Beechdene Care Home Ltd

Beechdene Care Home

Inspection report

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Date of inspection visit:
28 November 2023
29 November 2023
06 December 2023

Date of publication:
08 February 2024

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beechdene Care Home is a residential care home. It provides support for up to 14 people. At the time of the inspection, there were 14 people using the service. The service supported people with learning disabilities.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: People were not provided with a safe, clean, or well-maintained environment. Medicines were not always supported in a safe way. Health action plan documentation was not in place to ensure people received suitable health support.

Right Care: Staff were kind to people. However, the environment did not always ensure people were provided with privacy. Staff understood how to protect people from potential abuse, but we saw management had not always referred concerns of abuse to the local authority to investigate. Staff were generally well trained, but had not received training on how to administer a person's urgent 'as needed' medicine for their health condition.

Right Culture: The provider was intending to close the home within a few months. We saw multiple aspects of the home were not well maintained. We were not assured effective leadership was in place to ensure people were supported safely. Audits were not always in place. Those audits that were in place were not always effective. This meant we were not assured people were supported by the management team in the best way.

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

Rating at last inspection
The last rating for the service under the previous provider was good, (published on 27 July 2019). This service was registered with us on 15 February 2023 and this is the first inspection under the current provider.

Why we inspected
The inspection was prompted in part due to concerns received about environmental safety and staffing levels at the care home. These concerns were received from external stakeholders and members of the public. A decision was made for us to inspect and examine those risks. We initially decided to inspect just the key questions of safe and well led. However, due to concerns seen during the inspection, we assessed all areas at the service.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to safety, safeguarding people safe from abuse, and the governance of the care home. Please see the action we have told the provider to take at the end of this report.

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led Details are in our well led findings below.	**Inadequate**

Beechdene Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Beechdene Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Beechdene Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received in our 'share your experience' forms. These are online records, which members of the public can share their experiences of using, working at or visiting the care home. We contacted external stakeholders (like the local authority) to gather their feedback on the service.

We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 2 relatives. We spoke with a visiting health professional. We also spoke to 5 members of staff, including the manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included the relevant parts of 4 people's care and medication records. We looked at 3 staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

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

The last rating for the service under the previous provider was good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Alleged abuse was not referred to the Local Authority to investigate. Staff had recorded a person harming another person living at the service 3 times in a month. These incidents had not been referred to the local authority safeguarding team to investigate. The inspector asked for these incidents to be referred, however only 1 of the 3 incidents was then referred to the local authority safeguarding team. This poor referral process would impact an independent investigation by the local authority. Before the inspection, the local authority informed us the provider had also not referred other safeguarding incidents in a timely way.
- The provider had failed to ensure care plans were updated following these incidents. This meant staff did not have clear guidance about how to respond to future incidents or reduce the risk of reoccurrence
- Staff had received safeguarding training and told us what action they would take if they were concerned about abuse. However, due to incidents not being referred to the local authority safeguarding team; we were not assured this safeguarding training was effective.

The provider failed to ensure people were safe from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe from abuse at the care home.

Assessing risk, safety monitoring and management

- The environment was not safe. People were at risk of scalding from hot shower water, burning themselves on hot uncovered radiators and illness from food being stored in fridges that were too warm.
- People were also at risk of falling from open windows. Multiple windows in the property could open wide enough for people to climb out or fall from. This could result in serious injury. We raised this with the provider and some windows were restricted from opening fully. However, after this refurbishment we found 1 window still opened wide and another was not restricted enough for current national standards.
- Care plans and risk assessments did not provide staff with enough guidance on how to support people safely. 1 person was at risk of sudden deteriorations in their health condition. The care plan did not give clear details on symptoms to look out for, or action to take. This risked the person's ill health not being responded to promptly and safely by staff. We raised this concern with the manager and action was taken to improve the care plan

Preventing and controlling infection

- People were not kept safe from contracting Legionnaires disease. A site risk assessment had been completed, which identified the service was at high risk of developing legionella bacteria in the water system. Legionella bacteria can be inhaled in droplets of water and result in serious ill health from

legionnaires disease. The risk assessment required environmental refurbishments to occur within one month, these refurbishments had not occurred and were not planned in a timely way. Staff had not been provided with details on how to spot the signs of legionnaires disease in case people did develop the symptoms. Overall, there was a risk legionella would build up in the water system and cause ill health. There was a further risk care staff would not recognise the resulting symptoms of legionnaires disease.
● The care home was unclean. Bathroom light pull cords were made of string and were visibly dirty. This meant people could pull the light cord and get bacteria on their hands.
● Multiple bathroom sink taps did not work and did not have hand soap or drying facilities available. The provider advised this is because people could bring their own soap and towels to the bathroom. This does not allow for visitors to effectively clean their hands after using the toilet. We saw a bathroom was cleaned, but the staff member did not replace missing soap, missing hand towels or a used and soiled bathmat.

Visiting in care homes
We were assured people could have visitors in the care home. However, due to the cleanliness of the home we were not assured visitors would be safe from infection transmission.

Learning lessons when things go wrong
● Staff and the manager told us a person experienced daily episodes of agitation. However, when we reviewed records we saw limited incidents had been recorded. It is important to record when a person is distressed, so themes and triggers can be monitored, and staff can be given clear guidance on how to support the person safely.
● On the first inspection day, we expressed multiple concerns to the manager of the service verbally and by email. When we returned, we found limited action had been taken. We again expressed concerns and some further action was then taken to improve the safety of the service. We were not assured the management team would take timely and effective action when concerns were raised.
● Before the inspection, the local authority told us some concerns about the service. They found it was not clearly documented when people received 1 to 1 staff support. Records showed this concern had been raised in a team meeting, but we found this was still an issue at this inspection. Lessons had therefore not been learnt following local authority feedback.

Using medicines safely
● We identified a medicine had not been correctly stored in the controlled drugs cupboard. Controlled drugs are subject to stricter regulations as they are particularly addictive. This risked the medicine being mis-used.
● Staff did not have clear guidance on when to administer 'as needed' medicines. A person required a medicine if they became agitated. However, there was a lack of guidance on what calming techniques staff could use before the medicine was used, or what the person's symptoms would look like, or how to monitor the effectiveness of the medicine. We raised this with the provider and when we returned, we found improvements had been made.
● We found medicine stored in a cupboard for 1 person with no record of whether or not this was currently prescribed or being administered

The provider failed to ensure risks to people were managed safely in relation to health and safety, their conditions, their environment and medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Where people were funded for additional support hours, records were unclear how this was being provided. We were therefore not assured people were receiving the correct level of staff support

● There were 2 care staff to support 14 people. People and staff told us this was enough staff, we did not see people having to wait for staff support.
● The manager kept note of which people required support to leave the care home (for example health appointments). Extra staff would be arranged on a flexible basis to support these external appointments.
● Staff were recruited safely. References had been gathered from previous employers to ensure the staff were of good character.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The rating for the service under the previous provider was good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans were not in line with current standards. This is because care plans did not give clear details on people's mental or physical health needs.
- People were not supported in an environment which met the guidance from the health and safety executive. Shower water was hotter than the temperature set by national guidance and staff did not have clear guidance on how to prevent the risk of burns. We raised this with the provider, and action was taken to improve the environment and suitable guidance was made available to staff.
- Since 2005, people with learning disabilities should have a health action plan. This is a single document on people's health needs, with guidance on their current health conditions and treatment, and planned health care. There were no health action plans stored at Beechdene Care Home. This does not meet national standards and risks people not having their health needs effectively met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Care records did not always provide clear detail about people's health conditions and treatment. This risked staff not knowing how to support people's health needs effectively.
- We spoke to a visiting health professional, who advised staff were always quick to respond to any suggestions they made for the person they visited. However, when we reviewed the person's care records we saw health advice was not clearly recorded. Due to poor record keeping, there was a risk new staff might not understand or apply previous health professional recommendations.

Staff support: induction, training, skills and experience.

- One person required 'as needed' medication if they had a sudden deterioration in their health condition. Only one staff member had been trained to administer this specific medication, another staff member had poor knowledge of how to administer this medicine. There was a risk this person's urgent health need would not be responded to effectively. We raised this with the provider and training was arranged for staff.

Adapting service, design, decoration to meet people's needs

- The care home had multiple steps around the property. Some people at the service had reduced mobility and were at risk of falls. There were no individual risk assessments to guide staff on how to manage this risk effectively.

The provider failed to ensure care and treatment was based on national safety and best practice guidance.

The provider also failed to ensure people's care plans contained the information staff needed to keep them safe. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● With the exception on training on the administration of emergency medicines, staff had received training required to carry out their role. For example, staff had received first aid training, in case an incident occurred.
● People could have their own décor in their bedrooms.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● Some people found it hard to make decisions. The service had therefore assessed their decision making under the Mental Capacity Act. The recording of these decisions was poor, as it was not always clear what decision the person was being assessed for, or how the assessment had been completed.
● Where people were under continuous supervision, we saw applications had been made to deprive people of their liberty.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food and drink provided.
● We saw people given choices on what they would like to eat and drink.
● Records showed people were provided with enough to eat and drink

Requires Improvement

Is the service caring?

Our findings

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

The rating for the service under the previous provider was good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity.

- People's diverse needs were not always clearly recorded in care plans. A person could become distressed; but the care plan did not describe what sort of things could trigger this distress or how to support them. This lack of detail in care plans could impact staff's ability to treat people well.
- People told us staff were kind to them. We saw people engaging positively with the staff team. A relative told us "The background noise is always happy. It's like someone's home if they had a large family."

Supporting people to express their views and be involved in making decisions about their care

- People told us they were involved in making decisions about their care. A person showed us their favorite drink, which staff had just supported them to buy from the shop. While people were engaged in making decisions, these conversations and actions were not always recorded. Not recording this drink preference meant new staff might not know what the person's favorite drink was.
- People living at the care home, had access to meetings, this allowed them to feedback on their experiences at Beechdene Care home

Respecting and promoting people's privacy, dignity and independence

- The kitchen could be accessed from the outdoor courtyard, or via a person's bedroom. Staff were seen repeatedly walking through the person's bedroom to enter the kitchen to prepare meals. This did not allow the person privacy as their room was a regular walkway for staff.
- A person told us their bedroom blinds had broken a year ago. They told us they needed to get changed in another room to allow privacy.
- It was not clear from records how people's independence was promoted. Care plans were not always clear on what tasks a person could do for themselves.

Requires Improvement

Is the service responsive?

Our findings

Our findings
Responsive – this means we looked for evidence that the service met people's needs.

The rating for the service under the previous provider was good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
● The provider had not identified and recorded people's aspirations and dreams. This is a current expectation for services supporting people with learning disabilities.
● We were informed most people at the service preferred showers to baths. However, most baths within the property were not effectively working which negatively impacted people who preferred baths.
● People told us they could choose how they wished to spend their time. We saw people engaging in ways they preferred.
● We saw people enjoy setting up the Christmas tree with staff. A person showed us they had their own decorations in their room, so they could decorate their room as personally as they wished.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● We were informed 1 person used picture cards to communicate. These picture cards were visibly unclean, which could impact staff and people's use of them. The use of these cards was also not reflected in the person's care plan. So, staff did not have clear guidance on how best to use the pictures for the person.
● Staff were seen speaking to people in a way they understood.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People told us they could take part in events outside the care home. One person said 'They hire a minibus. So we go out together when we want. I also like to go into Mansfield shops and go out for burgers and they take me when I want."
● We saw relatives visiting people at the care home. Relatives told us they were always welcome by the staff team. A person told us, "My [relative] visited on my birthday – [they are] always welcome. [Staff] like our family to visit."

Improving care quality in response to complaints or concerns
● There were no recorded complaints. People and relatives told us they felt able to raise complaints and any concerns would be acted upon.

End of life care and support

● At the time of the inspection, nobody required end of life support. Records showed 5 staff had not received training on end of life care. This meant there was a risk if somebody's health deteriorated and they needed end of life care, suitably skilled staff would not be available to support them.

Inadequate

Is the service well-led?

Our findings

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

The rating for the service under the previous provider was good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Some audits were not in place. The manager told us there were no checks of window restrictors in the home. An effective audit could have identified window restrictors were not fitted and people may not have been placed at risk of harm from incidents from windows.
- Where audits were in place, they were not always effective. The manager advised care plans were checked daily but this check was not written down. Staff also reviewed care plans monthly but we found this was not effective. We found concerns with care plans that could have been identified and resolved by an effective audit. For example, an effective audit should have identified 1 person's episode of distress and agitation were not being recorded; to enable potential triggers to be identified and acted on.
- The provider advised they intended to close the care home within a few months. This was because refurbishment was required to the property, which would not be possible with people living there. We identified some aspects of refurbishment could be completed in a more timely way. Multiple sink taps did not work which would impact hand washing at the service. Timely maintenance had not been completed at the service.
- When we were first provided with training details, the records suggested multiple staff had not been trained. When we raised this with the manager, they found additional records suggesting staff had received training. Not keeping training data in a single accessible place, can make oversight of staff skills ineffective.
- Cleaning schedules suggested cleaning had occurred, however we found visible dirt and mold around the property. We were therefore not assured there was effective oversight of the cleanliness of the property.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We were not assured the provider was open when things went wrong. Due to the concerns about Legionella developing at the property, we asked the provider to send us an action plan. They advised they would test regularly and if Legionella developed, they would inform the CQC within 2 hours. When we returned to the service a few days later, we found Legionella had developed in the water system. This bacterial outbreak had been effectively treated. However, the provider had not followed the action plan as we had not been informed of the positive Legionella test.
- The provider had not always notified us of reportable events that occurred. These are events that the provider is legally required to tell us about. For example, we were not informed about the allegations of abuse reported in the Safe Section of this report.

Continuous learning and improving care; Working in partnership with others

● After the first inspection day, we fed-back our urgent concerns to the provider. When we returned the next day, we found limited action had occurred to resolve these concerns. We asked the provider to complete an action plan, telling us what they intended to do and by when. When we returned on a third day, we found only parts of this action plan had been followed. For example, not all windows had been restricted to prevent falls and radiators were still hot and risked burning people.
● Before our inspection, the provider had received feedback that staff did not have enough guidance on how to administer 'as needed' medicines. We found this risk was ongoing, so effective action had not been taken.

The provider failed to ensure effective oversight of Beechdene Care Home. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● People did not always have good outcomes. This was because the environment was not managed safely and staff did not have clear guidance on how to support people.
● People told us they enjoyed living at Beechdene Care Home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings had occurred at the service, but these had not resulted in change. Meeting minutes showed that record keeping, environment and cleaning had been previously raised. However, we found risks in these areas were ongoing.
●The provider had an equality policy in place, to ensure people were treated fairly. We saw staff engaged with people, while considering their communication needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not kept safe when abuse was alleged.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor oversight of the home

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 12 HSCA RA Regulations 2014 Safe care and treatment The environment was not managed safely. People did not always receive medicines in a safe way. Staff did not have clear guidance on how to support people.

The enforcement action we took:

We imposed urgent conditions on the providers registration. This requires them to take action to improve the safety of the care home