Tudor Care Limited

Beechfields Nursing Home Limited

Inspection report

1 Wissage Road
Lichfield
Staffordshire
WS13 6EJ

Tel: 01543418354

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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

This comprehensive inspection visit took place on the 26 June 2018 and was unannounced.

Following the inspection we wrote to the provider and asked them to take urgent action due to the significant concerns we found. We carried out a second day of inspection on 4 July 2018 to check if the provider had taken the action they had told us they had taken in the action plan they sent to us.

Beechfields Nursing Home Limited 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. Beechfields Nursing Home Limited is registered to accommodate 35 people in one building. Some of the people living in the home are living with dementia. At the time of our inspection 23 people were using the service. Beechfields Nursing Home Limited accommodates people in one building and support is provided over two floors. There are communal lounges and dining areas, a conservatory and a garden area that people can access.

There is not a registered manager in place. Since our inspection a new manager has been appointed and is in the process of registering with us. 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.

At our last inspection in November 2017 we rated the service as inadequate .Following that inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led to at least good. The provider has been sending us monthly actions plans.

At this inspection we found people continued to wait for support. This included when they needed support with eating and drinking and support with their mobility. The lack of staff support placed people at risk. Risks to people were not always investigated or reviewed after incident and accidents occurred within the home, or action taken to reduce the risk reoccurring. This information was not used so that lessons could be learnt in the future. When people displayed behaviours that may challenge we could not be sure the behaviour management plans in place gave staff the information to offer a consistent approach. People were not protected from potential abuse as incidents were not reported appropriately when needed.

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; the policies and systems in the service did not support this practice. Staff received an induction and training, however we could not be assured how effective this was as staff competency and knowledge was not always checked or considered by the provider.

Improvements had been made to the management of medicines, however we found some medicines were

unaccounted for and the system the provider had in place had not identified this. Audits were completed, however they were not effective in identifying areas of improvement and it was unclear how the information was used to drive improvement within the home. The provider had sent us an action plan which stated how they were going to comply with previous regulations they were in breach of. Despite marking the actions as completed, we found they were still non-compliant in some areas. The provider had not made or sustained the necessary improvements from previous inspections. The provider sought feedback from people living at the home, however this information hadn't been used to make changes or improvements to the home. Improvements had been made to the recruitment of nurses and there were systems in place to ensure their registrations were in date, further improvements were however needed.

People felt there could be more to do within the home and staff had little time to spend with people as they were rushed. Care was task focused and impacted on people's dignity. Some interactions were not always kind and caring. When people were living with dementia their communication needs had not always been fully considered or the support they needed to make choices.

Infection control procedures were in place and followed. When people complained, they were happy with the outcome, there were complaints procedures in place that the provider followed. People were supported to access health services when needed. Medicines were stored in a safe way. Staff felt listened to and knew who the manager was. Relatives and friends could freely visit the home.

People enjoyed the food and were offered a verbal choice. The provider worked jointly with health professionals who came into the home. The provider was displaying their rating in line with their requirements.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 was not safe.
Risks to people were not always managed in a safe way. When incident or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk. People were not always protected from potential harm or concerns investigated or reported when needed. People did not always receive support when needed. The provider was not using information so that lessons could be learnt within the home. Infection control procedures were in place. The provider ensured staffs suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
Capacity assessments were not always in place and there were no evidence decisions were made in people's best interest. When people were being restricted this had not always been considered. The training staff received was not always effective to ensure they supported people as needed. People did not always receive enough fluid or support at mealtimes. People had the opportunity to attend health appointments when needed. Information relating to current legislation was available for staff to consider.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated in a kind caring and dignified way. People's individual choices were not always respected. People were happy with the care staff that supported them. People were offered verbal choices as to how to spend their day. And they were encouraged to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People's care was not assessed or reviewed to ensure it was relevant to their needs. People's communication needs had not been fully considered. People and relatives did not feel involved with planning their care. People did not always have the

opportunity to participate in activities they enjoyed. People's cultural needs were considered. People knew how to complain and were happy with the provider response.

Is the service well-led?

Inadequate

The service was not well led.
The providers remains in breach of regulations and have not made the necessary improvements needed to comply. The provider had not notified us about all significant events within the home. Audits were not driving improvements. Staff felt supported o and listened to. The provider was displaying their rating in line with our requirements.

Beechfields Nursing Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on the 26 June and 4 July 2018 and was unannounced. The inspection visit was carried out by three inspectors 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.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. A notification is information about events that by law the registered persons should tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to formulate our inspection plan

We spent time observing care and support in the communal areas of the home. We observed how staff interacted with people who used the service. We spoke with four people who used the service, six relatives or visitors, and three members of care staff. We also spoke with two nurses and the manager. We did this to gain people's views about the care and to check that standards of care were being met. After our inspection we spoke with a social worker who supported some of the people living at Beechfields Nursing Home Limited.

We looked at the care records for ten people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home, staff recruitment procedures and actions plan that were in place. We

gave the manager the opportunity to send us any information after the inspection for us to consider. The day after the inspection we received various documents including environmental risk assessment, the complaint policy and documentation relating to people who lived at the home. We considered this information when writing our report.

Inadequate

Is the service safe?

Our findings

At our last two inspections we found medicines were not managed in a safe way and risks to people had not always been considered. This was a continued breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We also found the provider did not have a system in place to ensure staffs suitability to work within the home. And people were not always protected from the risk of abuse. This was a continued breach of Regulation 19 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At our last inspection we also found that there were not always enough staff available to offer support in a timely manner. This was a breach of Regulation 18 (1) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We also raised concerns around infection control procedures and the food hygiene rating.

At this inspection, although we found some improvements had been made to the management of medicines and the provider's recruitment procedures, other necessary improvements had not been made. We also found new areas of concern.

At our last inspection we found the provider did not have suitable arrangements in place to ensure accidents and incidents were recorded and investigated to keep people safe. At this inspection we found the same concerns. Records showed when incidents and accidents had occurred, a form had been completed detailing the incident. However, we could not see what action had been taken to mitigate further risk. For example, for one person we saw the record of an incident that had occurred. The form stated, 'I heard shouting for help. I went into lounge and found person on floor'. The person had independently undone their safety belt and fell trying to reach a specific item. This fall had resulted in the person fracturing their hip. After this incident a care plan had been put in place identifying this person was 'known to take the belt off'. There was no other information detailing how the risk could be reduced or control measures put in place to keep the person safe.

When other incident and accidents had occurred, we could not see how they had been investigated or what action had been taken. For example, one person was 'found on the floor in the middle of the lounge'. There was no investigation as to how this had occurred. Another person 'was found to have spilled a hot drink on their chest'. The person did not have a risk assessment in place in relation to this. A third person was, 'found by care staff sitting on floor at the bottom of chair in lounge'. Again, there was no investigation on how this had occurred or information in the person's file detailing this as a risk. As no further action was being taken we could not see how the provider used this information to ensure lessons were learnt when things had gone wrong in the home. On our second day of inspection we saw the provider had put a form and system in place to ensure future incidents or accidents were investigated. As no further incidents had occurred, we could not review this system at this inspection, to ensure it was effective.

We observed one person being transferred between their arm chair to their wheelchair. Two staff did this by standing either side of the person and lifting them under their arms. The person appeared distressed by this. This practice is unsafe and does not meet the guidance from the health and safety executive for moving and handling in care homes. We spoke with one of the staff members who was transferring this person, as earlier

in the day we had seen this person transferred using the hoist. The staff member, when asked said, "No they are a stand" (meaning that they thought the person could stand). We checked the records for this person. In various care plans and risk assessments throughout this person's file it was documented this person needed the hoist to transfer. Information included, 'requires hoist and medium access sling' and 'Non weight bearing, hoist only, does not stand'. The nurse confirmed to us this person should use the hoist. This meant that this person was not transferred in a safe way and was placed at risk. After the inspection the provider sent us information stating there would be an internal investigation and all staff that had been on shift during our inspection would be retrained in moving and handling.

At our last inspection we found risks to people's safety and well-being had not been assessed consistently and staff had not been given detailed guidance to reduce and mitigate risk. This was in relation to managing behaviours that may challenge. At this inspection we found the same concerns. We were told two people displayed frequent behaviours that may challenge. Although one person had been referred to the community psychiatric nurse (CPN) for support, there was no guidance in place for staff to follow on how they should respond to these behaviours and what action they should take to support these people. Staff gave differing information on how they supported one of these people with these behaviours. One staff member said, "We walk away and give the person a lot of time." Another staff member said, "We take other residents to safety and take [person] back to their room." This demonstrated an inconsistent approach which meant we could not be sure this person and others were kept safe.

At this inspection we found the provider had not ensured risks relating to the home environment had been assessed or mitigated. We saw work was being completed in some of the bedrooms. A written sign had been put on the door (bedroom doors or main door) identifying this. However this was not in line with a format that all people living at Beechfields Nursing Home Limited would understand. As the doors were unlocked people could access these areas independently. When we went into the rooms we saw people were presented with potential risks such as saws and screwdrivers as well as obstacles such as benches and holes in walls. After the inspection the provider sent us information stating that these rooms now had locks fitted on the doors while the work was carried out. We checked this on our second day of inspection and found that the locks had been fitted. However, one of the locks remained open. We discussed this with the manager who actioned this immediately.

Furthermore, as it was a hot day all the external doors had been opened. People, if they wished to do so, could independently access the garden area. We raised concerns as there was a large step from the home to the garden which posed a risk to people and the paving in the garden was very uneven. We raised further concerns as the fence from the garden to the car park and subsequently the main road was unlocked and on two occasions wide open. We raised this as a concern as at our last inspection when we identified that a person had left the home without the knowledge of the staff. The person was still living at Beechfields Nursing Home Limited. This meant environmental risk had not been considered.

Although we found improvements had been made in the way medicines were managed overall, further improvements were needed. We completed a stock check on homely remedies. A homely remedy is another name for non-prescription medicines that are available over the counter. In this instance it was paracetamol. We found there were 29 tablets that were unaccounted for. The manager or nurse was unable to provide an explanation for this. This meant we could not be assured medicines were managed in a safe way.

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

At our last inspection people were not always protected from the risk of abuse. At this inspection we found the same concerns. Records showed there were procedures in place in relation to safeguarding people. However, when we looked at incident and accident records we saw some incidents had not been reported to the local authority as the lead agency for investigating safeguarding concerns. For example, we saw an allegation of a person 'making inappropriate sexual advances to another person'. And someone who was unable to mobilise had been left out in the garden acquiring sunburn. We spoke to the manager who confirmed these had not been considered as potential safeguarding concerns. Furthermore, when falls or incidents had been unwitnessed the provider had not conducted an investigation to consider how this may have occurred. Staff demonstrated a mixed understanding on safeguarding. One staff member said, "I'm not sure what it covers." One staff member who had started working at the home over four months ago told us they had not received training in this area. This meant people were not protected from potential abuse. After our inspection we raised some of these concerns with the local authority safeguarding team for their consideration.

This is a breach of Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

At our previous inspection we found people did not receive timely support. At this inspection we found the same concerns.
Relatives raised concerns about staffing levels within the home. One relative explained what happened when they pressed the call bell, they said, "Sometimes it's good and sometimes it lousy. We have been known to wait two hours. I know meal times are busy but it's a long time." Another relative told us, "You can wait a long time for them to come, which isn't great if my relation has a water infection and needs to go quickly." Staff also raised some concerns about the staffing levels within the home. One staff member said, "I don't know how they work the numbers of staff to care for people." They went on to say, "I think people need more stimulation."
We saw one person was asleep in bed, this person's breakfast was on a table next to them. We saw the food was there for 35 minutes until the person woke and started to eat the breakfast. A further 25 minutes later staff returned to this person who was still eating their breakfast. The staff who said they had come to remove the breakfast did not offer any support to the person. A further 10 minutes later the person finished their meal. The records in relation to eating and drinking we reviewed for this person stated, 'staff to encourage'. Therefore, as this person did not receive encouragement from staff they did not receive the support they needed to eat and drink.

People did not receive support to transfer in a timely way. We saw that one person waited 30 minutes until staff could find a suitable chair for this person to transfer to. Another person was seated in their wheelchair next to their chair for 40 minutes. We raised this concern with one of the nurses. They said, "I know, I'm sorry." This person was never transferred to their chair instead they were transferred to their bedroom.

At mealtimes people had to wait for support. At lunchtime, for over 40 minutes, there were no care staff in the dining room to support people with their meals. People who could eat their meals independently were supported by the kitchen staff to receive these. We raised our concerns with the manager as one of these people was not being supervised and had recently choked. Furthermore, the people who needed assistance to eat their meals had to wait for staff to become available to help. We saw one person waited over 35 minutes for assistance.

We saw that for long periods communal areas were left unsupervised and people were shouting for support. We saw one person shouted for over 25 minutes until staff entered the room and offered support. Another person intermittently shouted for support for 40 minutes, a staff who was off duty and completing training

offered support to this person. During this time this person stood up independently on two occasions. This person had been identified at risk of falling. This meant the deployment of staff placed people at an increased risk. Two other people had to wait for two staff to offer them assistance so they could transfer to the dining room; staff supported these people into the dining room 40 minutes after lunch had started. When people received their meals in their rooms it was over 50 minutes after lunch had started to be served until these people received their meals.

This is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

After the first day of inspection we asked the provider to take urgent action to ensure people were safe. When we inspected the home on the second day we found that a staff member had been allocated to the communal areas at all times when people were present, during our inspection we saw this staff member was present. Another staff member had also been allocated to the dining room to ensure people were supported. After the second day of inspection the provider sent us a copy of the dependency tool they would be implementing within the home.

At our last two inspections we found improvements were needed to ensure staffs suitability to work within the home. At this inspection we found improvements had been made and a system was in place to ensure nurse's registrations were valid and in date. We reviewed all the staff files for the nurses employed within the home and found no concerns. We saw improvements had been made for the recruitment of care staff. One staff member told us they had been unable to start working in the home until all the necessary checks had come through. However, for two staff we saw one only had one reference in place and for the other staff member they did not have a previous employment reference, meaning further improvements were needed.

Improvements had been made to the management of medicines in the home since our last inspection. One person told us, "They give them to me [tablets]. It's just the one in the morning. I never miss one." The provider had changed the pharmacy within the home and the manager told us this had been positive. They told us they now received medicines that lasted them longer periods so stock levels were adequate and were not running out. When staff administered medicines to people we saw they spent time with them ensuring they had taken their medicines. We saw staff checking with people if they were in any discomfort and offering them their prescribed 'as required' medicines. When people had medicines that were on an 'as required' basis we saw there was guidance known as PRN protocols available for staff to ensure people had these medicines when needed. There were effective systems in place to store medicines to ensure people were safe from the risks associated to them.

There were infection control procedures in place and these were followed. We saw staff used personal protective equipment such as gloves and aprons when needed. Staff confirmed this was freely available to them. We saw the provider had been rated a four star by the food standards agency. The food standards agency is responsible for protecting public health in relation to food. The provider also completed an audit in relation to infection control and when needed action was taken to make improvements.

Requires Improvement

Is the service effective?

Our findings

At our last two inspections we found that the provider was not meeting the requirements of The Mental Capacity Act 2005 (MCA) to ensure people's rights were upheld. Staff were also not applying the act to ensure they acted in people's best interests. This was a continued breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At our last inspection we also found some training was not up to date and staff lacked the knowledge and skills to support people living with dementia.

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 or 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. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When people had restrictions placed upon them there were not always capacity assessments in place. One person lacked capacity to make decisions for themselves. There was no individual capacity assessment in relation to the bed rails they were using and no evidence the decision to use these had been made in their best interests. This meant that bed rails were put into place which restricted the person, without following the principles of the MCA.

When other people were potentially being restricted these restrictions had not always been considered. We saw one person was unsettled in their chair due to their movements. Staff then transferred this person to their bed. This person did not have capacity to consent to this decision. This person remained in their bed during the course of our inspection, including mealtimes. It had not been considered this maybe a restriction. We also saw another person who tried to stand from their wheelchair and mobilise. They were told to sit back down by staff. There was no capacity assessment in place in relation to this or any recorded best interests decisions. This had also not been considered as part of the person's DoLS applications.

When capacity assessments had been completed for people they were not individual or specific to the decision being made as required. One person had a capacity assessment in place, the decision being assessed was documented as, 'Person had vascular dementia'. There was no information recorded as to how this decision had been reached or why it was being assessed. We did not see any evidence that decisions had been made in people's best interests.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

At our last inspection we found staff training was not up to date and our observations showed staff lacked the knowledge and skills to support people living with dementia. At this inspection we found the same concerns. A relative raised concerns about staff knowledge. They said, "Although they start off not knowing

by the time they learn they leave. There is a heavy turnover of staff. They use a lot of agency." Although some staff told us the training they received helped them support people, the training was not always effective. For example, staff told us they had received MCA and DoLS training however some staff did not demonstrate to us an understanding in this area. One staff member said, "It's about mental health." Other staff told us they had not received training in key areas such as safeguarding since starting work at the home. One staff member who had been working at Beechfields Nursing Home Limited for four months had not received safeguarding training.

After the inspection the provider sent us the training matrix to review. Out of the 22 care staff on this matrix only 11 had received safeguarding training. As safeguarding's had not always been reported in line with procedures this meant staff did not always understand their roles and responsibilities in this area. Staff also told us they had received moving and handling training however we observed unsafe practices during our inspection. We also reviewed the training matrix in relation to dementia as at our last inspection we had found concerns. Out of the 43 staff on the matrix only seven had received training in this area. This meant the training staff received did not always enable them to support people as needed, and that the provider was not checking the competencies of staff after they had received training.

This is a breach of Regulation 18 (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

People did not always receive enough to drink. During our inspection it was a very hot day. Although people were offered drinks, we did not see staff encouraging people to drink more and people were not always supported to receive these drinks. For example, during breakfast one person had their drink next to them in their room. We observed this was next to them for one hour and ten minutes. We did not see staff offer them support with this drink despite the person's care plan stating, 'staff to encourage'. They did not finish this drink. Another person who was sat in a hot area of the home had refused a drink in the morning. We did not see they were offered an additional drink. At lunch time when we reviewed records there was no record they had received a further drink.

For another person we saw, they had a drink in a beaker which was initially out of reach. After the person had called for assistance staff pulled the table and drink closer to the person however, again, they did not offer assistance. We saw the person try to independently drink from the beaker however as it was the wrong way round it was unsuccessful. We saw that most of this drink the person spilt down them. Furthermore, later in the afternoon this person's drink was again out of reach, this time we saw the person stood independently to reach this knocking it over and spilling the whole of the drink on the floor. There were no staff in the communal area to witness this. We raised this concern with the nurse.

People were offered a verbal choice of meals and were happy with the food they received. One person said, "I eat all of it. It's always hot and plenty of it." A relative said, "They come around the day before. If there is anything they don't fancy they can have a jacket potato." However, we could not be assured people always received the support they needed to eat. At lunch time people struggled to eat their meals as there were no care staff present in the dining room. For example, one person was sat with their lunch in front of them, they were attempting to eat this however this was unsuccessful and they were dropping their food. There were no staff available to offer assistance. We saw this meal was taken from the person uneaten. For another person we saw they were trying to eat their dessert independently. We observed that this person had tried to eat this and was enjoying it. However due to their dexterity they required support. Although we had observed the person trying to eat this we saw that staff came in and assumed this person did not want this meal. They took the dessert from the person and replaced it with something different. This meant people did not receive the support they needed to eat their meals.

People did not always receive care that was responsive to their needs. We saw that one person had continued to lose weight since January 2018. Although we saw after three months a supplement had been prescribed for this person, we also saw a referral that had been completed had not been sent as the person's weight had increased during one month. The person had continued to lose weight for a further three months and the referral had still not been sent. There was a care plan in place for this person identifying that snacks should be offered, they should be weighed weekly and staff should offer encouragement. Records we reviewed showed us the person was still weighed monthly. Furthermore, we did not see staff encouraging this person at mealtimes or offering support to eat and drink as documented. This is a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People had their needs assessed and plans were put in place to meet their needs. Although we saw comprehensive plans were in place for some people we saw these were not always followed. For example, when people needed encouragement to eat and drink we did not always see this implemented. For other people when they needed specialist support this was provided for them. For example, one person was diabetic. We saw specific guidance was in place for staff to follow. Recordings of the person blood sugars needed to be monitored and we saw this was recorded. When blood sugars were certain recordings action needed to be taken and we saw this had happened. We also saw, alongside this care plan, there was up to date information from diabetic organisations detailing the support staff needed to provide.

The home was decorated in accordance with people's choices and needs. People had their own belongings in their bedrooms. There was a garden area that people could access with support. People who were living with dementia were not always provided with the support they required. People were asked what they would like to eat before their meal but there were no pictures or prompts used to support these people to make their choices. We did not see any signage or adaptations that would offer appropriate support for people living with dementia. For example, all bedroom doors were the same but numbered; there were no pictures or personal objects that may help people identify their rooms. There was no signage throughout the home guiding people to communal areas such as the bathrooms.

Staff told us they received an induction when they started working in the home. One staff member told us they had the opportunity to shadow more experienced staff and they had found this helpful. The manager told us how they had implemented the care certificate. The Care Certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. They said that all new starters would complete the care certificate as part of their induction. There was a log on the training matrix identifying which staff had enrolled on the care certificate.

People had access to healthcare professionals. One person told us, "They have a GP if I need them." We saw documented in people's notes and the nurse confirmed that the GP visited the home when needed. Records we looked at included an assessment of people's health risks. The nurses told us they worked jointly with health professionals to ensure they delivered effective care and support.

Requires Improvement

Is the service caring?

Our findings

People and relatives were happy with the staff that supported them, however they did not feel they had time to spend with them. One person said, "They don't really get time to chat in the day they are too busy." We observed there were long periods where staff did not offer support to people in communal areas or when people were in their rooms. As staff were rushed and completing tasks they did not always have time to spend with people or explain what they were doing. For example, when people needed support with their drinks or when they were in uncomfortable positions. As staff were rushing around we heard they shared private and sensitive information about people in the communal areas. We heard one staff member tell another over breakfast what support they had offered to one person and what other support they needed. We also observed that staff stood over people to assist them with meals, before quickly moving onto the next person. Some staff left people before they had finished their meals. This meant staff did not have time to treat people in a kind and caring way.

Although people told us their privacy and dignity was promoted we did not always observe this. One person said, "They always knock on the door." A relative commented, "Sometimes you hear them asking other people in the lounge if they want to use the toilet. They are not quiet about it." Staff gave examples of how they treated people with respect and promoted their privacy and dignity. However, we heard staff talking about people's care needs in communal areas and when people were supported to use specialist equipment we saw people's clothes were not always adjusted so their dignity remained.

People told us they made verbal choices about their day. One person said, "I choose what I want to do. They ask me if I want to go into the lounge but I prefer to stay in here (bedroom). Staff gave us examples of how they supported people to make choices. One staff member said, "We ask people what they would like to wear and if they want to stay in their rooms." Some care plans we reviewed reflected people choices as well as likes and dislikes. When other people made choices we were unclear if these were always considered. For example, staff told us that one person remained in bed however they would get up before lunch for a few hours and maybe have their lunch in the communal areas. They confirmed the person liked this. During our inspection we saw that the person remained in bed and ate their meals there. This person was unable to tell us if this was their choice. We discussed this with staff who told us the person remained in bed as they were 'running behind.'

People were encouraged to be independent. One person said, "I can get myself about so the staff just keep an eye on me." Staff gave examples of how they encouraged people to be independent this included, people doing tasks for themselves where possible and offer guidance to people so they could not it for themselves and not support.

Relatives and visitors we spoke with told us the staff were welcoming and they could visit anytime. One person told us, "They do welcome my husband. He comes daily he is the only family I have got." A relative said "I'm made very welcome." Another relative told us they could visit any time. We saw relatives and friends visited throughout the day and they were welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

One person had been discharged from hospital following an injury. It was unclear how this person was being supported with their mobility. There was no short-term care plan in place advising staff how to support. There was a previous care plan where it stated the person was hoisted. This had been updated and stated, 'not being used at present due to injury'. We discussed this with staff. One member of staff said, "We have never hoisted this person I don't know where the recommendation came from." Whereas another staff member told us this person was hoisted 'sometimes.' There was no evidence that this person had been seen by a health professional since they had been discharged from the hospital several weeks earlier to offer advice. The nurse and manager confirmed this to us. During feedback the nurse confirmed to us the referral (to whom) had been made.

People told us they were not involved with reviewing their care. One person told us, "I'm not sure really, maybe they did it with my relation." Another person told us, "They did something when I moved in it's never been reviewed or updated. If it has they haven't done it with me. Some things have changed, nothing major but I would like to be included." The care files we looked at did not show how people had been involved with reviewing their care.

We saw an external activity was taking place on the day of inspection, however this was not shared with all residents so only the people present were offered the opportunity to participate. The people who were participating in the activity did not seem to be enjoying it and were looking away and falling asleep. For long periods throughout the inspection we saw people were asleep and little interaction was demonstrated between staff and people. People and relatives raised concerns about the lack of activities within the home. One person said, "Nothing to do." A relative told us, "I think my relation would like activities. There doesn't seem to be much going on. Generally though I feel they would join in with a bit of persuasion." The manager acknowledged this was an area for improvement.

The manager told us they were aware of the Accessible Information Standards (AIS) and that this was an area that needed developing, however staff did not always demonstrate an understanding of this. AIS were introduced by the government in 2016, it is a legal requirement for all providers of NHS and publicly funded care provision to make sure that people with a disability of sensory loss are given information in a way they can understand. For some people they used headsets as a way of communication and we saw these were used during our inspection. Staff we spoke with knew what this equipment was however when asked did not understand the importance of this for the person. For other people we did not see information was available in different formats such as pictures or visual prompts, when they were unable to communicate verbally. The provider had started to consider, as part of their assessment process, people's cultural needs and support they would need in relation to other protected characteristics, including sexual orientation or gender. The provider was not currently supporting anyone with any specific needs.

People knew how to complain and felt more confident if they chose to. One person said, "I would go to the manager". A relative told us, "I know how to complain if I wished to". One relative who had raised a concern told us this had been actioned straight away by the provider and they were pleased with the outcome. There

was a procedure in place to manage complaints and we saw when complaints had been made they had been responded to by the provider in line with these procedures. This demonstrated there were systems in place to deal with concerns or complaints.

At this time the provider was not supporting people with end of life care, so therefore we have not reported on this at this time.

Inadequate

Is the service well-led?

Our findings

At our previous two inspections we found there was a lack of systems in place to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We also found that we were not always notified of significant events within the home. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2019. At this inspection we found the provider had not made the necessary improvements.

We have now inspected this location on five separate occasions since November 2015. Despite meeting with the provider and receiving action plans we found the provider had not made the necessary improvements to comply with these regulations. We have previously taken enforcement action against this provider and there is currently a condition on the provider's registration that people cannot be admitted into the home without the written permission of the CQC. We have also imposed other positive conditions on the provider's registration.

Furthermore, when improvements have been made these were not sustained. For example, at the inspection in November 2015 we identified breaches of regulations. These were in relation to Regulation 11, 17 18 and 19 of the Health and Social Care Act 2008. At the next comprehensive inspection in October 2016 we found improvements had been made in these areas and no breaches of regulations were identified. However at the next two inspections in June 2017 and November 2017 we again found breaches of regulations 11, 17, 18 and 19. At this inspection the provider is again in breach of regulations 11, 17 and 18. This demonstrated the management systems in place were not driving improvements and were inconsistent.

In the action plan dated 28 May 2018, the providers again gave us assurances they understood and could meet the legal requirements under the regulations, this included regulation 18 (registration regulations). The action plan in relation to regulation 18 stated, 'Incident/accidents have been reviewed and audited as required and where necessary disclosure to relevant authorities are being made'. At this inspection we found that when incidents or accidents occurred they were not investigated or reported to the local authority as required. We also found there was no effective system in place to audit these incidents. Therefore we could not be assured the provider understood the requirements of the regulation to ensure they were compliant.

As noted in 'Safe', when incidents had occurred we did not see action was taken to mitigate further risks. When incident or accidents occurred this information was not considered or used to make improvements for the people living at Beechfields Nursing Home Limited. We saw and the manager confirmed, that when an incident occurred there was no information available so that lessons could be learnt or improvements made. When accidents or incidents occurred and forms were completed, we saw that some initial action was taken. For example, when people fell they were physically checked over by a nurse. However, there was no further action taken. We saw one person had fallen three times in one month. Although the information had been recorded on a falls data sheet no other action had been taken to mitigate the risk or reduce further occurrence. The care plan or risk assessments had not been updated or reviewed after the falls had

occurred and a referral to an appropriate professional for support had not been considered. We had raised this as a concern at our last inspection.

We saw that some audits were completed within the home however they were not always effective in identifying areas for improvement. For example, we saw that audits were completed in relation to incidents and accidents. These recorded the amount of incidents that occurred, the times falls had occurred and the amount of people that had been affected. The provider could not demonstrate how this information was used to drive improvement within the home. We also saw that an infection control audit was completed on 25 January 2018. This had scored 83%. There was no action plan in place identifying where areas of improvement had been identified. This meant the provider had not taken necessary action to make improvements within the home.

We saw that a medicines audit had been completed. However, this had not picked up a medicines error we had identified during our inspection. This meant audits were not effective in identifying concerns.

We saw a survey had been completed to capture the views of relatives and friends of people who used the service. Where areas of improvement had been identified we did not see what action had been taken to make the improvement. The provider could not demonstrate what action had been taken to make the improvements or how this had been shared with people or their relatives.

This is a continued breach of Regulation 17 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

The provider had not notified us of all significant events that occurred within the home, in line with their legal requirements. For example, we had not been notified about events in the home that related to alleged abuse.

This is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

There was no registered manager in post and one has not been registered with us since February 2018. There is currently an acting manager in post whilst this position is recruited to. Staff felt supported to by the acting manager and the provider. One staff member said, "The manager and provider are always visible; I even have the providers telephone number." Another staff member told us they had the opportunity to attend staff meetings and if they had concerns they were happy to raise them with the manager. They felt that they would listen and take action if needed. Staff were happy to raise concerns and knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "I am aware of the whistleblowing policy and I recognise its importance." We saw there was a whistle blowing procedure in place. We saw the service worked in partnership with other agencies, for example a local health team visited the home each day.

We saw that the rating from the last inspection was displayed around the home in line with our requirements. The provider does not have a website to their display their current rating.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us about all significant events within the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments were not always in place and there was no evidence where decisions were made in people's best interest. When people were being restricted this had not always been considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed in a safe way. When incident or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential harm. Incidents were not always investigated or reported when needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive enough fluid or support at mealtimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider remains in breach of regulations and have not made the necessary improvements needed to comply. Audits were not driving improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People continued to wait for support. The training staff received was not always effective to support people.