B & L Premier Care Limited

Beechdale House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 March 2016 and was unannounced.

Beechdale House Care Home provides accommodation and nursing care for up to 40 people. At the time of our inspection, 30 people were using the service. The home is set on a main road and has two storeys. Two of the rooms were shared, and the rest were single rooms. There were communal bathrooms and toilets. There is one lounge and a separate dining room.

At our last inspection of the service on 10 February 2015 we identified that there was a breach of Regulation 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010. The registered person did not have suitable arrangements to protect service users against the risks associated with unsafe management of medicines. At this inspection we found that further work was required in this area.

There was a registered manager in post at the time of our inspection. 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.

People were not always protected from the risks of harm or abuse. Staff we spoke with knew what to do if abuse was suspected, but we were not confident that the service always made referrals to the local authority in a timely way.

Risks had not always been managed to keep people safe. Risk assessments had been completed but these were not always acted upon, which meant people could be left at risk of harm.

We were not confident that people who required medication received this as the prescriber had intended. Not all staff who administered medicines had completed an annual assessment to assess their competency in the area. Medication audits were not being regularly done to check any areas that required improvement. This meant that there was a greater risk that errors would be made.

Action had not been taken in a timely manner to ensure the environment was maintained in a safe way. Substances and equipment were accessible that could have posed a serious risk to people's safety. There was no schedule of servicing for some medical equipment, and we had concerns about fire safety, the lack of an up to date gas check certificate and electrical certificates. This meant we were not sure people were safe in the environment of the service.

Two recruitment records we looked at did not contain the mandatory Disclosure and Barring checks (DBS).The provider told us they were agency workers but not all of the files we checked were agency workers. One staff file had handwritten references on scraps of paper from an unidentifiable person. This meant we could not be sure that all staff had been safely recruited.

The provider was not using any tool to help them decide on safe staffing levels. There were insufficient staff to meet people's needs and manage risks.

The environment was not clean and this increased the risk of infection spreading. There were insufficient cleaning staff on duty. Chairs and furniture were not always clean. There was a lack of hand washing signs and hand gel dispensers.

The training given to staff was not always sufficient to ensure people had the skills and knowledge they required to do their job. This was because staff training information was not available for all staff, and not all staff had undertaken training that was required. Some staff were not receiving regular supervisions.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was not acting in accordance with the MCA, including DoLS. The provider had referred all people using the service for a DoLS, when not all of the people lacked capacity. There was a person already subject to a DoLS but the provider was not meeting the conditions of the DoLS, nor did staff realise the person was subject to a DoLS. This meant the provider was failing to follow accurately the MCA and DoLS processes, and people may not have had their rights fully protected by the law.

Adequate food and drinks were provided, but we did not see evidence that people were always offered choice, or appropriate support with their dietary intake.

People's privacy, respect and dignity were not always maintained. We saw people were sometimes not kept private when accessing the toilet, people were spoken to inappropriately, and someone was left in a wheelchair facing the wall for over an hour. People in distress, or need of support were not always responded to in a dignified or caring manner. Some staff showed care towards people, but we noticed this appeared to be directed at more able people.

People were referred for their health needs to GPs and other relevant health professionals.

Staff did not always approach people in a caring way. Whilst we saw three staff show care towards people, other staff spoke across people and ignored their signs of distress.

People's privacy and dignity was not always respected or promoted. People were not always supported to express their views or be involved in decisions about their care. People were not always offered a range of activities suitable to their needs and preferences.

People were not always responded to in a timely way when they needed support. We saw a person who needed to use the toilet and no staff were available to help. We had to call the registered manager to give support.

Although there was an activities timetable, there was no dedicated activity coordinator and people were not always offered activities suitable to their needs and preferences.

We could not be sure that care plans contained all the relevant information to ensure people's needs and preferences could be met. The complaints procedure was not adequate.

There were insufficient quality audits and checks to demonstrate that the provider was making improvements and listened to people's views to improve the service. There was limited opportunities for

people and their relatives to give their views of the service as the annual questionnaires showed that many replies had been completed by staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There were not always enough staff to meet people's needs and keep them safe.

The necessary recruitment checks were completed before staff commenced employment at the home.

Risks to people had not been consistently assessed and action had not been taken to reduce risks to people.

Medicines were not managed safely.

The environment was not safe. The service was not clean and people's risk of infection was increased.

Is the service effective?

Inadequate

The service was not effective.

Staff were not acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. This meant that people's rights were not always being protected.

Not all staff were receiving the support or training that they required to meet people's needs.

People were supported with their eating and drinking but not always in a dignified way.

People were not always supported to maintain good health. People had access to external health provision when they needed it.

People's individual needs were not always met by the design and adaptation of the environment.

Is the service caring?

Inadequate

The service was not caring.

People were not always provided with care that was person centred and met their needs. People were not involved in their care planning.

People were not always treated with dignity and respect.

People were not always enabled to express their views or were involved in their care.

Is the service responsive?

Inadequate

The service was not responsive.

People showing signs of distress were not always responded to in a timely way.

People were not always given opportunities to engage in activities that were meaningful to them.

The complaints system was not effective and complaints had not been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

People were not always assisted to give their views and opinions about the service.

There was no effective quality assurance system in place to identify improvements needed and ensure that they were carried out.

The service did not demonstrate good leadership.

Beechdale House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor, and an expert by experience on the first day, and two inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had a history of providing support to older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We contacted local commissioners to obtain their views about the service.

We spoke with ten people who used the service (although not all of these were in detail due to people's varying abilities) and four relatives. We spoke with the nominated individual, the registered manager, an agency nurse, a senior carer, three care staff, and the cook. We reviewed eight care records, three staff files, and the provider's policies and procedures, accidents and incidents, the staff training matrix and records of staff supervisions. We looked at records of environmental checks.

Some of the people using this service were unable to communicate verbally, so we observed how staff interacted and supported people to help assist us in understanding the quality of care they received. We

used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection, we spoke to two GPs, two community nurses and three members of the Dementia Outreach team. The Dementia Outreach team consists of health staff who are specially trained to support homes who care for people that are living with dementia.

Inadequate

Is the service safe?

Our findings

At our last inspection, we identified that there was a breach in Regulation 13 of the HSCA 2008 (Regulated Activities) Regulations 2010. Some of the concerns around medicine management raised at our last inspection had been addressed, but we still found several areas of concern.

The medicine round had already started at 08.30 hours. This was not finished until 11.25am and the lunchtime medicines round started at 13.10. This was unsafe as there should be a four hour gap between when medicines were given. The late finishing of the morning medicines round meant that there was a greater risk that medicine doses would not be appropriately spaced to ensure the safety of people who used the service.

The medicines were not always signed for at the time of administration. Nurses were supposed to sign for a medicine once they have observed the person take it. One person asked what their medicine was for, and the nurse who was giving the person her medicine was unable to explain. People have a right to know what medicines are being given and the nurse should have been aware of what the medicine was for.

The registered manager told us that the second staff member witnessing the administration of controlled drugs would be a care worker who had not received any medicines training. Controlled drugs are medicines that are closely monitored under The Misuse of Drugs legalisation and subsequent amendments. These types of medicines require extra care when being given, and have to be checked carefully and signed for by two people, both of whom have been trained for this task.

We saw that not all medicinal creams were dated when opened, which is a requirement. A member of the inspection team asked one of the nurses to show them morphine. Morphine is a strong pain killer, but the nurse got out Metformin, a drug to treat diabetes. English was not the nurse's first language and they did not appear to understand what we were asking for. This meant we could not be sure that people were receiving their medicines safely by staff trained to administer them.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person said, "I feel safe enough." Another person said they felt safe, but were unable to say why. A relative told us, "If I hadn't got trust in the staff, I wouldn't leave [person's name] here." Staff we spoke with were aware of the different types of abuse and who to report concerns to. Staff we spoke with had received training in safeguarding adults. The registered manager understood the necessary steps to take in the event of suspected abuse.

During the inspection we identified instances where potential safeguarding issues were not being managed appropriately. We saw in a person's daily records that they had been found to have some unexplained bruising. This has not been reported to the local safeguarding team. We saw an accident form that stated a person had been left on the commode. Staff had returned and the person was found on the floor. A

safeguarding referral had not been made to the local authority.

We saw an accident form recorded that a person was found in bed fully clothed. The bed, clothes, sheets and pad were stated to be wet through. There was no reference made to a safeguarding referral being carried out by staff. We made a safeguarding referral to the local authority for this person.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had not fully assessed the risks to people's health and safety and had failed to make sure that action was taken to reduce those risks. We saw a completed risk assessment tool for the use of bedrails, but this would not have prompted staff to have considered all potential risks for the use of bedrails.

People were not always protected from risks. A person's care plan stated they needed full supervision when mobilising. An accident form noted that the person was seen by staff to walk unsupervised in the lounge prior to having a fall. Staff did not intervene to support the person. We also saw the person walk unsupervised during our inspection.

Records showed that a person needed half hourly observations, as they were at risk of self-harm. On checking the observation charts, we found several gaps where the person appeared to have been unchecked for up to eleven hours. This meant that care was not always being provided in safe way, and risks had not always been identified or managed appropriately to reduce the risk where possible.

A person's care records stated that they should be supervised all the time while in a chair as they were at high risk of falling out of their chair as they could lean forwards. We observed the person was not supervised at all times when sitting in a wheelchair. This meant that care was not always being provided in safe way, and the home was not following the advice of the care plan.

We observed a person walking in slippers that were too big, which could increase the person's risk of falling. This was raised with the registered manager but the person was still wearing the same slippers an hour later. This person could have fallen due to the unsuitability of their footwear.

Some of the carpets were very worn and had been patched, and the lounge carpet was loose in one area. We noted a person walking with a frame got the frame caught in the carpet. The provider did rectify this when we raised it.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "Staff come as quickly as they can." Another person told us, "I rarely have to wait too long. They [staff] are very busy." Another person said, "I personally think they [staff] get very busy."

We observed there were not always enough staff to keep people safe or respond in a timely way when people needed help. All staff we spoke with told us there was not enough staff. A staff member said, "We are always playing catch up. There are not enough hours in the day."

Staff told us that they were not completing documentation until the end of their shifts due to a lack of time during the day. This meant that there was a greater risk that these records were inaccurate. The registered

manager told us that no tool was being used to calculate safe staffing levels, and the registered manager was unable to clarify how safe staffing levels were calculated.

We observed another person asked for their wheelchair to be turned round three times, but no staff were available to respond to them. We asked the registered manager to respond to a person in the lounge who was asking to go to the toilet as no staff were available. We heard an alarm bell sound which no staff responded to until prompted by an inspector.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the environment at the service and found some areas were not safe. One of the upstairs fire exits was not secure and we saw that three incident forms recorded that a person at risk of falls had been found unsupervised at the top of stairs at night.

One of the fire exits downstairs was not secure, and could be accessed from a corridor which contained people's bedrooms. This area was not regularly supervised by staff. People living at the service could walk directly into the kitchen from the same bedroom corridor.

We found an unlocked cleaning shed which contained hazardous materials, and the maintenance shed which also contained hazardous materials. We saw some pieces of wood with protruding nails which were not stored securely, and presented a potential risk to people at the service. There were dangerous substances not locked away in a sluice room that people walked through to use the toilet. An electric hand sander had been left plugged in and unattended in a bedroom corridor on the first floor of the location. Another cupboard in a bathroom was unlocked and contained a floor cleaner. All could have posed a risk of serious injury to people.

The registered manager told us that the annual gas safety check had been carried out in January 2016, but no certificate had been received yet. The periodic inspection of electrical testing stated that the findings were 'unsatisfactory.' We asked for evidence of re-testing, but this was not provided. This means that people could be put at risk. We noted that some equipment used to check people's health, such as blood pressure machines, had no schedules for an annual service to ensure the equipment still worked accurately. There were service records for the hoists.

The fire service had inspected the service last autumn, and had found several areas that were unsafe. The fire service had asked for improvements to be made. The provider told us these had taken place, but we saw no documentary evidence of this.

People were not protected from the risk of infection. We observed a staff member applying cream to a number of people's hands using the same tub of cream, and without changing their gloves. One of the nurses wore a long sleeved top, and was not therefore following safe infection control practices. We saw copies of an infection control audit carried out by the NHS last autumn, which still had areas that needed addressing.

The location was not clean and people were placed at risk of infection. We saw that corridors, the lounge, the dining room, toilets and bathrooms were not always clean. Chairs were stained and smelt of urine. Only one cleaner was employed to work from 8am to 2pm each day and all staff we spoke with told us that they did not think this was enough. There were no hand gels available throughout the home and there was no adequate signage for correct hand washing technique.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us the home was nice and a relative said, "They look after [my family member] well." Another relative spoke of how staff had supported their relative appropriately when the person had difficulty swallowing.

Some of the staff we spoke with seemed to know people's needs well. One staff member explained how they managed to support a person with behavior that challenges. They told us, "We're not allowed to restrain people. If [person] resists, we leave and return later. [Person's name] responds better to some staff than others." Another staff member clearly understood which people requir ed assistance to eat, and what dietary needs they had. Other newer staff members were less knowledgeable about people and their needs.

The nurse administering medicines was an agency nurse, and it was their second shift at the home. They told us they had not been given a summary of useful information for them to know before starting at the home. They said, "I would have appreciated a file that I could refer to and at other places I have worked there is usually a file." Another staff member said, "There was not enough induction." However, two other staff were happy with the induction they received. The registered manager told us that all new staff have a two day induction programme and then shadow a more experienced staff member for two weeks.

The registered manager sent us a staff training matrix after the inspection. The registered manager also gave us a list of current staff members on the second day of our inspection which they told us was a current list of staff. There were 38 staff members on this list, but only 24 staff on the training matrix. Six care staff on the staff list were not on the training records, which may mean they have not received the necessary training to carry out their roles. The training record stated when training was done, but did not say when it was next due. Nine staff had no training in relation to dealing with 'aggression' (This was the provider's description of challenging behaviour). This training was important as the service supported some people with behaviour that might challenge others. Some of the staff we spoke with felt the training had prepared them for their job role, but others did not, in particular newer staff.

We checked to see if staff had received regular supervision. We found supervision records to be chaotic and difficult to decipher. We saw that four care staff appeared not to have had supervisions since April 2015 and two nurses had not had any supervision since June 2015. Two supervision records mentioned appraisals but we did not see any evidence of these and neither were staff aware of appraisals. This meant that we could not be confident that staff had the support and supervision they required to fulfil the requirements of their role. This could place people at risk of receiving care that was inappropriate or unsafe.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people at the service were living with dementia and appropriate adaptations to the home had not been made to support them to walk independently around the home. 16 of 30 people's bedrooms did not have a name or photograph of the person on them to support the person to find their bedroom. A

number of communal use rooms did not have signs or symbols on them including the laundry, some toilets and the kitchen. There were also no signs to show whether toilets or bathrooms were occupied or not. People living with dementia need additional support from signage and pictures as they may no longer to be able to find their way around without this.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people, who were able to communicate, told us they enjoyed the food. A person said, "What I've had is very good." Others were less complimentary saying, "Some days I like it and some days I don't." Another person said, "The food is alright, but not much variety." The staff we spoke to knew which people were on special diets, and who needed support to eat and drink. There was no menu available for people to look at, and the cook told us they kept the choices of what people had asked for in their heads. We were told conflicting information about how meal choices were made by different staff.

All people at lunchtime were observed to have the same meal, which suggested that choice is not always offered. Several people required support to eat and drink. We saw whilst some staff spoke to people, other staff merely spooned food into people's mouths and spoke across the table to colleagues rather than interacting with people they supported.

Records showed that people whose weight had changed unexpectedly were referred to appropriate services, such as speech and language therapists and dieticians. We saw that staff had signed to demonstrate that people who needed dietary supplements had been given them.

When reviewing two people's position change charts and food and fluid charts, we noted that the charts had no entries recorded since 06.00 on 1 March 2016 which was six and a half hours before we looked at them. The charts had no entries recorded since 06.00 on 1 March 2016. Whilst fluid intake was recorded on charts for some people, there was no system to audit these and no action plan if a person was not having sufficient fluids. The service did not demonstrate that people's food and fluid intake was always checked sufficiently to ensure it was within safe guidelines.

Staff told us and records confirmed that people had been referred to their GP and other health professionals when needed. People told us and records confirmed that the service had frequent visits from a local GP service, and that other professionals were also involved, such as occupational therapists and dementia specialists, when required. This assured us that people's healthcare needs were being met.

One person had a pressure ulcer, but was not positioned correctly to minimize further risk of skin damage. We saw from charts used to record position changes were not always completed, and staff were completing charts at the end of their shift, rather than as they provided the care. We saw a person whose care plan stated needed their position changed at least five times during the day. This person was at high risk of pressure ulcers. This person was left in a wheelchair from 09.00 until 14.30 with no position changes.

We saw another's person's repositioning chart had indicated that the person required help to reposition every two hours to prevent skin damage. We found no changes had been made to the person's position for sometimes up to six hours. This was important, as people who are less mobile may be at increased risk of pressure ulcers without frequent repositioning. These records did not provide evidence that staff had taken appropriate action to minimise the risk of people acquiring skin damage.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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 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 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 checked whether the service was working within the principles of the MCA. The staff training matrix showed training in MCA and DoLS had not been completed by nine of the care staff.

The registered manager told us two people had a DoLS in place and they had applied for all of the people to be assessed for a DoLS. This showed a lack of understanding of MCA and DoLS, as it was unlikely that every person at the service lacked the capacity to consent to their care and treatment. The care plan we looked at contained mental capacity assessments and best interests checklists. However we saw on the DoLS authorisation made for one person that the home were not following the conditions laid out in the DoLS, and staff we spoke to were unaware the person was on a DoLS, or what the conditions were. One staff member told us, "If a person can't make up their mind, we do it for them." This was in response to a question about best interest decisions. These examples demonstrated that staff at the service did not all fully understand and follow the MCA and DoLS processes.

Staff we spoke to understood the importance of consent. One staff member said, "If a person refuses personal care support, we go back later and try again." However, we observed staff not explaining to a person what they were doing when assisting the person to move using a hoist, and several instances where staff took people in wheelchairs from one place to another whilst offering no explanation of what they were doing.

Some of the people at the service had behaviours that may challenge others. Some of the staff we spoke with said that that if a person was resistive to receiving care, they would leave the person and return later. The care plans did not give detailed information about how staff should intervene or manage when people showed behaviours that challenged. We saw a person with behaviour that challenged left alone in the lounge to eat their lunch with no support. The person threw their plate on the floor and we saw some staff walk past and ignore this. Some of the staff we spoke with told us they were not confident in dealing with people when they showed behaviour that challenged. We saw from records that few of the staff had training in dealing with behaviour that challenges.

Inadequate

Is the service caring?

Our findings

People's dignity and privacy were not always upheld. We heard a staff member say to a person whose first language is not English, "English, English you speak English." The person had been calling out in her first language for over an hour before the staff member attended.

We observed another person user doing up their trouser buttons with a staff member standing next to them after having been to the toilet. The staff member had not closed the door to protect the person's privacy. We observed staff describing people as, "The walkers" and "The feeders." We saw that care records referred to bedrails as "cot sides". We found a notice in a bathroom which stated, when referring to continence products, "Nappies go in bin."

We also saw that there were also no signs to show whether toilets or bathrooms were occupied or not to protect service users' privacy.

We observed staff talking about people in front of them, and other people. We heard staff talking over people to each other. We witnessed a staff member announce loudly to a lounge full of people, "Oh God, [person] is always doing that!" when a person tried to get out of an armchair. At teatime two staff members were heard talking to each other across a dining room table when assisting two people to eat. We noted some people wore stained or soiled clothing which was not changed by staff.

On the first afternoon of the inspection, a maintenance person was using some loud machinery at the back of the lounge area. We observed some people looked startled by the noise, but no staff reassured them or explained what the noise was.

We saw that a number of people were left sitting in their wheelchairs all morning, and one person was left sitting in their wheelchair facing the wall in the lounge for over an hour.

People who required pureed meals due to swallowing difficulties were assisted to eat from what resembled small children's coloured plastic bowls. These examples showed us that people's dignity was not being upheld by the service. There was one large lounge, and nowhere that people could speak in private should they wish to.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who were able to communicate verbally told us the home was caring. A person said, "Staff are very good. They are gentle." Another person said, when referring to one of the staff, "[Staff member's name] is a good person. They put the television on for me." A relative added, "Staff are good to [person's name]." When visitors arrived to see their relatives, they appeared to be at ease, and were known to staff. Staff we spoke with mainly seemed caring when talking about people they supported. We observed the cook talking kindly to a person who was celebrating their birthday. The cook offered to bake a birthday cake. Some

external professionals also told us that they found some of the staff were caring.

Observations were mixed. We saw three staff interacting well with people in a caring manner. Some people received less attention from staff, despite clearly having high levels of need. We saw a person being helped to change position. Staff did not speak to the person or explain what they were doing whilst supporting the person.

People were not always supported to express their views or have a say in how their care was planned or delivered. People and their families had not signed their care plans. This is important as signing a care plan can show that people were involved and had their wishes followed.

The care plans we looked at were not always up to date, and did not always therefore state what support a person may need. For example, the care plans for a person did not provide staff with sufficient information to be able to communicate effectively with the person. The communication care plan stated that the person was unable to communicate their needs. The care plan did not provide information on whether any communication aids could be used to support communication, or whether to use the person's first language when communicating.

The care plans for another person had not ensured the person's preferences and needs were met. We found that information in the care plan was not accurate. The person's communication care plan stated that they spoke in Polish and the person was described as "Polish." Later in the care records we saw that a list of words in Ukrainian had been provided by relatives and the person was described as Ukrainian. This meant there was a risk of this person receiving care that was not appropriate to their needs.

People's records were stored in the main office, and were therefore kept confidential.

Inadequate

Is the service responsive?

Our findings

During our inspection we reviewed the care plans of eight people to determine whether their care and treatment was appropriate, met their needs and reflected their preferences.

We saw that there were not enough staff to supervise service users at risk and respond promptly to service users requesting assistance. We observed a person whose relative had said tended to speak in her first language crying in the dining room with food down their clothing. The person was not attended to for ten minutes even though they were clearly distressed.

A person's care plan stated that they could become distressed and staff could hold their hands to reassure them. We observed this person becoming distressed on a number of occasions during the inspection when staff were nearby. No reassurance was provided by staff. Staff told us that they did not go to the person as they felt it made the person worse. Staff were not working in line with a clearly set out method of reassurance in the care plan to respond to the person's distress.

We saw a person who cried out throughout the day and no staff were available to spend time to reassure them. We observed another person in the lounge asked a staff member for a drink and this person only received the drink 42 minutes later.

We saw another person in the lounge ask for their wheelchair to be turned round three times but no staff were available to respond to them. We asked the registered manager to respond to a person in the lounge who was asking to go to the toilet, as no staff were available to respond to this person.

We observed two people who both needed support were trying to get up at the same time and only one staff member was available. A member of staff who was off duty but had come in for other business had to intervene or otherwise, one of the people could have fallen.

We also saw that there were no staff available to respond to a continuous alarm bell which sounded our inspector accompanied a staff member to investigate. All staff we spoke with told us there were not enough staff on duty.

Four people were left in wheelchairs all morning. Most wheelchairs are not meant to be used to sit in for long periods. We were told that staff had left people in their wheelchairs as they were due to go to the hairdressers. This showed a task centred approach to care, as people were left in their wheelchairs for the benefit of staff, rather than considering what was best for each person. We saw that a person was left sitting in their wheelchair facing the wall in the lounge for over an hour.

Throughout our inspection we observed a number of people, mainly who were unable to ask for help verbally, who appeared distressed. Staff did not respond in acceptable timescales to these people.

These examples demonstrated that the service failed to ensure that people's care and treatment was

appropriate, met their needs and reflected their preferences.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that there was a lack of meaningful activities during our inspection. A person said, "The days come and the days go." Another person described their days as, "Miserable, but what can I do?" In the morning one of the televisions was switched on, with a message on the screen stating it needed re-tuning. This remained so until after lunchtime when a staff member finally resolved the issue. There was no evidence of any books or newspapers. Notices in the reception area described a range of activities every day, but the only observed activity was a couple of staff trying to encourage some people to sing.

There was no dedicated activity coordinator at the service, but the cook told us she sometimes did activities in the afternoons. Activities that were written on the activity plan did not take personal preferences into account, nor were the activities suitable or stimulating for people living with dementia. People told us a weekly visit took place by a lay minister from the nearby Catholic church for those of this faith. A person's relative told us would arrange visit from a chaplain from a non-English speaking Catholic community for their relative. We found no other evidence of spiritual needs for other faiths.

In relation to managing complaints, some people we spoke with were unaware of the complaint process. A relative told us, "If I had something to say, I'd say it and it would be listened to." Staff told us if someone made a complaint, "You follow it through, document it, We haven't got any complaints." The registered manager told us the service hoped to deal with complaints within 24 hours, and that in the absence of the registered manager, the nurse in charge dealt with the complaint. We were aware a family had made a complaint in January 2016, but this had not been documented nor any actions taken, as the registered manager told us they had not been present at the home at the time. Another complaint had been made by a relative about their relation being left for long periods in a wheelchair and having soiled clothing on. The registered manager said she had offered to hold a meeting with the relatives, but told us they were happy with the home's response, so the meeting did not take place.

The provider's complaints policy did not contain a response time for dealing with a complaint, and did not contain any details to state that people could refer their complaints to other bodies like the local authority or Local Government Ombudsman if dissatisfied with the response they received. We looked at the booklet given to new people to the service, and this did not include information on how to make a complaint. The complaints policy that was displayed in the main reception was in a format that would not be accessible to all people living in the home.

These were breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Some of the people we spoke with did not know who the registered manager was, but two people were able to name the registered manager, and told us they would approach the registered manager if there was a problem. One staff member we spoke with said of the registered manager, "She's alright. If I had a problem I would approach her." The registered manager told us, "We give out questionnaires every year and I have an open door policy." However, the registered manager was not a visible presence during our visit.

There were insufficient audit processes in place to ensure that people received a high quality and safe service from the staff at the home. We asked the registered manager what auditing processes they used to assure themselves that people lived in a safe environment and received the appropriate level care for their needs. We were shown copies of audits for preventing the spread of infection and bedrooms and care plan audits. However these had not been completed since June and October 2014. The registered manager told us they had completed some other care plan audits, however they were unaware of how many, and could not provide sufficient evidence to support this. The registered manager also confirmed the other audits had not been completed since 2014.

The nominated individual told us they were aware that a lack of auditing processes at the home was an issue and showed us a newly formed monthly auditing process. We saw the records for January 2016; however, only 12 of the 56 tasks had been completed. This demonstrated that there was not an effective auditing system at the location, which placed people at risk.

We saw copies of people's satisfaction surveys, carried out in 2015. Many of the survey responses had been completed by care staff, with little evidence that it was people's direct experience.

We reviewed the registered manager's process for investigating and reviewing accidents and incidents that occurred at the home. We saw they recorded when a person had fallen, whether there had been an allegation of abuse or whether they were at risk of developing a pressure sore. On the majority of these forms the registered manager or other appropriate person made recommendations to staff on how to reduce the risk of reoccurrence. However, records showed the registered manager did not always record that they had checked to see whether staff had implemented their recommendations or whether they had been effective.

There was a lack of competency checks carried out at the service to check if staff had understood any training and were following through on information they had learnt. Staff we spoke with were unable to say when or if they had received competency checks.

An internal 'Annual Quality Assessment' had been completed on in September 2015 and a score of nearly 99% been achieved. This covered staffing, quality of care, care and medicines, health and safety, catering, domestic and laundry, and the environment. This was not reflective of our findings and it was not clear how this score had been generated.

We saw records that there had been a whistle-blower at the service last August. A whistle-blower is someone who reports certain types of wrong doing they have seen in the course of their work, about which it is in the public interest to disclose. The whistle-blower had raised serious concerns about the treatment of some of the people living at the service. The local authority safeguarding team had investigated but found no evidence to back the allegations.

We checked records of meetings held for people and their families. We saw that one meeting had taken place in February of this year, but this was the only meeting recorded. The registered manager told us that meetings were not held before because, "No one had turned up for them." Meetings are important as they provide a forum for people and their relatives to express their views, concerns and opinions.

We saw the records from a staff meeting held in 25 November 2015. The notes of that meeting stated, "Safeguarding can be avoided if staff are more careful, as they [inspectors] pick up on the smallest things like drag lifting, hoisting, cushions, leaving residents in wheelchairs with or without footplates." In relation to people living with dementia, the meeting notes stated, "It's our duty to provide care regardless of who they are. Use your dementia training and do not take insults from the residents." This shows that appropriate guidance to staff to enable them to improve the quality and safety of the service was not provided by management.

This evidence demonstrates that people were not protected against the risks associated with not having an effective system or process in place to assess, monitor and improve the quality and safety of the services provided.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a record of refurbishment plans that the provider had in place to update the home and make improvements. This gave details of what areas were being targeted each month. However we saw records showed that that no works had been done from April 2015 to the time of inspection.

We saw that all conditions of registration with the CQC were being met, however statutory notifications had not always been sent to the CQC when required.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

The provider's statement of purpose that we saw stated, 'The core values of Beechdale House Care Home focus upon safety, choice and rights, confidentiality, underpinned by privacy, dignity, independence, wellbeing and fulfillment.' Based on our observations, we did not find that the provider was meeting these values. We did not observe a happy or calm atmosphere at the home and staff morale did not seem good.