

Victorguard Care Limited

# The Beeches Care Home

## Inspection report

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## Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service caring?

Inadequate ●

Is the service well-led?

Inadequate ●

# Summary of findings

## Overall summary

### About the service

The Beeches Care Home is a care home providing personal and nursing care to older people and people living with dementia. The service accommodates up to 60 people over 2 floors in 1 building. At the time of the inspection there were 37 people living at the home.

### People's experience of using this service and what we found

Serious shortfalls were identified which impacted on the safety and quality of care people received. We raised specific issues at the last inspection relating to medicine management which had not been addressed. The registered manager had been seconded to another role overseeing other services and a new manager had recently started in post. There was a lack of effective leadership at provider level and governance arrangements had failed to identify the significant issues we found at this inspection.

Medicines were not managed safely which exposed people to the risk of harm. People were at risk of harm as systems were not in place to effectively assess, monitor and review risks relating to people's health, safety and welfare. The recruitment process was ineffective and as a result there were gaps in recruitment forms and incomplete processes. The provider had a dependency tool in place to assess the number of staff required. However, staff deployment around the home was ineffective and often meant people were not supported in a way that met their needs and requirements.

Feedback from relatives was generally positive however the feedback from people living in the service was mixed. We observed multiple occasions where people were not treated with dignity and respect, and there was an overwhelming lack of choice given to people. We saw staff were often unaware of the importance of being available for people and responding at times of their distress. A closed culture among staff was observed in the home which contributed to the shortfalls identified at this inspection.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider was responsive to inspection findings and provided assurances they would make the required improvements to improve the safety and quality of care.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The last rating for this service was requires improvement (published 13 December 2021), and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

## Why we inspected

We carried out an unannounced inspection of this service on 21 October 2021. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We inspected and found there was a concern with promoting people's privacy, dignity and choice, so we widened the scope of the inspection which included the key questions of caring. This report only covers our findings in relation to the Key Questions safe, caring and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Beeches Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

## Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, safe medicine management, privacy, dignity and choice, staffing and good governance at this inspection.

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 time frame 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 caring?**

The service was not caring.

Details are in our caring findings below.

**Inadequate** ●

### **Is the service well-led?**

The service was not well-led.

Details are in our well-led findings below.

**Inadequate** ●

# The Beeches 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.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection was carried out by 3 inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

The Beeches 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. The Beeches Care Home is a care home with 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. A manager had been in post for 3 months and had submitted an application to register. We are currently assessing this application.

### Notice of inspection

This inspection was unannounced. Inspection activity started on 4 April 2023 and finished on 2 May 2023. We visited the care home on 4 and 6 April 2023.

### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

### During the inspection

We spoke with 9 people who were using the service and 1 relative of a person who used the service about their experience of the care provided. We spoke with 10 staff members including the manager, the deputy manager, chief of staff, 6 care staff and a member of the ancillary staff.

We reviewed a range of records. This included 8 people's care records, multiple medication records, and we looked at 5 staff recruitment files. A variety of records relating to the management of the service, including some policies and procedures, were reviewed.

### After the inspection

We continued to seek clarification from the provider to validate evidence found. This included quality assurance records and training data.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

### Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not always stored safely and securely. In one treatment room we found that cupboards and a trolley were not locked. Staff had not been monitoring the temperature of the room medicines were stored in so we could not be assured that these had been stored at the recommended temperature.
- Information to support staff to administer medicines safely was not always available. For people who were prescribed medicines to be taken when required there was not always person-centred information for staff to follow to ensure these were given as prescribed. Allergy information was not always completed on relevant records. There was a risk people might have been given medicines they were allergic to.
- For people who needed their medicines hidden in food and drink to be administered covertly there was no information from an appropriate healthcare professional such as a pharmacist to ensure this was carried out in a safe way
- Staff were not recording when thickened fluids were being given to people at risk of choking and aspiration so we could not be sure these were being managed safely.
- Medication administration records for topical preparations such as creams were not always completed so we could not be assured that people were having them applied correctly.
- For medicines containing paracetamol that required a 4-hour interval between doses we saw that this was not always observed and 2 people received doses of medicine before they were due.

We found no evidence people had been harmed, however systems and practices were either not in place or not robust enough to demonstrate medicines were being safely managed. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The manager was responsive to our feedback and has started to take action to address the issues we identified.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not assessed and managed safely and there was a lack of evidence for lessons learnt where things went wrong.

- Where risks had been identified, actions had not always been taken to ensure people's safety. For example, sensor equipment put in place to mitigate a risk of falling had not always been put in place for 1 person. This meant staff would not be aware when that person stood up or fell.
- Staff were not following guidance to keep people safe. People's care plans detailed regular repositioning and support to be offered with continence needs. We observed these practices were not being followed or promoted routinely which increased the risk of pressure damage to people already vulnerable and at risk.
- Staff were not maintaining contemporaneous care notes and we found multiple inaccuracies and gaps in documentation relating to the care provided including pressure area care, dietary intake and continence care.
- People with limited mobility were not always supported safely by staff to move and transfer from 1 chair to another. We observed 2 separate occasions where staff used unsafe moving and handling techniques. One person told us, "I feel safe except for when they hoist me. They sometimes bang my feet and it hurts, but it's not too bad when it's the usual staff."
- Personal emergency evacuation plans were not all up to date or accurate about people's current moving and handling requirements in an emergency.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Staffing and recruitment

- Staff deployment in the home was not always effective to ensure there were enough staff on each unit to meet people's needs and keep them safe. People were often left with no staff supervision or interaction in communal areas.
- One person told us, "We could do with more staff to keep the order, staff come and go", another person told us, "I think there is enough staff to look after us."
- Staff had received some supervisions however we found this lacked detail, purpose and were not personalised. Supervisions were not always carried out at three-month intervals as set out in the provider's policy.
- Staff skills mix was not managed well in the service which meant one unit was not being well-led due to a lack of skilled and competent staff being deployed on it.
- The staff recruitment process was not robust or effective. Multiple documentation was missing from the staff recruitment files we reviewed. This was inclusive of application forms and there was occurrences of incomplete references and missing identity documentation.

The provider had failed to deploy enough suitably competent and experienced staff to meet the needs of people in the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Systems and processes to safeguard people from the risk of abuse

- Systems were in place to protect people from the risk of abuse and harm.
- Most staff had completed safeguarding training and understood their responsibility to report concerns. However, 1 staff member told us, "I have not received my safeguarding training and I do not have access to the safeguarding policies." This staff member had undertaken previous training at a different workplace and so did have some transferable knowledge.
- Where safeguarding incidents had occurred, referrals had been made to the local authority safeguarding team and notified to CQC.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- Systems were in place to monitor DoLS applications and authorisations and to make sure conditions were being met.
- Where people lacked the capacity to make their own choices and decisions we found capacity assessments, and best interest decisions were completed.

#### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

# 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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not consistently treated with compassion and kindness. We observed multiple missed examples where staff had opportunities to communicate, reassure and socialise with people and they did not. There were occasions where people were calling out for reassurance and support, and this was not offered. For example, we saw 1 person shouting out for help. Staff ignored this and it was only when the inspector went to talk to staff they went to support and reassure the person.
- We observed people in their bedrooms were not being offered the same care and support as people in the communal areas. One person told us, "You have to wait when you buzz, up to 30 minutes. Sometimes there isn't anybody around and sometimes I wee myself and worse. It's terrible."
- People who were cared for in bed were not fully dressed. We observed people were left in bed with minimal clothing, no covers on and doors open, their privacy and dignity was not being preserved.
- Staff were not promoting the use of appropriate footwear, especially where people walk with purpose in the home. We saw, despite the care plans stating appropriate footwear was required, 2 people were not seen to be wearing footwear on either day of the inspection despite walking constantly in the home.
- People were not supported to make choices and did not have their preferences respected. Staff did not always give people choices. For example, we observed mid-morning and afternoon snacks and drinks being provided on both days of inspection. We routinely observed staff not offering people choice of drinks or choice of snacks. A couple of biscuits were chosen by the staff members and placed in front of people. This was despite 1 person stating they liked "biscuits with fruit in" and asking for current tea cakes mid-morning.
- Care records did not show how people and their relatives were involved in their care.

People were not always treated with respect, dignity and compassion. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded to inspection feedback immediately and has implemented changes to improve the quality of care being provided.

# 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.

At our last inspection we rated this key question requires improvement. 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; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Significant shortfalls were identified at this inspection with a repeat breach of regulation relating to medicine management and new breaches of regulations relating to safe care and treatment, staffing and dignity and respect.
- There was a lack of consistent and effective leadership and a lack of management presence on the units. This led to a lack of oversight and leadership in the home.
- The provider did not have an effective system in place for audits and monitoring. Some audits were in place and had identified some of the shortfalls we found on inspection, however there was no action plan or follow up of this, therefore no improvement in quality was made.
- Weight management was poor. People had been weighed recently and the manager had identified several people who had lost weight. A referral had been made weeks prior to the GP but this had not been followed up. Internally there was no oversight or monitoring of people's intake, no guidance to staff on how to monitor and report on changes in intake, and no action taken by the provider to mitigate weight loss in the interim period.
- Accidents and incidents were not effectively managed or monitored. There was a lack of action and efficient oversight of these occurrences, leading to missed opportunities for lessons learnt.
- The provider could not demonstrate continuous learning and improvements. The shortfalls identified at this inspection concluded the quality and safety of the service had deteriorated since the last inspection.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The manager was relatively new to the role, but they acknowledged the shortfalls we identified and expressed their commitment to making the necessary improvements.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager was open and honest throughout the inspection and took action where shortfalls and safety concerns were raised about poor manual handling techniques. The manager understood their duty of candour. However, there was a closed culture in the service which the manager had already identified and

was actively working towards improving.

- One relative told us, "It's a new manager, he has introduced himself and calls into the room when I am visiting to ask if I am happy. I am not aware of any family meetings, I have not been invited to any as of yet but there are regular surveys."
- One person told us, "[Manager] is nice, he will help where he can, I don't go to resident meetings." Other people told us there were no resident meetings and 1 person told us, "There is no one about to take care of the problems, no one takes any notice. They just think you are moaning."
- Staff provided positive feedback about the manager and said they felt the new manager was an improvement for the service. One staff member told us, "In the past it was not well led but with [manager] now it's better. I can raise concerns with [manager], he is approachable and fair to all the staff."
- Surveys had been provided to people and relatives and collated for quality review. Team meetings with staff were taking place in the service. The manager also confirmed they had planned to hold a family member meeting soon after the inspection to discuss and open communication channels.

Working in partnership with others

- Records showed staff engaged with health and social care professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment  The provider failed to ensure safe systems were in place to assess and monitor risk to people, and failed to ensure medicines were managed safely. (1) (2) (a) (b) (c) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The provider failed to ensure the service deployed sufficient numbers of suitably trained, competent staff across the units. Supervision and periodic review systems were not effective or person centred. (1) (2) (a) (b)

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 10 HSCA RA Regulations 2014 Dignity and respect  Service users were not being treated with dignity or respect and staff failed to provide choice to people. 10 (1) (2) (a) (b) (c)

### **The enforcement action we took:**

WN served with draft report

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider had failed to ensure effective systems were in place to assess, monitor and improve the quality of the care provided in the service. 17(1) (2)(b)(c)

### **The enforcement action we took:**

WN served with draft report