Beeches Care Homes Limited

Beeches Care Home

Inspection report

Darnhall Crescent, Bilborough, Nottingham, NG8 4QA
0115 929 4483

Date of inspection visit: 7 October 2014
Date of publication: 21/01/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 7 October 2014. Beeches Care Home provides accommodation and personal care for up to 43 people. On the day of our inspection 32 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present during this inspection.

At our inspection in January 2014 we found that the care provider was not meeting the legal requirements in respect of people's care planning, safeguarding people who use services from abuse, management of medicines and supporting staff. We took enforcement action against the provider regarding care and welfare. We followed this up during an inspection in April 2014 and found some improvements had been made.

During this inspection we found that sufficient improvements had not been made in respect of safeguarding people from abuse and the care and welfare of people who use services. Sufficient improvements had been made in respect of management of medicines and supporting staff.

Summary of findings

People were not kept safe because there was not always an appropriate response to incidents when they occurred.

People received their medication when they needed it and medication was stored and recorded appropriately. There were sufficient numbers of staff to meet people's needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS is part of the MCA, which is in place to protect people who lack capacity to make certain decisions because of illness or disability. DOLS protects the rights of such people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

People's rights to make decisions had not always respected because assessments of people's capacity to make decisions had not always been carried out. Although there was no one living at the service who was currently subject to a DoLS, the manager was aware of their responsibility in relation to this and had systems in place ready to follow the requirements of the DoLS.

Staff had the knowledge and skills to care for people. People's health care needs were met and appropriate referrals were made to health care professionals for additional support when needed.

People had access to sufficient quantities of food and drink which they enjoyed.

People were not always involved in planning their care and making decisions. People told the staff treated them with dignity and respect and were supported to maintain any hobbies and interests they had.

People did not always receive support in line with their care plan. People found the acting manager and deputy manager approachable and they would have no hesitation in making a complaint.

People were aware of different ways they could provide feedback about the service. However, the systems in place to monitor the quality of the service were inconsistent and did not always result in improvements.

We had not received the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 always safe.

People were not protected from the risk of abuse because they were not protected from the impact of other people's behaviour.

People received their medication as prescribed and medicines were administered, stored and recorded appropriately.

Requires Improvement

Is the service effective?
The service was not always effective.

People's right to make decisions was not respected because there was inconsistent use of the Mental Capacity Act (2005).

People were cared for by staff who received appropriate training and supervision.

People had access to sufficient food and drink.

Requires Improvement

Is the service caring?
The service was not always caring.

People were not always involved in their care planning and making decisions about their care.

Staff cared for people in a kind and considerate manner.

People's privacy and dignity was respected.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People did not always receive care and support in line with their care plan.

People found the management approachable and they would have no hesitation in making a complaint.

Requires Improvement

Is the service well-led?
The service was not always well led.

People were at risk of not receiving a quality service because the systems to bring about improvements were not effective.

We had not received the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

There were meetings for people and staff to provide feedback about the quality of the service.

Requires Improvement

Beeches 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 7 October 2014 and was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

Before the inspection, we asked the provider to complete 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.

During our inspection we spoke with seven people who were using the service, one visitor, three members of care staff, the acting manager and the deputy manager. The registered manager was not present during our inspection. We also observed the way staff cared for service users in the communal areas of the building using a recognised tool called the Short Observational Framework for Inspection (SOFI). SOFI is used to enable an understanding of the experiences of people who were not able to communicate with us. We carried out a tour of the building and looked at the care plans of five people and any associated daily records. We looked at three staff files as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2014 there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risk of abuse because information about incidents had not been shared with the local authority when required. We saw that there had not been sufficient improvement at this inspection to prevent similar incidents happening again therefore the provider remained in breach of Regulation 11.

The people we spoke with offered positive comments and told us they felt safe at the care home. One person said, "I feel safe here, I've no concerns." Another person said, "Yes everything is fine, there is always someone I can talk to." One relative told us that they felt their loved one was safe living at the home.

The provider had ensured staff were trained to recognise and respond to abuse, however we found that people were not protected from incidents of physical abuse. We found that no action had been taken to keep people safe when incidents of physical abuse happened between people who used the service. We found no guidance in their care plan and there was no report made to the local authority for consideration under safeguarding procedures. We saw four people had been injured as result of other people's behaviour. We could not identify any action being taken to minimise the risks to people or respond when they had been injured. People did not have a plan in place to protect them and minimise the chance of them being harmed by another person's behaviour.

This meant there had been a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

We also found a breach of Regulation 13 at our inspection in January 2014. Medication was not stored and recorded appropriately. We found at this inspection there had been improvements in the recording and storage and this regulation was met.

People told us they were happy with the way in which their medication was being managed. One person said, "I manage some of my own medication and the staff look after the rest. It works perfectly." Another person said, "It's always on time, I know what I should be getting and it's been fine so far." We observed medication administration being carried out in the correct manner and medication was kept securely.

People did not raise any concerns about the recruitment of new staff. The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

People told us that they felt there were enough staff to meet their needs, although a relative we spoke with felt there could sometimes be delayed responses to people's requests. During our inspection we observed there were sufficient staff to meet people's needs. The provider had systems in place to ensure there were sufficient staff to meet the needs of the people using the service. The acting manager and deputy manager told us they had assessed people's needs and as a result, staffing levels were being increased to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

At our inspection in January 2014 there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff were not provided with all the necessary training and did not receive regular supervision. During this visit we saw action had been taken to make the required improvements.

All of the people we spoke with told us they felt well cared for by staff and that they were competent. One person said, "The staff are really great, they know what they're doing."

All of the staff we spoke with told us they received all of the training and support they needed to carry out their duties safely. One member of staff told us they had been supported to undertake a vocational care qualification which helped them further enhance their knowledge about providing effective care. In total, sixteen staff had obtained a vocational care qualification.

All staff told us that they felt supported through the supervision process and that this had improved in recent months. The acting manager met regularly with staff to discuss their performance and plan any training they needed. This helped the acting manager to ensure people received effective care from staff who had the required skills and competencies. Staff confirmed they were receiving training to meet the needs of the people they supported.

People's rights to make decisions about their care was not always supported in accordance with the Mental Capacity Act 2005 (MCA). Staff told us they had received training regarding the MCA. Three of the five care plans we looked at did not reflect they had followed the MCA code of practice to assess people's ability to make their own decisions or to act in their best interests when they did not have the capacity to make their own decisions. For example, one person had been deemed not to have the capacity to manage their own medication. No assessment of their capacity to make this decision had been carried out. This person's right to be supported to make decisions for themselves had not been respected.

This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

People told us they were free to come and go and we observed there were no restrictions on people's freedom. The acting manager and deputy manager told us they were aware of Deprivation of Liberty Safeguards (DoLs) and had appropriate procedures in place to ensure people's freedom was not restricted unlawfully.

People we spoke with told us they enjoyed the food and that they were given plenty to eat and drink. One person said, "The food is fantastic, all cooked fresh." Another person said, "The quantities are big and we can always ask for more." We were also told, "If I don't like what is on the menu they will make something different. The cook knows me so well anyway so I never go hungry."

We saw that people had a choice of food and drinks offered to them and we observed people's requests for specific drinks were responded to by staff. We saw that people enjoyed their lunch and they were provided with an alternative choice where required. Specialised diets were catered for, such as soft foods and low sugar alternatives.

People told us that they had access to the relevant healthcare professionals when required. One person said, "I am seeing my doctor again today because I haven't been too good lately." Staff were supporting people to access healthcare services. We found the manager ensured they used recognised assessment tools when assessing people's health. For example, they assessed the risk of people developing a pressure ulcer and put in place the support required. The acting manager ensured all contacts with external healthcare professionals were recorded appropriately.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy living in the home. Each person told us that they were treated well and the staff were caring and compassionate. One person said, "I am very happy here, it's a wonderful place." Another person told us, "They really do care here, I wouldn't want to go anywhere else." We spoke with a relative who told us that their loved one was well cared for.

We observed occasions when staff interacted with people in a kind and caring manner. We saw staff respond to choices people made and staff explained what they were going to do prior to giving people care or support. For example, one person had become disorientated when trying to find a toilet to use. The staff member supported the person in a kind yet discreet manner to locate the nearest toilet. We observed that staff knocked on people's bedroom doors and waited for permission before entering. However people using the service did not always experience a consistently caring approach. There were occasions when staff did not interact with people in a kind and caring manner. For example, during the lunch period we saw staff placing meals in front of people without communicating with them.

We asked people if they were able to be involved in making decisions and planning their own care. One person told us that they were able to make all of their own decisions and that staff respected their decisions. Six of the people we spoke with told us that they were not involved in planning their care and had not seen their care plan. Staff told us that they involved people in making day to day decisions about their care.

Caring relationships were not being fully developed with people through consulting with them about things that mattered to them, such as their preferences in how they received care and support. For example, one person had been living in the home for two months and staff had written a care plan for them. This person had not been consulted about the content of the care plan and this person told us they had not seen their care plan. Staff could not be sure they were supporting this person in their preferred way because they had not been involved in planning their care and providing consent.

People told us they were treated with dignity and respect by staff. One person said, "Yes the staff are so kind." Another person told us, "All the staff are good, they let me do what I can for myself."

We observed that the layout of the building allowed people to have privacy in their own bedroom or in smaller, quiet lounges. Equipment was provided to support people to maintain their independence such as grab rails, raised toilet seats and assisted bathing. People could receive visitors at any time of the day and privacy was respected by staff.

Requires Improvement

Is the service responsive?

Our findings

At our inspections in January 2014 and April 2014 there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because care was not always delivered in line with people's care plans and care plans did not always contain up to date information. We saw there had not been sufficient improvements at this inspection.

People were not always provided with the care they needed. One person's needs were described as requiring support to minimise the risk of choking. We observed that this person was not supported during the mealtime. Their care plan also identified that they were at risk of falling and required a staff member to be with them whilst they were walking. We observed this person walking around the home without the assessed level of support.

People were at risk of receiving care that was not responsive to their needs. Care plans did not always contain up to date information about people's changing needs. Staff told us they sometimes found it difficult to keep care plans up to date.

This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

People were provided with choices about how they wished to spend their time. For example, entertainment was provided during the morning and staff asked people if they wished to participate. Staff respected people's choices and some people chose not to participate. One person told us, "I much prefer to do my own thing, staff respect that."

People told us they were happy with the activities taking place and were consulted about the activities they wanted to take part in. One person said, "A group of us go down to the local market on a Thursday." Another person told us, "I go to the pub sometimes as well as the local shops."

People who preferred not to join in the group entertainment were supported to maintain their own individual interests and hobbies. A member of staff told us that they read poetry to a person who enjoyed this. One person showed us that they had recently had their nails painted and told us they enjoyed this. The staff we spoke with were able to tell us about how different people preferred to be supported. Staff were aware of different people's likes and dislikes and how this impacted on the provision of care.

We found there were meaningful activities for each individual. These were planned to take place every day both inside and outside of the home to protect people from social isolation. People's spiritual needs were supported by visiting their preferred church or by the local minister providing a home visit. The staff responded to choices that people made about how they wished to spend their time.

The decoration of the care home was designed to assist people who may find it difficult to navigate around the building. The corridors were colour coded and had murals on the walls. Communal bathrooms and toilets had pictures on the door to assist people in understanding what the room was for.

People told us they felt would feel comfortable raising concerns or making a complaint. One person said, "I've never had to, but I would have no hesitation in doing so. I think it would be taken seriously." Another person said, "The management are very approachable, I wouldn't be concerned about making a complaint." We observed people were comfortable speaking with the acting manager. The provider made sure people were given information about how to make a complaint. The information was provided in a suitable format to meet the needs of the people who used the service.

Requires Improvement

Is the service well-led?

Our findings

We were told that the registered manager would be resigning their position. A new acting manager and the deputy manager told us that they would be applying to jointly register as manager for Beeches Care Home.

The quality systems in place did not drive continuous improvement in the service and did not ensure that people were receiving a consistent level of care. We saw that audits had been completed to check the quality of care plans but information from incidents was not being used to update care plans and ensure that risks were being managed properly.

People told us they thought the home was clean and hygienic, however we found the audit system for infection control was not effective and there was a potential risk to people who used the service We observed potential infection control risks such as stained bedding, stained commodes and sticky armchairs containing food debris. We also saw records showed that guidance from an external specialist about monitoring a person's fluid intake was not acted on. The system for auditing the quality of people's care had not highlighted this.

There was no accountability to respond to things that happened such as incidents and accidents. There had been no analysis of incident records in order to detect patterns in the incidents that had happened and put in place procedures to minimise any future risk to people who used the service.

This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

Records were not always accessible in a timely manner. For example we asked for information about complaints and we were told that this information could not be located. Prior to our inspection, the provider told us that they had received 15 complaints over the past 12 months. However, on the day of our inspection staff were unable to locate the complaints folder. This meant we could not assess whether complaints had been properly documented, investigated and resolved in a timely manner.

This meant there had been a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

Records we looked at showed that CQC had not received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service. We had not been notified of the deaths of several people and safeguarding investigations which had been carried out by the local authority. The acting manager sent in these notifications following our inspection.

This meant there had been a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 and the action we have asked the provider to take can be found at the back of this report.

People we spoke with told us the acting manager and deputy manager were approachable. One person said, "They've not been here for very long but they seem to want to listen to us." Another person said, "I see them around the home, they seem very nice." During our inspection we saw that the acting manager and deputy manager were visible in the communal areas of the home and spent time talking to people who used the service, visitors and staff.

People were encouraged to communicate their experience of the care they received and the things that mattered to them. There were regular meetings where people could give their opinion about the quality of the service and make suggestions for improving it. We saw that people were encouraged to attend and contribute to these meetings and that their suggestions had been listened to and acted on where possible.

Staff told us they felt there was a positive and open culture in the home and they were being supported by the acting manager and deputy manager. The acting manager was encouraging staff to be open and communicate their views on the quality of the service. There were regular staff meetings and we saw that staff were able to contribute their views during these meetings.

The acting manager and deputy manager recognised where the service needed to improve. They told us they were aware of areas for improvement we have identified in this report. In the days following our inspection visit the acting manager provided information about how they had made improvements based on our inspection findings.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Service users were not protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them by means of the maintenance of an accurate record of each service user. Records relating to complaints received could not be located promptly when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Service users, and others who may be at risk, were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided.

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not effectively operate systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The registered person did not notify the Commission of the death of a service user whilst services were being provided in the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission of an incident of abuse or allegation of abuse in relation to a service user.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

The enforcement action we took:
We issued a warning notice and told the provider to make improvements by 4 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not have suitable arrangements in place to ensure that service users are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and by responding appropriately to any allegation of abuse.

The enforcement action we took:
We issued a warning notice and told the provider to make improvements by 4 December 2014.