Premier Nursing Homes Limited

Beechwood Care Home

Inspection report

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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?	**Inadequate**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We undertook this unannounced inspection on the 26 May 2015. We last inspected Beechwood Nursing Home on the 16 July 2014. We found the home was not meeting the regulations regarding meeting people's nutritional needs and management of medicines. We carried out a further inspection on 2 September 2014 to ensure the regulations were being met. At that inspection we found the home was meeting the regulations that were assessed.

Beechwood is a purpose built home.It is registered to care for up to sixty people who need nursing or personal care or some of whom may also be living with dementia. It is located close to the town of Northallerton and is convenient for the shops and other facilities. The home is over two floors and has a passenger lift. All bedrooms are single with en-suite toilets and wash hand basins. There are secure gardens to the front of the home.

The home employed a registered manager who had worked at the home for over one year. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The service was not safe. Although some of the people we were able to speak with told us that they felt safe both relatives and staff told us they felt there were insufficient staff at the home. Relatives described staff working non-stop. We saw that on one occasion staff took 5 minutes to respond to someone who had called for assistance. We observed throughout the day that care staff were consistently busy with care tasks. We witnessed poor care practices during our visit**.** We saw people were left for long periods of time in communal areas without any presence of staff. There was a shortage of staff due to sickness. You can see what action we have asked the provider to take at the back of the full version of this report.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show that staff employed were safe to work with vulnerable people.

Staff we spoke with understood how to make an alert if they suspected anyone at the home was at risk of abuse. Training had been given to staff about safeguarding procedures.

We identified issues with boxed medicines. We found that they were only counted on arrival and not checked again until the next month. Prescribed as necessary (PRN) medicines were not always recorded separately and so there were no details of why the medicine was needed. Eye drops were not dated when they commenced. This meant that there was the potential for errors occurring and not been addressed quickly which may mean that people received out of date medicines.

The home's infection control procedures were not good as there were unpleasant odours in all of the corridors and several bedrooms. You can see what action we have asked the provider to take at the back of the full version of this report

We found restrictive practices were being used at the home. Staff were not always following the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions for themselves. You can see what action we have asked the provider to take at the back of the full version of this report.

The home provided nutritious food as we observed this during breakfast and lunch. However, we observed people to have been left without food or drink for long periods of time, especially those people who had risen early. People were not always supported well to eat their meals by staff at the home. You can see what action we have asked the provider to take at the back of the full version of this report.

Staff were described as being 'A lovely bunch of lasses' and we saw some good practice where staff were seen as being kind and attentive. However, we did see poor practice such as people living at the home looking unkempt; having had clothes on that were stained and several people had no socks or stockings on.

A lack of robust care planning impacted on people's health and wellbeing. Care plans lacked information or contained contradictory information for staff to provide care and support in a manner which responded to the person's needs consistently. You can see what action we have asked the provider to take at the back of the full version of this report

We did not observe any activities taking place during our visit to the home.

People and their relatives completed an annual survey. This enabled the provider to address any shortfalls identified through feedback to improve the service.

We found the home to lack good management and leadership, which had led to potential risk on the everyday management and care delivery of the establishment.

There were auditing and monitoring systems in place to identify where improvements were required. However not all audits we saw were up to date this included infection control and cleanliness of the service, and fire safety. We did not see that the home had an action plan to address these. You can see what action we have asked the provider to take at the back of the full version of this report.

Summary of findings

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.

The home followed safe recruitment practices to ensure staff working at the service were suitable. However, there were insufficient staff available to meet people's needs safely.

A failure to assess and respond to people's care needs appropriately increased their risk of harm.

The service did not apply good infection control practices in keeping the home clean and free from odours.

Is the service effective?

Requires improvement 

The service was not effective.

Staff received training relevant to their role, however staff were not appropriately trained in providing support to people living with dementia.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However these principles were not always applied appropriately in line with legislation and guidance.

People were provided with a choice of nutritious food although they were not always supported well to eat their meals by staff at the home.

People had regular access to healthcare professionals, such as GPs, speech and language therapists and dietician.

Is the service caring?

Inadequate 

The service was not caring.

People who were able to speak with us told us they were happy with their care. Several relatives we spoke with raised concerns about the care provided at the home.

It was clear from speaking with some staff they had a good understanding of people's care and support needs and knew people well. We saw some good practice where staff knew people well. Unfortunately we also saw poor care practices where people living at the home looked unkempt and uncared for and were not supported well in their day to day lives.

We found staff lacked the skills and understanding in providing up to date dementia care.

Is the service responsive?

Requires improvement 

The service was not responsive.

Summary of findings

People did not always receive person centred care due to lack of information and strategies for staff to follow when dealing with people who challenged the service.

There was no programme of activity that was stimulating and meaningful for people living at the home.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Inadequate

The service was not well led.

People we spoke with told us that they had concerns regarding staffing levels, the provision of care and the cleanliness of the environment.

Inspectors found the home to be lacking in good management and leadership, which had led to potential risk on the everyday management and care delivery of the establishment.

There were systems in place for monitoring quality at the service in place. However these were not always effective. For example audits regarding infection control and fire safety had not been carried out regularly and were no longer up to date.

The provider had actively sought the views of people and was in the process of collating them in the form of an action plan to improve the service.

The manager ensured notifications required had been completed and sent to the CQC in a timely manner as required by law.

Beechwood Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We inspected the home on 26 May 2015. The visit was unannounced. We brought this inspection forward because we had received some concerns about the service. At the time of our inspection there were 56 people living in the home. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of four inspectors. As this was short notice we did not request an expert by experience to be part of the inspection. This was because we had brought this inspection forward as we had received some concerns about the service.

Before the inspection the provider is asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document should be returned to the Commission by the provider with information about the performance of the service. We were unable to review the Provider Information Record (PIR) as the Care Quality Commission did not request this prior to the inspection.

During our visit we spoke with three people who used the service and four visitors. We spoke with the registered manager and nine members of care staff including the deputy manager. We looked at all areas of the home including people's bedrooms, the kitchen, laundry, bathrooms and communal areas. Because of people's complex care needs we were not able to ask everyone directly about their care. However we observed the care and support people received in the communal areas of the home which gave us an insight into their experiences. We reviewed records relating to the management of the home including the statement of purpose, surveys, the complaints procedure, audit files and maintenance checks. We looked at eight people's care plans and observed how medication was being given to people. We checked the medication administration records (MAR) for six people and observed the medicines round on both floors. We also looked at the recruitment, training and supervision records for three members of staff.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. We planned the inspection using this information.

Commissioners from the local authority had contacted the Care Quality Commission as they had concerns about the service regarding the protection and safeguarding of people who lived at the home. We contacted Healthwatch to ask for their views and to ask if they had any concerns about the service. Healthwatch did not have any concerns about the home.

Inadequate

Is the service safe?

Our findings

Comments from people we spoke with about feeling safe were varied. One person living at the home told us they felt safe since a child safety gate had been fitted to their bedroom door. They told us this was to stop other people living at the home entering their room. We had mixed responses from relatives and visitors to the home about people being safe. One relative confirmed they felt people were safe and there were enough staff. They said, "Every time I visit there is always a member of staff in the lounge keeping an eye on everyone." Another relative when talking about their relative said "He's safe here. The environment for someone like (name of person) is hard. There are no quiet spaces and you get the interference of other patients." Another visitor told us, "I don't think there are enough staff, they are always rushing and sometimes when I visit its ages before I see anyone." One relative did comment on an unpleasant smell in the home as their only concern.

Two relatives said there was sufficient staff at the home, whilst several other relatives we spoke with told us they felt there was not sufficient staff. We spoke with a relative by telephone after receiving concerns from them about there not being enough staff. They told us, "Because there were not enough staff I found my relatives care was very basic they fell numerous times which caused bad bruising to their body. My relative has dementia they cannot complain themselves. I was told by one member of staff there were two care staff to eighteen people."

We arrived at the home at 6.30 am in morning as we had concerns raised with us that people living at the home were being got out of bed early. We had been informed that people were being got up from around 5.00am by night staff and that they were then left in lounges until breakfast which was around 9.00am.

When we arrived night staff were on duty. There was a registered nurse who was an agency nurse and three care assistants on the first floor. There was a senior care assistant and two care assistants on night duty on the ground floor.

On our arrival we conducted a tour of the building and found that there were four people up on the ground floor main lounge at 06:40am. On the first floor we saw there were seven people up and dressed, they were sat in chairs or walking around. We were told by staff that people had wanted to get up and dressed. None of the people we saw had capacity for us to ask them to discuss this issue with us themselves.

At 7am on the ground floor in the main lounge we saw three people were sat in their seats and no one had either a hot or a cold drink. At 8:10 am we went back into the main lounge, there were now six people up and dressed, but only one person had a hot drink. One person was sat at the dining table but then moved back into the lounge, we asked them if they had a drink, or breakfast, they replied, "There's not much to eat." At this time there was no evidence of food being served. Another person was asleep in their chair from 7am indicating that they may have preferred to remain in bed. We saw they were given breakfast at around 9:30 am and ate independently. They then fell back asleep with a cup of tea in their hand (cool). The tea spilled all over their arm and front. Staff approached them and took off their protective apron and removed the cup but did not take them to their room to attempt to change their clothes and they were left in a wet top.

We spoke with both night and day staff during our visit to the home. We were informed that night care staff had felt under pressure from day staff to ensure people were up and dressed. We asked staff where this perception had come from. A member of staff informed us it was not from the registered manager as they had made it clear that people should only be got up when they were awake. This had been discussed at a staff meeting and records we looked at supported what staff had told us. One member of staff told us, "I usually work nights." We asked them how early people got up. They said, "I don't like people to be woken before 6am. We start at 6am and change people's pads and dress them." This indicates that people were got up as a matter of the home's routine rather than in line with their preferences.

We were given copies of four week rotas for the home. These were from 27th April until the 24th May 2015. We found that day staffing on the first floor nursing unit was as follows: Deputy manager supported by an agency registered nurse and four care assistants. There was also one domestic. On the ground floor there were two senior care assistants supported by three care assistants. One

member of staff had called in sick. We were informed that there were four domestic staff for the whole building each day. Two domestics worked full time and two worked part time.

We found from the rotas we had been given that the staffing levels we saw on the day we visited were consistent with what was usually in place and what we had been told by the registered manager. We were told by the registered manager that staffing was planned to be at the level but that short notice sickness has left them short the home manager had attempted to bring staffing levels up by calling other staff to cover and by calling an agency but were unable to secure more staff. Allocation of staff and duties had to be changed to prioritise care needs.Our observations indicated that there were not sufficient staff on duty on the day of our inspection to meet the care needs of people who used the service.Staff were not able to carry out routine duties and deal with people in a timely manner because there was pressure to move on to the next task. We observed for example one person sat for a long period in their wheelchair without footplates, their feet did not touch the ground making this uncomfortable. We saw one member of care staff moving a person in a wheelchair without footplates. We observed one person remove the side of the wheelchair in order to pick their slipper up from floor. Two members of staff including the manager walked passed this person and did not notice what had happened. The inspector alerted a member of staff to the safety implications of this situation. We saw another person who was unsteady on their feet, using a walking frame with slippers on the wrong feet, consequently the back of the slippers were not sat on their heel properly so they were loose posing a significant trip hazard. We saw another person without any footwear at all. This meant that people were being put at potential risk from falls. Staff were again alerted by the inspector to these risks. We observed one night care assistant go to provide personal care alone when the person's care plan stated there should be 2-3 care staff to provide personal care. When we asked the member of staff if they were going to assist the person they told us they were. The other care staff were in the dining room and the nurse was doing the medicine round so there were no other staff that could have assisted this member of staff. We also observed at breakfast in the dining room that people were not sat close enough to tables to manage to eat comfortably and where they needed some assistance there were not enough staff to provide it.

One member of staff came in early for training and helped with breakfast because there was a shortage of staff and we observed them assist people with breakfast on the first floor. We observed staff rushing over tasks, and having little or no time to stop and speak to people other than saying "Are you ok?" as they passed. We observed one person had finished their breakfast and attempted to stand up to move away from the table on four occasions. A member of staff encouraged them to sit down and told them, "I'm sorry I need to wait for a member of staff to help us because you aren't safe to walk with just one person." After a period of time a second member of staff came to assist. We observed one person walked from the lounge chair to the dining table twice, and eventually returned to the lounge. We saw no evidence of them having had a hot drink. This person we observed as not having any breakfast despite being up at 6.35am on our arrival. We saw that this person went to eat breakfast at 09:30am. We saw breakfast still being served at 11am. We were informed by the Registered Manager that lunch was due at 1pm. We saw that this did not get served until 13.30 -13.45pm.

We spent time on both floors talking to people and observing staff interaction with people. We heard one call bell ring for a long period. We timed the call bell at 5 minutes before staff answered.

We spoke with several members of staff during our visit. One member of staff told us that one person living at the home needed three care staff at times due to their agitation and resistance regarding personal care. They stated that they were often short staffed due to people calling in sick. They went onto say if staff phoned in sick the managers would try and get a member of staff from upstairs to help out, however, this was not always possible which left two members of care staff for 27 people living with dementia. We spoke with staff about dependency levels. They gave us examples such as on the ground floor there were 11 people needing support from two care staff for their personal care. As well as care, night staff told us they had a list of cleaning jobs to do, this included cleaning the lounges, washing the supper pots, cleaning chairs, and washing zimmer frames and wheelchairs. When we spoke with one member of staff and asked if they considered there to be enough staff on duty they said, "Not always. I know that day staff expect us to get people up but my view is that if they are asleep they should be left." Another member of staff said, "I normally work days. We (day staff) don't say anything when people are not up but it does help

if they are." One member of staff told us, "The worst thing about working at the home was, being short of staff." One nurse said that they had struggled overnight because there was a person who required constant supervision when they were awake. They had put one of the care assistants on one to one observations which meant that they were left with only two care assistants for 31 people. They told us they had also had an incident to deal with involving two people living at the home being aggressive towards one another. They told us they felt that staffing was not appropriate. They said that although staff were very nice and worked hard they were not always appropriately trained and the example they gave us was that they felt staff did not understood infection control properly as they said staff were going between the kitchen and providing care which they considered to be unhygienic.

We spoke with the registered manager regarding the staffing levels and they agreed that more staff were needed. The manager confirmed vacancies and recruitment was needed to ensure the home had more staff stability and that vacancies were being covered by additional hours by the homes staff or agency staff. We gave feedback to the registered manager and the management team that the lack of sufficient numbers of suitably trained staff had impacted on the delivery of care for people living at the home. The provider needs to review staffing levels at the home to ensure that they are able to respond to people's changing needs.

This is a breach of Regulation 18 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to protect people against risk associated with not maintaining appropriate staffing levels.

The home was arranged on two floors. The top floor was nursing care with the ground floor for people requiring residential care. We saw that there were lounge areas on both floors. In the first floor lounge we found five chairs did not have proper cushions on them. The original cushions were missing or there was a pressure cushion. Chairs we saw were grubby and stained. The carpet in this room was also stained. We saw food debris under the radiators. During our tour we observed six child safety gates fitted to people's bedroom doors effectively providing a restraint. We discussed this with the registered manager and senior managers from the organisation who were present during our feedback. We raised our concerns about this practice not only being restrictive for people but could also be potentially dangerous. We have also contacted North Yorkshire Fire and Rescue service for further guidance on this matter.We contacted North Yorkshire Fire and Rescue service for further guidance on this matter. The advice we were given by the fire officer was that fire doors should not be prevented from closing in the event of a fire. Where people were requiring assistance to be evacuated from their rooms i.e. in a wheelchair or they required to be moved by an escape mattress, a child gate could impede people's escape and this should be considered in the fire risk assessment with a personal emergency evacuation plan for all relevant persons. In such cases, it must be ensured that procedures are in place to ensure that all such doors are always available in an emergency, staff are properly trained and the procedures are included in the premises emergency plan. The minimum width of an escape route should not be less than 900mm where wheelchair users are likely to use it. Wider escape routes will be needed if residents are to be evacuated in beds. Any device should be usable without key or code and with only one fastening.

When we toured the premises we found there was an unpleasant odour in all of the corridors and several bedrooms and we did not notice or smell any air freshening devices. We saw copies of the cleaning schedule the home had in place. The cleaning schedules we looked at covered all areas of the home and had been signed by ancillary staff who had completed the tasks. Although the signed cleaning schedules were available the cleanliness of the premises on observation did not reflect this input.

This is a breach of Regulation 15 (Premises and equipment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to protect people against risks associated with the adequate maintenance of the environment.

We observed poor care practices regarding infection control. For example we saw one member of staff gathering items to assist a person to get up and dressed. We saw them put protective clothing on (apron and gloves) and went into the person's room. We saw sometime later they came out with the person and brought them into the dining room and brought them a cup of tea still wearing the same protective clothing they had used to carry out personal care.

Inadequate

Is the service safe?

We recommend the provider reviews current infection control practices used by staff at the home.

We checked care planning documents for eight people from both the residential and nursing units. We saw that risk assessments were in place and were clearly linked to the persons identified need. For instance there were risk assessments in place when a person had problems eating. Staff used a malnutrition universal screening tool (MUST) and from the results determined the level of risk. This led staff to take actions to lessen the risk which were all recorded in people's care plan. There was an instruction for staff to check one person hourly day and night but we did not see any records of this being done. We saw in this person's care plan advice for the Speech and Language Therapy (SALT) team for the person 'to be sat upright when eating or drinking' but the plan written by staff said, 'Needs to be on a 45 degree angle when feeding' This did not correspond with SALT advice as upright is 90 degrees and therefore the information written by staff was incorrect and could have caused the person to choke if placed in this position. We were unable to observe what actually happened in practice as the person was sleeping all morning. We fed this back to the registered manager to ensure that the person was safe and that staff were following correct procedures. We also saw risk assessments covered other areas for example moving and handling people when a hoist was required and where people used wheelchairs. However we observed a person being assisted by staff with a standing hoist transfer. We saw the person clearly did not feel safe and vocalized this. The person was unable to understand instructions by staff to 'hold on' which resulted in the person expressing anxiety. We observed one member of staff being very patient and offered reassurance the other was less so which increased the person's anxiety. We saw in one person's care plan that they had a blister in their groin due to the wrap around their night continence pad being too tight. These were night pads and staff should have been aware of how to use them correctly.

This is a breach of Regulation 12 (Safe care and treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to protect people by doing all that is reasonably practicable to mitigate any such risk.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these to be overall safe. Senior staff administered medicines and we saw that they did so safely as we observed a medicine round during our visit on both floors. We saw that medicines were kept locked in cupboards or medicine trolleys. We looked at the medicines for six people. These were found to be accurately maintained as prescribed by the person's doctor. We saw that a person who was a diabetic their blood sugar result was recorded and the record was kept with the insulin administration sheet so that staff were aware of the person's status. We saw where a person who could not communicate and required a pain relief medicine, appropriate protocols were in place to determine if and when pain relief medicines were required. This ensured that the person was not put at risk from suffering pain. We saw from records that boxed medicines were only counted on arrival and not checked again until the next month. This meant that it would potentially be a month before any errors were identified. Prescribed as necessary (PRN) medicines were not always recorded separately and so there were no details of why the medicine was needed. We also found that one person's eye drops had not been dated when opened and stated dispose after 4 weeks. We checked the medication administration records (MAR's) for six people and found that they balanced and were correct with no gaps or errors made in the records. Overall we found staff to be knowledgeable about the uses of medication. For example one member of staff had noticed that a person had been prescribed drugs which were not usual to take together. They questioned this with the GP who then stopped one of the medicines. They then discussed this with the consultant who agreed with the changes.

We recommend the provider reviews the current systems in place for the recording of all medicines including prescribed as necessary (PRN) medicines.

Records showed that staff recorded accidents and incidents that happened at the home. The manager told us that accidents and incidents were all investigated and reported upon. A risk assessment was undertaken where necessary and action plans developed to reduce the risk of a reoccurrence. We saw that there was a personal emergency evacuation plan (PEEP) in each person's care plan we looked at. We saw that the home used a traffic light system. Red (high risk) record stating 'needs two for support, wheelchair, hoist, no capacity' We found this to be a very clear system and we were told at feedback that this

Inadequate

Is the service safe?

links to a file kept on each floor which was to be given to fire officer in event of fire. We gave feedback to the registered manager that the system could have been more effective if there had been some colour coding on bedroom doors in case a rescue was needed.

We looked at staff records and found that staff had been recruited in a safe way. When they applied to work at the service they provided two references and checks were carried out with the Disclosure and Barring service to check that they were suitable to work with vulnerable people. They did not start work until these checks had been carried out. We saw evidence the service managed staff disciplinary procedures.

We spoke with staff about safeguarding people. When asked about their understanding of safeguarding one member of staff said that they had been trained elsewhere but not at this service, although they knew what action they needed to take. Three members of staff who had worked at the home for some time told us they had completed safeguarding training and gave good examples of what to do and were clear regarding immediate action and then reporting on concerns. We were given a copy of the homes training record for staff. This showed us that the majority of staff had completed safeguarding training . This meant that people who used the service could be confident that staff knew what to do if they witnessed any abuse.

Requires improvement

Is the service effective?

Our findings

Comments from people about the service being effective were varied. People told us that they felt their relatives were well supported with most aspects of their care. One relative said, "The care is fairly effective although I come and find a messy room quite often and there is often no cushion in his chair." The relative showed us their relative's bedroom which had clothes all over the floor where they had emptied drawers. They went on to say, "I am not impressed with the food. When I ask if they have had their five a day they (staff) look at me blankly. (Name of person) had a bad back and I've had great difficulty persuading staff to get him to see a doctor. I was told they weren't sure when he was coming." When asked if they were involved in their relative's care they said, "They (staff) told me it wouldn't be necessary for me to see the GP." Another relative said, "Once when I visited I saw that people were given their meals by staff but they did not help them to eat. I saw one person asleep with their meal in front of them. I asked a member of staff if they could warm the person's meal. I heard the member of staff say "Do you not want your lunch (name)" and saw them take their meal away."

We observed two of the staff handovers between night and day staff, one on each floor which we were told was held at the start of each shift. This was organised and key information about how people were, in terms of feedback about people's health and well-being was shared at the handover. This meant staff starting their shift had been made aware of any concerns about people's health and all care staff knew what was expected of them. However, we found it difficult to establish which staff were working on the ground floor. One care assistant seemed to think they were working on this floor and was giving people their wheelchairs (these had been parked down the corridor for overnight cleaning), however, they then went upstairs to work on the first floor.

We saw one person had been asleep since at least 7am in a chair. We did not see them with any food although we saw they had a mug of tea at approximately 6:50 am. At 10am the person was still sleeping in the chair. At 10:12 they were woken by a nurse to give them their medicine. The nurse sat with them and offered to take them for breakfast. They indicated that they wanted to go to the toilet and at 10:20 they were taken. When we saw this person again they were sleeping in another lounge. We had not seen them have any food but the deputy manager told us that she had given them food. The person did not wake again until lunchtime when they came to the dining room. This meant that the integrity of the person's skin could break down because the person had stayed sitting in the same position for several hours. There was also no evidence that the person was being stimulated because of the lack of activities taking place.

We observed breakfast being served between 9:15 and 11:15 am. We saw staff offering people choices for example we saw people being asked 'where would you like to sit, would you like a drink' and so on. We saw people being offered a choice of breakfast such as porridge, a cooked breakfast and toast. There was plenty of food on offer, which looked appetising and we saw that the food served was hot. Where people required fortified foods we saw that they received this as we saw porridge being given to people which had extra cream and honey. We saw a member of staff give one person scrambled egg and beans as they slept in their chair. Staff left the food in front of them and it was there for 25 minutes with no one attempting to remove it, wake the person or offer support. After this time the person woke themselves and started eating cold food. They had a pot of yoghurt like supplement to eat also. They had no spoon and no one noticed so they began to eat it with their fork. Eventually a member of staff just walked up and took the plate away leaving the person looking bemused and wondering where the plate had gone. This meant that people did not always receive assistance with their meals where this was required and could be put at risk from not receiving food or drink as needed. We did see some good practice where one member of staff was seen to be very patient and kind when assisting someone to eat. The member of staff explained that the person often did not wish to eat. We saw that the member of staff gave a lot of encouragement and used distraction techniques in order to make sure the person ate their food.

People were offered clothes protectors but we observed people's clothes were stained with food. We saw sample plates being taken around by staff to demonstrate the food choices available but for some people this was at least 20 minutes before they were given their meal. We observed one person being shown both sample plates and observed them say they did not want either because they did not like the food on offer. The care staff acknowledged that they did not like the food. We returned to see what the person had been given and saw they had been given cheese and

Is the service effective?

pepper rolls and potato croquets which they had said they did not like. They went on to tell us that we could have it because they were not going to eat it.Inspectors did not see this person being offered any other alternative.This meant that people were not always given the food that they wanted to eat and meant that people could be put at risk from weight loss because they were not provided with the food they required. At 2:40 pm we found that people still remained sitting at the tables in the dining room.

We recommend the provider reviews how people are supported with their meals to ensure their nutritional and hydration needs were met at all times.

We looked at eight people's care plans. All care plans we looked at had been evaluated monthly. One relative we spoke with confirmed they had Power of Attorney and had been included in developing their relatives care plan. The care plans we looked at showed that the registered manager had assessed people in relation to their mental capacity, to determine if people were able to make their own choices and decisions about their care. Best interest meetings had been held for people with the appropriate agencies and relatives had been involved. However, Deprivation of Liberty Safeguards (DoLS) had not been taken into account for people where restraint was being used. For example we looked at people's care plans where child safety gates were fitted to their bedroom doors. This was to check the home was following correct procedures in line with current legislation. We saw written in one person's care plan 'To prevent entry by others as unable to protect self or use call bell.' We saw there was a plan in place for 'delay of exit from this room' saying 'staff to remove the safety gate immediately in event of emergency.' We saw that a Deprivation of Liberty Safeguards (DoLS) authorisation had been applied for all six people, although the restrictive practice was already in place and being used. We were informed by staff that they knew why one person had this gate fitted on their door as their relatives had requested this, but had no idea why others were in place. The staff told us that it was to keep people out of rooms. They told us that they had been previously removed but when a person's family objected they were all reinstated. We were told by staff that (DoLS) authorisations had been identified as an issue by the operations team supporting the home at the moment.

We found that one person sat in a specialist chair which reclined. They did not have a risk assessment in place relating to restraint although they were unable to move unaided. Restricting people's movements in this way is a form of restraint; The restrictions were unlawful because they had not been authorised by the local authority following the correct processes. or followed the correct procedure and legislation when people did not have capacity to consent to them being in place**.** This was restrictive practice and did not meet the principles of the Mental Capacity Act. Staff had not considered the use of less restrictive practices such as the use of telecare. Telecare is support and assistance provided at a distance using information and communication technology. It is the continuous, automatic and remote monitoring of users by means of sensors to enable them to continue living independently, while minimising risks such as a fall. This meant that staff were not using best practice guidance when managing those people with a history of falling and therefore people may not receive the help they require in a timely manner.

We saw in one person's care plan where they were at risk from falls from their bed. We saw that the bed had been lowered and a crash mat (this is a special mat to prevent people hurting themselves) was in place. The bed had bed rails but we could find no evidence of anyone giving their consent and no best interests decision had been made about this. We saw that a best interest decision had been made for this person regarding assistance with hygiene and their continence needs. The care plan described how staff carried this out in detail. Again staff were not working within the principles of the MCA

This was a breach of Regulation 11 (Need for Consent)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not protected people against the risks associated with the need to consent.

We looked at eight people's care plans and saw that where people required intervention form other professionals this had been done. For example one person had been at risk of aspiration pneumonia due to swallowing difficulties. We saw that they had been assessed by the (SALT) team. We saw in this person's care plan that staff had to assist with feeding because this person was on a special diet (pureed or soft mashed food). They were given either the soft mash or pureed food after staff assessed their alertness. Clear pictorial and written guidance on what the special diet food looked like was in this person's care plan. We saw

Requires improvement

Is the service effective?

clear instructions telling staff what to do in case of choking. We saw in records we looked at that a dietician was involved with people who had difficulties with eating and fortified diets and supplements were provided for those people who needed them. We also saw risk assessments covered other areas such as moving and handling people when a hoist was required and where people used wheelchairs.

We spoke with staff about training. Staff told us about their induction training. One member of staff said, "I got two days one on each floor. I have done first aid, e-learning, manual handling, COSHH, bed rails and fire training." We asked if staff had any training in dementia awareness as the service provided care for people living with dementia and they answered, "No." Another member of staff said, "On day one I was shown around and did fire safety training. On day two I did moving and handling, first aid, food hygiene, COSHH, bed rails, health and safety and fire training. I was then put on the rota." Both staff told us they enjoyed working at the service. The registered manager told us a programme of training was in place for all staff. We were given a copy of the staff's training record and we saw that staff had received training in areas which the registered provider had deemed mandatory such as health and safety, medication, fire safety, first aid, food safety and safeguarding adults. One member of staff said they felt they were well trained and supported. They said, "I have nearly completed my NVQ 3 and have completed dementia awareness, safeguarding, MCA/DOLS and mental health training." This meant that people who used the service could be confident that staff received appropriate training to carry out their duties they are employed to do.

Staff confirmed when speaking with us that they received regular supervision and had annual appraisals. We saw from records that staff received regular supervision from the registered manager or a senior member of staff. This gave them the opportunity to discuss work related matters and share information in a one to one meeting. We saw from recent records that nutrition had been the topic discussed in those one to one meetings.

Inadequate

Is the service caring?

Our findings

There were mixed responses to people being cared for well. Several people told us that overall staff at the home were caring and that they were well looked after. One person living at the home said the staff were "lovely ..'you can really talk to them and they listen, they are good listeners."

One relative we spoke with said, "There is no problem whatsoever, staff are gentle and kind to him." They went on to say, "Staff have done a good job. He was very distressed at night and he is now sleeping well. However I feel that they are not dealing with the person." One visitor said about the staff "Can't fault them. A lovely bunch of lasses. I have no complaints." Another visitor said, "I have no concerns at all, carers are absolutely wonderful I can't speak too highly of them."

Other relatives we spoke with did raise concerns with us about how people were cared for at the home. One visitor said they often had to change their relative's clothes and laundry often went missing. One relative raised their concerns with the Local Authority and told us "I would not put my relative in Beechwood again just thinking about what my relative may have experienced upsets me." The relative finished off by saying "Do insist with these people who own these places to remember they are our loved ones and I for one want peace of mind if they are in these care homes." Another visitor to the home told us of their experience when they visited the home. They said that the person they were visiting had asked staff to help. They observed staff grab the person under each arm and put them in to a wheelchair which was not the correct way of moving a person. The care staff told the visitor they were monitoring the person they were visiting but the visitor told us this was not the case as the person they were visiting was attempting to get out of the chair and no staff came to assist them

However, we observed some good care practices during our visit. We saw that staff crouched down to talk to people at eye level, and saw use of touch. When we spoke with one member of staff we observed that they knew people well and could tell us about them when asked. We saw they were very patient and kind when dealing with people's needs. The member of staff said, that the best thing about working at this service was "One person seems to recognise my voice and I can help them to eat where others (staff) cannot."

Unfortunately we also saw that several people looked unkempt, one person had their hair done and was wearing some make-up but we saw that their clothes were stained and the trousers they were wearing were too short for them. We saw several people had no socks or stockings on. One person had a button missing on their dress and had the middle part of their body exposed. When we pointed this out to a member of staff they said, "Oh yeah I've noticed that', we suggested the person was supported to wear something more suitable. This meant that members of staff made no attempts to change this person's clothing, until this was pointed out to them by an inspector. We saw another person in the afternoon was left in underwear in their room. This person's bed was not made. Another person again in the afternoon was not dressed. We observed one person was left in a wheelchair for at least an hour with no pressure relieving cushion at all in place. We saw one person in one of the lounges who was unshaven and no socks on. This may have been due to the lack of staff time, which also may have contributed to the attitude and approach of some of the staff available.

During our tour of the premises we observed rock music playing in one of the lounges and dining room which intermingled with music coming from the kitchen. We were unsure if people sat in this area had requested this music or not. This meant that people were subjected to listen to different types of music being played all at the same time which may add to their confusion.

We spent some time observing care in the lounge and dining room areas to help us understand the experience of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We saw in one lounge where there were three people that. most of the time people were asleep. One person kept attempting to move a side table around, it fell over on two occasions and made a loud bang but no staff attended. It was almost half an hour without any staff intervention in this lounge.

We recommend that the provider reviews best practice guidance in the provision of care for people with dementia.

We saw that where people required an end of life care plan these had been completed. This meant that staff were clear as to how people wanted their care needs met when they were at the end of their life.

Inadequate

Is the service caring?

Our general observations were that staff communication was poor. People living at the home were spoken too in passing by staff but there was no meaningful engagement. We heard people being asked “Are you ok” repeatedly without staff waiting for a response and staff appeared too busy.

Care plans we saw contained information on the person’s likes or dislikes. However, we found that in practice people received poor care which was not always person centred.

People looked uncared for as their clothing had not been changed where necessary. People were left in stained clothes or clothing that needed repairing or replacing. Staff did not make sure that people were dressed in appropriate clean clothes. We gave feedback to the registered manager and the management team that the lack of sufficient numbers of suitably trained staff had impacted on the delivery of care for people living at the home. This meant that people were not always cared for well.

Requires improvement

Is the service responsive?

Our findings

Most people we spoke with told us that the home was not responsive. Relatives shared with us their experiences and were able to give us good examples as to why they felt the home was unresponsive. One relative said communication was poor. They said they often made requests which were not actioned. For example the chair in their relative's bedroom needed replacing, they had been promised this would be done but this had not happened. Another relative said, "They do not take my relative out as they need a member of staff but I take them out." One relative told us, "(Name of person) has a fair amount of cognition but this place is killing it because there is no stimulation for them." Another relative told us there were no activities and people's clothes went missing all of the time." One relative did make positive comments about the home. They told us, staff communicated well with them and they gave an example when their relative was ill, they said staff telephoned them straight away.

During our visit to the home we observed that there did not appear to be a lot of activities to keep people occupied nor did the staff have the time to just sit and talk to people. The lack of sufficient staff available to either take people out or spend time with them was evident during our visit to the service.

During our observations we saw people had access to an outside garden but we did not see any staff offer to take people out. There was a memory board displaying date, day, time and weather. There was some pictorial signage telling people where the dining room was and toilets and bathrooms. We saw a sensory room although this was not used during our visit. We saw in people's care plans recorded what people like to do for example one person enjoyed taking cuttings from plants. However we did not see any activities taking place during the day.

When we spoke with staff one told us they thought people could do with more entertainment. One member of night staff we spoke with gave a good example of helping people and giving them choices such as what they would like to wear for the day.

We recommend that the provider looks at how improvements can be made for people to have access to proper and appropriate activities.

We reviewed the care plans of eight people living in the home. Care plans we looked at detailed where there were any concerns about nutrition. We saw that these were comprehensive and detailed people's likes and dislikes and clear for staff to know what support was required and staff used a malnutrition universal screening tool (MUST) and from the results determined the level of risk. We saw that people's weights were recorded where there were concerns about weight loss the appropriate professionals were involved. We saw that all the care plans we looked at had been reviewed by staff at the home.

However we found that for one person when we checked equipment that was being used for them which was an air mattress we found that this had been set incorrectly for the weight of the person. We found that this person's care plan stated 'If does not move independently after four hours assist to move.' There were no records of this happening. When we asked staff they told us it was just part of the routine when carrying out personal care and was not recorded separately. We saw instructions for one person to be repositioned 2-4 hourly we did not see any record of this being done. We saw in records where one person became agitated when staff were providing personal care when showering them. Staff were unclear of what action to take and continued to shower the person which would have added to their distress. There were no instructions or strategies in place for managing this aspect of the persons care. Staff we spoke with told us that this person required three staff when assisting them with their personal care. This was fed back to the registered manager who told us that staff would have liaised with the community psychiatric nurse (CPN); we could not find any record of this. The manger also told us that three care staff were not providing care, they said two were and one person passed things so they could do it as quickly as possible. They also said they advised care staff would try and encourage the person, they would then go back and try at different times of the day. This was in conflict with information provided by staff; who told us that the person was aggressive on all personal care interventions. The registered manager accepted this was not recorded within the person's care plan. We were told that one person hoarded food in their room and so the domestic staff cleaned the room each week, however, there was no evidence of this in their care plan or risk assessment regarding this. There was brief mention of the issue in the DoLS application that had been made.

Requires improvement

Is the service responsive?

This was a breach of Regulation 9 (Person-centred care) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not protected people against the risks of inappropriate care which met their needs and was person centred.

People told us about how the management of the home responded to feedback or to any complaints. People we spoke with told us they would speak to the manger if they had any issues or concerns. Relatives we spoke with said they would feel confident any complaints would be responded to. We looked at the home's complaints log. We saw that there had been eight complaints made since the last inspection. We saw that most complaints had been made regarding people's personal possessions going missing. One complaint had been made from a relative regarding the standard of care their relative had received. All the complaints we looked at had been responded to appropriately by the registered manager and were monitored by the organisation.

Inadequate

Is the service well-led?

Our findings

The home employed a registered manager who had worked at the home for over one year. During the visit we saw the registered manager visited the communal areas of the home. They engaged with people living in the home and were clearly known to them. People we spoke with all said they knew the manager and she was visible around the home. Relatives and visitors we spoke with said they knew about relatives meetings being held and the homes newsletters that were available.

Most people we had spoken with were relatives and despite describing staff as 'caring, gentle and kind' raised various concerns. They told us that staff were always busy and were rushing and were not always visible. One relative told us they had concerns that people did not always receive their meals. Relatives also had concerns about the strong odours in some areas of the home. During our visit to the home, inspectors saw poor practices by staff where people's care was either unsafe or poor which have been detailed in the report and which we have asked the provider to address. We found the home to lack good management and leadership, which had led to potential risk on the everyday management and care delivery of the establishment. This meant that the home was not well led by a management team who were effective and managed the home in the best interests of people who lived there and staff who worked at the home.

We spoke with staff and several told us that the best thing about working at the home was the staff who were 'lovely with a good approach' and the worst thing was 'staffing levels and having to use agency staff.' One member of staff told us that staff had lost their motivation when there were shortages and became frustrated. They went onto tell us they had worked 60 hours every week for four weeks because of shortages to try and prevent the use of agency staff but they had become very tired. When we asked about the registered manager one member of staff said "They are lovely but had to learn the job." They went on to say, "They used to work in day services so had no experience of residential care. Unfortunately they asked the staff for advice and did not keep the management distance which caused some difficulties." Another member of staff told us that the Registered manager was 'supportive and described them as having an 'open door policy'.

We looked at the minutes from the last staff meetings. We saw the last one was held in May 2015.We were informed that staff meetings were held three monthly. The registered manager informed us that they did a weekly staff communication bulletin to keep staff up to date. Throughout our visit to the home it appeared that due to the shortage of staff and the attitude and behaviours of some staff, had impacted on the delivery of care to people living at the home and to staff morale. Inspectors felt clear management structures were required to be put in place to ensure people's care needs were always being met in a consistent and safe way. Day to day responsibilities needed to be defined to both staff and managers so that people's care was not compromised.

From the staff records we looked at we saw that staff had received regular supervision and appraisals with their line managers.

No one who lived at the home that we spoke to were able to tell us if there had been a residents meeting or if surveys were undertaken. However we were informed by the registered manager that a recent survey had been carried out in April 2015 and replies were just being returned. This information was being collated by the organisations head office, and a report on the results from the surveys would then be compiled.

Notifications had been reported to the Care Quality Commission as required by law.

The manager told us that they carried out quality audits regularly. We looked at the audits carried out by the manager. These showed that most audits had been carried out regularly each month. These audits covered areas such as medication, care plans, nutrition and staff files. We saw that the last audit for the kitchen had taken place in February 2015. We saw that audits regarding the environment and infection control had also last been carried out in February 2015.We did not see any action plans drawn up identifying the issues we had raised about the odours. This meant that all audits were not up to date, and were not being completed in a timely way to ensure that any work that was required was identified and action plans were put in place to ensure the home was safe, clean and well maintained for people living there. We also looked at the fire records and saw that the last time the fire system had been recorded as being tested was on the 6 May 2015. Records stated that these were required to be tested on a weekly basis and we found this was not the case.

Inadequate

Is the service well-led?

This was in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not protected people against the risks associated with insufficient assessment and monitoring of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had failed to protect people against risk associated with not maintaining appropriate staffing levels.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had failed to protect people against risks associated with the adequate maintenance of the environment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to protect people by doing all that is reasonably practicable to mitigate any such risk.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not protected people against the risks associated with the need to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

The provider had not protected people against the risks associated with the provision of person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not protected people against the risks associated with insufficient assessment and monitoring of the service.