Beachcroft Homes Limited

Beechcroft House Residential Home

Inspection report

St Johns Road
Rowley Park
Stafford
Staffordshire
ST17 9BA

Tel: 01785251973

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Ratings

Overall rating for this service	Requires Improvement

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**

Summary of findings

Overall summary

The inspection took place on the 29 February 2016 and was unannounced. At our previous inspection in 2013 there were no concerns identified in the areas we inspected.

Beechcroft Residential Home provided accommodation and personal care to up to 25 people. There were 21 people using the service at the time of the inspection.

There was a registered manager in post. 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 fully safeguarded from abuse as although staff knew how to report abuse internally they did not know the safeguarding procedures if they suspected institutional abuse.

Action was not always taken to minimise the risk to people when a risk of harm had been identified following an incident or a change in people's needs.

Staffing levels had not been assessed based on the individual needs of people. Staff felt there was not enough staff to keep people safe during the evening.

People's medicines were not managed safely. Some medication was unaccounted for and safe systems for administering medicines were not being followed.

The guidance of the Mental Capacity Act 2005 (MCA) was not being followed when people's mental capacity had changed to ensure they were supported to consent to their care and support.

People's dignity was not always supported and maintained.

People, liked being at the service. However, restrictions were in place which did not demonstrate that people's individual preferences were being respected.

The systems the provider had in place to improve the quality of the service were ineffective as people's views were not listened to or acted upon.

People liked the food and their nutritional needs were met. People received support from a range of health care professionals when they needed it.

Staff were supported by the registered manager and received training to be able to fulfil their role effectively.

Safe recruitment procedures had been followed to ensure they were fit to work with people prior to employing new staff.

We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. People were at risk due to staff not knowing the safeguarding procedures. Risks of harm to people were not always minimised to ensure they were kept safe following incidents. Staffing levels had not been set based on people's individual needs. Medication systems were not safe.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the MCA were not being followed to ensure that all people consented to their care. Staff received training and support to be effective in their roles. People's nutritional needs were met and they received health care support when they needed it.

Is the service caring?

Requires Improvement

The service was not consistently caring. People choices were not always respected. People were not always treated with dignity and respect. People's right to privacy was not always respected.

Is the service responsive?

Requires Improvement

The service was not responsive. People's complaints were not listened or acted upon and their individual preferences were not respected.
People had the opportunity to be involved in activities and hobbies if they chose to.

Is the service well-led?

Requires Improvement

The service was not well led. Staff felt supported by the registered manager, however not by the provider. People's views and complaints about their care were not listened to and acted upon. A plan for continuous improvement was not in place and restrictions to people's human rights were evident.

Beechcroft House Residential 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 was 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 29 February 2016 and was unannounced.

The inspection was undertaken by two inspectors.

We reviewed the information we held about the service. This included safeguarding concerns, previous inspection reports and notifications of significant events that the registered manager had sent us. These are notifications about serious incidents that the provider is required to send to us by law.

We spoke with five people who used the service and sat in the communal areas with people to observe their care. We spoke with two relatives, four care staff, the cook, the registered manager and a visiting health professional.

We looked at the care records for four people who used the service and the systems the provider had in place to monitor the service. We looked at two staff recruitment files and the staff rosters. We checked people's medicines and medication administration records. We did this to check the effectiveness of the systems the provider had in place to maintain and improve the quality of service being delivered.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at the service. One person told us: "Oh yes, very safe, I wouldn't be here if I wasn't". Staff we spoke with all told us that if they suspected someone had been abused they would report it to a senior member of staff. However, three members of staff did not know the whistleblowing procedure and who to report suspected abuse to if they thought the allegation would not be managed safely by the manager or senior. This meant that people were at risk as staff were not aware of how to report abuse to the external agencies who investigate abuse allegations.

We saw records that one person was often found in other people's rooms at night and had recently been found on the floor in a state of undress in the middle of the night. The registered manager told us that this person had been assessed as requiring more support than the service was able to give and the person's social worker was looking for a more suitable placement. However nothing had been put in place to minimise the risk to this person whilst a new service was found and the person was still wandering at night unsupervised and entering people's rooms. This meant that this person and others were at risk as adequate control measures were not in place to prevent further incidents.

People told us they did not have to wait long for staff to support them. One person told us: "If I ring my call bell and the staff are slightly delayed they will always apologise, I never have to wait too long". However staff we spoke with told us that there had been four new people recently admitted into the service and although the staffing had increased by one during the morning, they felt that more staff were needed to support people in the evening. They told us if the senior carer was busy then then there were only two staff available to support people and a high proportion of people required two staff to support them to mobilise. One staff member told us: "The trouble is everyone seems to want to go to bed or need support at the same time and some people just have to wait, we are just spread too thin". The registered manager told us that the provider did not have a tool to allocate the staffing based on the needs of the people who used the service.

We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment, induction and training of staff. We saw that pre-employment checks had taken place and they had received a meaningful induction prior to starting work at the service.

We looked to see how people's medicines were managed and saw that they were stored safely and administered by trained staff. However we found that two people had some medicines that were missing and unaccounted for. Records stated that these people should have a certain amount of medicines available but the records did not correspond with the balance. We saw on another person's medicine record that staff had crossed out some entries and the records were not clear as to whether the person had their medication or not. The senior staff and registered manager agreed that the crossed out entries made it unclear and caused confusion for the next member of staff administering the person's medication. They were unable to tell us if these people had taken this medicine or not. We saw that senior staff were signing to say they had applied topical creams and administered the medication to the person when actually the care staff were completing this. At mealtimes the senior staff passed the medicines to the care staff to give to the person and topical creams were applied by care staff during personal care. The meant that the person

signing for the medication could not be sure that the medicine or cream had actually been received as instructed on the prescription. People's individual medication records would have benefitted from photographic identification of the person to support staff to be sure that they were administering the right medication to the right person.

Other people's risks were assessed and we saw that people had the equipment they needed to keep them safe such as walking frames and pressure cushions to prevent damage to people's skin whilst sitting. We saw staff moved the equipment when the person moved seats ensuring they were sitting on the cushion at all times. Some people required support to stand. We saw staff used the equipment the person had been assessed as requiring in a safe manner.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager told us that most people who used the service had capacity to consent to their care and support. However we were told that at least one person's needs had changed and they were showing signs of confusion. The registered manager told us that this person made allegations against the staff due to their confusion. This person had bed rails on their bed which had been put on to prevent them from falling out of bed at night. This person's mental capacity had not been assessed and the staff and registered manager were making assumptions that the allegations being made were due to their confusion. This meant that the registered manager and staff did not understand the principles of the MCA by ensuring that people's capacity to make decisions and complaints about their care were taken seriously.

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. No one at the service had a DoLS authorisation in place and the registered manager told us that no one was being restricted of their liberty so no referrals had been made to the local authority. However we observed two people required support with decision making due to their mental capacity. One person who lacked capacity whereabouts was being monitored frequently due to them wandering at night. A member of staff told us that if some people attempted to leave the service they would be persuaded to come back in as they were deemed not to be safe to go out alone. This meant that the principles of the MCA were not being followed to ensure that some people were not being restricted of their liberty without lawful permission.

These issues constitute a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that were supported and trained to fulfil their roles. Staff all told us that they had received regular training and this was on going with regular updates. Staff had regular one to one meetings with the registered manager to discuss their performance and identify any further training they may require. When areas of weaknesses were identified the registered manager took the appropriate action to ensure that staff practises were supported to improve.

All of the people we spoke with told us they liked the food. One person told us: "We would never go hungry and the food is lovely". People had three choices of main meals and desserts and we saw that the lunch time meal included fresh vegetables and meat from the local butchers. Mid-morning everyone was offered fresh fruit cocktail which we saw most people enjoying. We saw that one person who had been recently admitted into the service following an illness and stay in hospital had gained weight. They told us: "I've never eaten so much, three good meals a day and plenty of snacks in between". Drinks of people's choice were offered frequently throughout the day and we saw that if someone had forgotten to drink or fell asleep that staff

gently reminded people to drink it. Fresh cups of tea and juice were offered if they had gone cold or been sitting too long.

People were supported to attend health care appointments with professionals such as their GP, opticians, dentists and community nurses. When people became unwell the appropriate health advice was sought. A visiting health professional told us they had no concerns about the care people received and they thought that the staff although busy did the best they could for people.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke to told us they were happy at the service, although several people told us it could be even better if there were no restrictions on what they could or couldn't do. Two people told us that they had requested to sit in the lounge at tea time and eat their tea as one of their favourite TV programmes was on. They had been refused and told that they had to go to the dining room for all meals. One of these people told us: "It's lovely and homely here, but they take it from a home to an institution with these rules". We spoke to the registered manager about this who told us: "They eat their breakfast and lunch in the dining room so why not their tea". They had not recognised and respected people's wishes to be able to watch a favourite programme whilst eating their tea. All of the staff we spoke with told us that the provider had said that people had to use the dining room for meals to prevent spillages on the lounge carpets.

Two other people told us: "You can't get up before 6.00am". One person told us: "I am an early riser and would get up earlier but I can't". Staff we spoke with told us that night staff would support people to get up and dressed if they wanted to or if they had continence needs that needed meeting and then people would have to sit in their chairs in their bedrooms until the day staff came on duty. The registered manager told us that they thought that people couldn't get up before 6.00am due to health and safety issues and they had been directed by us (CQC) in the past that this was the case. At a previous inspection in 2012 we had noted that people were being made to get up between 5.00am and 6.00am to help the day staff coming on duty.

Several people told us that they had to be downstairs for breakfast between 8.00 and 8.30am every morning. We asked the staff and registered manager if this was the case and they told us it was. Staff told us that people would be taken their breakfast in bed if they were unwell otherwise people had to come down for breakfast at the allocated times. These issues showed that the provider and registered manager did not understand and respect the need for people to be able to make their own choices about their care and support.

We saw records that showed that one person had experienced an upset stomach which meant they had to go to the toilet quickly. This person required support from staff to use the toilet facilities as staff would need to support them with their walking frame and walk with the person to the toilet. It was recorded that following the first time of needing the toilet they had asked to be supported again. Staff had responded by telling the person that all of the toilets were full so they would have wait. The person had become unsettled and the staff recorded 'they became rude to staff' and were incontinent. Staff had not recognised this person's need to access the toilet facilities quickly and to find other arrangements. When they had become distressed by this they were called 'rude'. This showed that people were not always treated with dignity and respect at all times.

People had their own bedrooms. One person told us: "Staff don't always knock before coming in, but if I've called the call bell I suppose they assume it's ok for them to come in".

These issues constitute a breach of Regulation 10 of The Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Relatives and friends were free to visit at any time and we saw frequent visitors throughout the day. The relatives we spoke with told us that they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

Restrictions that had been implemented in the service prevented people from receiving care that was personalised and that met their individual preferences. Two people told us that their relatives had written complaints to the registered manager about having to access the dining room at tea time. One person told us: "I think the manager has seen the complaint but nothing has changed or been done". The registered manager told us that they thought the complaints may be in the in-tray in the office but they were unsure. We observed tea time and saw that everyone was taken through to the dining room for their tea and no one was offered the option to remain where they were. This meant that people's complaints were not respected, listened to and acted upon.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to admission into the service the registered manager assessed people's needs to ensure that they could meet them. We saw that when people's needs changed the registered manager sought advice and support from other professionals. A health professional told us: "One person needs to move on to nursing care but the staff are doing their best whilst they are waiting for another home". However this person required more support within the service to meet their needs whilst a new placement was being found as they were currently receiving care that was unsafe. No precautions or change to their care had been implemented during the interim period.

The registered manager reviewed and up dated people's care plans on a regular basis but we could not see that people themselves were involved in their reviews. Most people who used the service had capacity to be involved and agree to their care and support. Resident meetings took place and we saw they were in a tick box format with a list of questions to be asked by staff. No concerns had been identified in the records of the meetings we saw. However, it was evident that people's views were not respected due to the issues raised by people who used the service who had not been listened to when they had complained.

Relatives we spoke with told us that they were kept fully informed of their relative's well- being. One relative told us: "We visit most days and the staff let us know how they are, they are very welcoming when we come".

On the day of the inspection there were no planned activities and people sat in the lounge areas with the television on. Some people had papers to read and some people chatted between themselves. One person played scrabble with a volunteer. One person told us how they had made lanterns at Christmas and how they planned to do it again at Easter. They said: "We made the Lanterns and then the staff put them on the wall in the dining room, it was lovely to see something I had made on the wall, and I really enjoyed that." Another person told us they enjoyed a gentle exercise session that took place weekly. Two relatives told us how the staff helped people and their relatives celebrate the different seasonal occasions. They told us they decorated the rooms and held functions in which people could invite two of their relatives to attend.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, however they were not up to date and aware of the relevant legislation required to manager a care service. They were unaware of our (CQC) methodology and The Health and Social Care Act Regulations 2008 (Regulated Activities) Regulations 2014. Rules and restrictions were inhibiting people who used the service and they were not respecting people's human rights to make choices about their care. For example, people not being able to eat where they chose and not being able to get up before 6.00am.

Staff we spoke with all told us they felt supported by the registered manager and that they were approachable. However they felt that the provider was unapproachable and didn't value them. They told us that the provider had put the restrictions in place about people eating in the dining room so as not to soil the carpets. Staff told us they had individual supervision sessions with the registered manager, however they did not have regular staff meetings where they could discuss their concerns or ideas for improvement as a team.

The registered manager told us that the provider did not have a tool to assess and allocate staffing levels based on the individual needs of people who used the service. Staff we spoke with told us that the provider was not responsive when they had asked for more staff during the evening shifts and that they were struggling to meet people's needs during these times. Extra support had not been put in place to meet the person's needs who was awaiting a new placement and this person was at risk of harm due to falling.

There were annual questionnaires for people to complete about the quality of service and a complaints procedure. However the provider and registered manager had not responded when people had complained about their tea time experience and the complaints procedure had not been followed.

Systems to manage people's medicines were not safe. Some medication was unaccounted for medication and policy and procedures were not being followed in relation to administering and recording of the administration of people's medicines. The registered manager was not aware of these issues when we identified the concerns.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always supported to consent to their care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People's complaints were not listened to and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's complaints were not listened to and acted upon.