressed behaviours and required additional staff support, risk assessments were not always in place. One person received 1:1 support from staff during the day due to experiencing distressed emotions, putting themselves and others at risk. A risk assessment was not in place and the staff member supporting the person on the day of the inspection site visit could not tell us why the person required 1:1 support. This put the person, other people using the service and the staff member at risk.
● Environmental risks were not always managed safely which placed people at risk of harm. For example, 2 window restrictors were not in place which meant the windows could open fully. This placed people at risk of falls from height. Hoists and wheelchairs were stored in communal areas which placed people at risk of

trips and falls. Drinks with thickening agents were left unattended on railings in corridors. This placed people at risk of accessing unsuitable fluids and increased the risk of choking incidents.

Systems had not been established to ensure care and treatment was provided safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff did not always wear Personal Protective Equipment (PPE) effectively and safely. On the day of inspection, we observed staff members wearing face masks under their nose. This placed people at risk of spread of infection.
● Walls and doors were scuffed, and some communal carpets were soiled which increased the risk of infection.
● Despite this, we observed cleaning taking place and relatives and people told us the home was clean. One relative told us, "They are always cleaning. We know they have refurbishment programme in place."
● The provider shared their action plan which included plans for refurbishments.

Learning lessons when things go wrong
● Lessons were not always learnt when things went wrong. Concerns identified at the last inspection had not always been addressed and incidents were not always investigated.
● The provider responded to all complaints and apologies were made when things went wrong.

Staffing and recruitment
● People were supported by enough staff to meet their needs safely. However, we raised concerns over the length of time it took for staff to support a person with personal care in the morning during the day we visited.
● People were supported by staff who were recruited safely.
● Staff were required to provide satisfactory references and Disclosure and Barring Service (DBS) checks prior to starting their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● People told us staff respected their choices and decisions. One person said, "I have choices. I choose what time to wake up and go to bed. I choose what I want to do. The staff help me."

Visiting in care homes

● Visiting arrangements in place were compliant with current best practice guidance. One relative told us, "We can visit whenever we want, we just sign in when we arrive."

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity. For example, we observed 1 person's bedroom door was open, and they were in a state of undress and in need of their personal care and continence needs being met. Staff did not address this until we raised it with them multiple times.
- People were not always supported in a dignified way at mealtimes. For example, 1 person had eaten their lunch with their hands in their bedroom because staff had not given them any cutlery.
- Terminology used in care plan documentation was not always dignified. For example, 1 person's care plan referred to their behaviour as childlike. We discussed this with the provider, and they amended the care plan immediately and confirmed they would be discussing this with staff.

Systems had not been established to ensure people were treated with dignity and respect. This placed people at risk of harm. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our observations, 1 relative told us, "I think the privacy and dignity here is really good."

Ensuring people are well treated and supported; respecting equality and diversity
- People told us staff were kind and caring and treated them well. One person told us, "Staff are good, they know me well." Another person said, "I love it here. The nurses are excellent, they always help me when I ask, and they are always kind."
- Relatives told us staff were caring. One relative told us, "The staff are all very nice. The staff know [my family member] really well."

Supporting people to express their views and be involved in making decisions about their care
- People were supported to be involved in decision making. One relative told us, "I would be confident if there was a decision to be made, my relative would be included in it."
- People felt listened to and valued by staff. One person told us, "The staff always tell me what they are going to do before hand and ask permission. They keep me informed and ask me what I want."
- People were supported by staff who understood how to communicate with them to enable them to be involved in their care. For example, we observed a staff member speaking with 1 person in their preferred language to support them to be understood.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure monitoring systems were effective and people were not placed at risk of harm. This was a breach of regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17 (1) (Good Governance)

- The provider failed to ensure a robust system was in place to monitor risks to people. They failed to ensure risks were assessed and mitigated. For example, epilepsy, diabetes, distressed behaviours and call bell risk assessments were not completed. This placed people at risk of harm.
- The provider failed to monitor incidents of distressed behaviours and alert the local authority safeguarding team and other professionals to incidents of abuse.
- The provider failed to submit notifications in accordance with their regulatory responsibility. Two incidents involving catheter care were reported to the safeguarding team. However, the provider failed to submit notifications to alert us to these concerns.
- The provider failed to instil a culture of environmental safety monitoring within the staff team. Drinks with thickening agents were left unattended on railings in corridors. Doors to cupboards which were clearly labelled 'fire door keep locked at all times' were left open and a fire extinguisher was used to prop a door open.
- The provider failed to ensure staff were competently trained in health conditions which people experienced. This placed people at risk of harm due to staff not having the knowledge to understand the impact of people's conditions on their health and wellbeing.
- The provider failed to ensure action was taken in response to monitoring concerns. For example, no action was taken when 1 person's blood sugars exceeded the identified safe range and there was no action taken when the medicine fridge exceeded safe temperatures.
- Quality audits were in place, although these lacked specific detail and did not always identify the action taken to follow up on discrepancies or missed information. For example, daily checks and care planning audits were evident, but these did not identify follow on actions.
- The provider failed to learn and improve care practices when things went wrong. For example, a substantiated safeguarding concern highlighted improvements were needed to overall governance and the

previous inspection breached regulation 17 (good governance) due to concerns over the quality monitoring systems in place. The provider had not learnt lessons by improving governance systems. The continued lack of oversight of the care and support provided placed people at risk of harm.

Systems had not been established to ensure effective governance of the service provided. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to all our feedback. With support from the local authority quality team, they introduced improved auditing systems. Risk assessments were completed and discussed with the staff team. Increased management observations were introduced, and environmental safety concerns were discussed with the staff team. Statutory notifications were submitted retrospectively, incidents involving distressed behaviours were investigated and reported to the local authority safeguarding team.

● The provider shared their action plans highlighting how they were introducing new quality auditing systems and shared their plans for renovation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibilities under the duty of candour, and we saw examples of apologies made to people and relatives.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture was not always inclusive and person centred, we observed instances where a person's personal care needs were not met in a timely and dignified manner and where a person was not provided with cutlery to eat a meal. Despite this, people told us they were happy living in the home and felt empowered to make their own decisions.
● Staff spent time engaging positively with people and we observed people having their nails painted and staff laughing and talking with people.
● Staff told us the culture of the service promoted good outcomes for people. One staff member said, "Care staff really enjoy their job. We try and care for people the best we can and encourage people to do what they can."
● A visiting professional told us the culture was supportive. They told us, "The registered manager and the care staff are very approachable and supportive both to myself and the people living in the home."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they felt involved in the service. One person told us, "The registered manager comes and checks on me and asks if I am okay or if I want something."
● Relatives told us the provider regularly communicated with them but we received mixed feedback regarding the provider proactively seeking feedback. One relative told us, "They occasionally have an open evening we can go to. They don't send questionnaires." Another relative said, "Recently we did a questionnaire and they have acted on the feedback."
● Meeting minutes evidenced staff were kept informed of changes and in the general running of the home. One staff member told us, "We have handovers to discuss any changes and we have team meetings where we can contribute and discuss concerns."

Working in partnership with others

● The provider worked alongside the local authority to improve care at the home. Professionals told us the provider engaged positively but had not always addressed concerns that had previously been raised.

● People told us they received support to access health professionals. One person told us, "I am told about any changes and they [staff] help me to see a doctor if I want one."

● Relatives provided positive feedback regarding the provider's partnership working. One relative told us, "They have worked really hard to get my relative the right equipment. They have worked really hard with the occupational therapist and physiotherapist."

● Records and feedback from visiting professionals showed the provider worked alongside other health professionals such as physiotherapists, palliative care leads, speech and language therapists (SALT) and tissue viability nurses.

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 10 HSCA RA Regulations 2014 Dignity and respect Systems had not been established to ensure people were treated with dignity and respect. People's personal care needs were not met in a timely and dignified manner and people did not always have the opportunity to enjoy their meal in a dignified way.