Sunny Okukpolor Humphreys

The Beeches Nursing and Residential Care Home

Inspection report

Church Lane
Kelloe
County Durham
DH6 4PT

Tel: 01913773004

Date of inspection visit:
01 October 2018

Date of publication:
05 June 2019

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focussed inspection of The Beeches Nursing and Residential Care Home on 1 October 2018.

The Beeches Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides nursing and personal care for up to 31 people some of whom are living with a dementia. Care is provided over two floors. At the time of the inspection there were 20 people who used the service.

At our last comprehensive inspection of The Beeches Nursing and Residential Care Home on 13 and 22 August 2018 we found evidence that people who used the service were at risk of significant harm. We found breaches in seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The inspection identified that people did not receive safe care and treatment. We found serious concerns with the management of medicines. Risks for people who used the service were not always adequately assessed to ensure people were safe. We found areas of the service to be unclean and infection control was poor. The passenger lift had not had a thorough examination as required under the Lifting Operations and Lifting Equipment Regulations (LOLER). The arrangements for fire safety were inadequate. At times there were insufficient staff to meet the needs of people who used the service and this had resulted in people's care being compromised. Profiles were not available for all agency staff who worked at the service. This meant the provider could not be sure agency staff were suitably qualified and had the clinical skills to support people and to confirm they were of good character.

At the inspection on 13 and 22 August 2018 we also found that staff had not received supervision on a regular basis. The standards within the induction programme provided at the service were not aligned with the standards in the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in social care. There were no records to confirm agency staff had received an induction in relation to people who used the service, expectations and safe working practices. We found that the provider was in breach of regulation in relation to consent because the Mental Capacity Act (2005) guidelines were not always followed. Many bedrooms and communal areas in need of redecoration and refurbishment. There was insufficient monitoring and oversight of people's nutrition and hydration. People were not always treated with dignity and respect. Staff failed to ensure people's needs were met and this compromised their dignity. Care records were insufficiently detailed to ensure the care and treatment needs of people were met. Activities and outings were limited and particularly for those people living with a dementia. Quality monitoring of the service was ineffective as it had not identified the concerns that we had found at the inspection. We rated the service as inadequate.

Due to our concerns we served a Notice of Decision to restrict admissions to the service without prior agreement of the Care Quality Commission.

We carried out this focussed inspection of the service on 1 October 2018 to determine if any improvements had been made in relation to safe care and treatment. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Beeches Nursing and Residential Care Home on our website at www.cqc.org.uk. The inspection highlighted some improvement. However, we did identify a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the registered manager was absent from the home. However, the deputy manager had stepped up and was acting as manager. 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.

We found serious concerns with the management of medicines. The recording of medicines was not accurate and specific guidance to support staff with the administration of medicines was not always available. We found gaps in the recording of the temperatures of the medicine fridge. In addition, the temperature of the room in which medicines were stored was too high. This meant the quality of medicines may have been compromised. One person was prescribed pain relieving medicines to be applied as a patch. This patch should be changed every seven days to ensure a continuity of pain relieving medicines. However, records indicated that this person had gone longer than seven days. Documentation relating to the application of creams was confusing.

Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these events occurring.

We found the cleanliness and infection control to be much improved. Many carpets had been replaced and communal areas and bathrooms were cleaner. Some furniture had been replaced.

We found fridges and freezers to be cleaner with food stored correctly. However, the meat only fridge was found to have dirty seal and we did find some out of date ham within the fridge. We immediately reported this to the manager who removed this.

There continued to be concerns in relation to safety as we found doors to the laundry and kitchen were closed but not locked. Some people were living with a dementia and would not understand the possible consequences if they were to go into the laundry and kitchen.

The manager told us problems with the heating and hot water had been rectified. However, we found the water from some hot taps was cool.

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 remains inadequate.

The system for the management of medicines was not safe.

Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring.

The service was clean and infection control had improved. However, people were placed at risk of harm as the laundry and kitchen doors remained unlocked.

The Beeches Nursing and Residential Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of The Beeches Nursing and Residential Care Home on 1 October 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 13 and 22 August 2018 inspection had been made. At our inspection in August 2018 we found breaches in seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the team inspected the service against one of the five questions we ask about services: is the service safe?

No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring and during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

The inspection was undertaken by two adult social care Inspectors and a specialist advisor who was a nurse.

During the inspection we spoke with four people who used the service and one relative. We looked at communal areas of the home, the kitchen, laundry and some bedrooms.

We spoke with the provider, the manager, deputy manager, the operations manager who was also a registered manager of another service operated by the provider, two nurses, a senior care assistant and three care assistants.

During the inspection we looked at two people's care records in detail. We looked at the medicine records of nine people. We also walked around the service to check on people's safety, cleanliness and infection control. In addition, we took some water temperatures from taps in all areas of the service.

Inadequate

Is the service safe?

Our findings

During our inspections in November 2017, March 2018 and August 2018 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. At this inspection we checked some areas of this key line of enquiry to see if improvements had been made. At this inspection we looked at systems in place for the management of medicines, risks to people who used the service, the safety and cleanliness of the environment, including infection control. In addition, we checked water temperatures.

At our last comprehensive inspection in August 2018 we found serious concerns with the management of medicines. The recording of medicines was not accurate and specific guidance to support staff with the administration of medicines was not always available. At this inspection we found staff had addressed some specific areas of concern in relation to medicines, however we found additional concerns.

One person was prescribed a medicine to relieve pain on a 'as needed' basis (PRN). However, the dose on the Medicine Administration Record (MAR) differed from the dose entered on the PRN protocol. PRN protocols assist staff by providing clear guidance on when and why medicines should be administered, the maximum amount that can be taken and how often. Without clear direction the person was at risk of harm of receiving too much or too little medicine to relieve their pain.

Another person was prescribed a medicine to relieve their breathlessness, however the dose on the MAR chart differed from the dose entered on the PRN protocol. Without clear direction the person was at risk of harm of receiving too much or too little medicine to relieve their breathlessness.

Another person was prescribed eye drops to relieve their dry eye condition, however the dose on the MAR chart differed from the dose entered on the PRN protocol. In addition, the PRN protocol did not detail that this eye drop was prescribed for the left eye. Without clear direction the person was at risk of harm of receiving too much or too little medicine to relieve their dry eye condition.

At our last inspection in August 2018 we found one person was prescribed a medicine to decrease the amount of acid in their stomach and this should be administered 30 minutes before food. However, there were no specific instructions on the MAR in relation to this. No action had been taken by staff to rectify this.

The MAR for one person did not contain a photograph of the person to reduce the risk of medicines to be given to the wrong person. In addition, their allergy status was not clearly recorded. This was noted at our inspection in August 2018.

One person was prescribed medicines to be administered as a patch. The service had a system in place for recording the site of the application and the days when the patches were renewed or replaced. This was necessary because the application site needs to be rotated to prevent skin damage. However, we saw gaps in recording when patches had been applied and removed. This had been noted at our inspection in August 2018.

We looked at records for another person who was prescribed pain relieving medicines to be applied as a patch. This patch should be changed every seven days to ensure a continuity of pain relieving medicines, however, records indicated that this person had gone longer than seven days.

Some people who used the service received support with medicinal creams. We found that a number of medicinal creams were out of date in people's rooms. In addition, some of the creams we found in people's rooms were not documented on the MAR as prescribed by the person's doctor.

We found documentation in relation to the application of creams confusing. The MAR of one person was not specific and stated the cream was to be applied to sore areas, however it did not say how often this should be applied. The Topical Medicine Application Record (TMAR) stated the cream was to be applied "as and when required after washing/changing. In addition, the person's body map had not been completed to show where the creams should be applied. Without clear direction the person was at risk of harm of receiving too much or too little cream to relieve their soreness.

For another person the MAR stated that the cream was to be applied 'as needed to dry skin'. However, the TMAR stated that the cream was to be applied 'daily after washing or when itchy'. Without clear direction the person was at risk of harm of receiving too much or too little cream to relieve their dry and itchy skin.

One person was prescribed a barrier cream to protect their skin from damage. The MAR for this person stated that the cream was to be applied 'as directed' to their sacrum. However, the TMAR stated that the cream was to be applied to all pressure areas including sacral area and both hips. The body map had not been completed to show where the creams should be applied. Without clear direction the person was at risk of harm.

At the last inspection in August 2018 we found medicines which required cool storage were stored appropriately in a fridge which was within a locked room. Temperatures were recorded twice daily, however, minimum and maximum temperatures were not recorded. In addition, there were some gaps in recording of fridge temperatures. At this inspection minimum and maximum temperatures had still not been recorded and we found gaps in the recording of fridge temperatures.

At our last inspection we found temperatures for the treatment room where medicines were stored, were recorded daily. However, some of the recordings were above 25 degrees Celsius. This is higher than the recommended temperature of between 15 and 25 degrees Celsius. At this inspection we found on occasions the temperature of the room in which medicines were store continued to be too high.

Fridge and treatment room temperatures need to be recorded to make sure medicines were stored within the recommended temperature ranges. This meant that the quality of medicines may have been compromised, as they may not have been stored under required conditions.

The manager told us they had plans to rectify the issue with temperatures and a new room had been identified to store medicines.

At our last inspection in August 2018 we found risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring. At this inspection we found action had been taken to lessen some risks, however further work was needed.

At our last inspection staff told us one person was transferred in a shower chair with a chair strap from their

bedroom to the shower, when they were to go in the shower. There was no assessment undertaken to ascertain that this was a safe method of transfer for this person who had poor posture. This placed the person at risk of harm. At this inspection we found the manager had contacted the person's doctor to request a referral to an occupational therapist who would undertake the assessment. However, at the time of the October 2018 inspection the person had still not been assessed. The manager chased up this referral during our visit.

One person had a care plan for behaviour that challenges. There was no information within the care plan to provide guidance to staff on how to support this person. In addition, staff did not record the actual incidents that had occurred. It is important to record incidents so that other staff can recognise the signs and triggers more easily. It is also important for staff to be aware of how to respond to the person to support the person and potentially reduce the number of situations where challenging behaviour may occur.

One person was diagnosed with diabetes, which was managed via insulin use. The person's blood glucose levels were checked by staff on a regular basis. However, on a number of occasions their blood glucose levels were too high. There was no guidance in the person's care plan as to the what staff should do in the event the person's sugar levels were too low or too high. Without clear direction the person was at risk of harm as their diabetes may have been incorrectly managed.

At our last inspection we found concerns with the environment, equipment, cleanliness and infection control. We found stained carpets, stained and dirty bed linen, unclean bathrooms, dirty toilet brushes and a commode which was stained with faeces. We found the laundry room to be dirty. In addition, staff frequently left the laundry doors open which meant people could access the laundry and come to harm.

At this inspection we found the cleanliness and infection control to be much improved. Many carpets had been replaced. We found communal areas and bathrooms to be cleaner. Some new chairs had been replaced. We spoke with a relative who told us, "There has been a big improvement in the cleanliness in the last few weeks. They seem to be getting new furniture. The bedroom is basic but clean."

At this inspection we found doors to the laundry and kitchen closed but not locked. Some people were living with a dementia and would not understand the possible consequences if they were to go into the laundry and kitchen. Within the laundry there was contaminated clothes, bedding and towels, in addition to equipment, hot water and cleaning products. Leaving the door to the laundry open placed people at risk of harm.

At our last inspection we looked in the kitchen and found fridges and freezers were dirty both on the seals and internally. We found that raw meat was not stored correctly in the fridge. We found a rotten cucumber in with other cucumbers and the liquid from the rotten cucumbers had contaminated the others. During this inspection we visited the kitchen area and found fridges and freezers to be much cleaner, however the meat only fridge was found to have dirty seal. We found food to be stored correctly. However, we did note some out of date ham within the fridge and immediately reported this to the manager who removed this.

Throughout the year the service has had problems with the heating and hot water. This meant at times there had been no hot water or heating. The manager told us that the problems with the boilers and heating were now rectified. We saw records to confirm staff were taking water temperatures on a regular basis that were within normal limits. However, when we took some temperatures during this inspection we found the water from some hot taps was cool. In addition, we could not find records to confirm water temperature testing of the sink within shower rooms or hand wash sink within the kitchen. We pointed this out to the manager and provider at the time of our inspection.

All the above constitutes a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Treatment of disease, disorder or injury	The system for the management of medicines was not safe. Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring.

The enforcement action we took:

We placed a condition on the providers registration. The Registered Provider must not admit any new service users without the prior written agreement of the Care Quality Commission.