HC-One Limited

Beeches Care Home (Nottingham)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beeches care home is a care home providing personal and nursing care to 34 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The home is across two floors with people who receive nursing support living mostly upstairs. The service can support up to 54 people.

People's experience of using this service and what we found
People were not always kept safe due to a lack of risk management and mitigation. People were not always supported with their needs in a timely manner. People were not adequately protected from the risk of infection due to poor infection control practices. People were not always supported to take their medicines safely.
People did not always receive personalised care and people's care plans did not always contain relevant up to date information. People had limited interactions and not many activities were available on a daily basis.

The service was poorly led, whilst there were systems and processes in place these were not being utilised effectively. There was little oversight of the service which had led to the care, quality and safety of the service diminishing.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 3 July 2019) and there was a breach of regulation 12 (safe care and treatment). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection control, risk management, staffing, personalised care and leadership.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Beeches Care Home (Nottingham)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors and an assistant inspector on the first on-site day and two inspectors on the second on-site day.

Service and service type
Beeches is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We observed the general interactions between staff and the people they were supporting. We spoke with twelve members of staff including care assistants, nursing staff, maintenance, area director, deputy manager, relief manager, area quality director and administrator.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at two staff files in relation to recruitment and multiple agency staff profiles. A variety of records relating to the management of the service, including polices and procedures were reviewed.

Following the days on site the provider sent further documents including training data and quality assurance.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not kept safe from the risk of infection.
- National guidance around cohorting and isolation were not being followed. People who were newly admitted into the service were not always supported by staff wearing the correct level of personal protective equipment (PPE) and signage was not up to indicate designated rooms and bathrooms.
- Agency staff COVID-19 tests results were not being recorded by the home, lateral flow tests on the day were not being checked or recorded prior to agency staff starting their shift. This meant there was a heightened risk of transmission of COVID-19; which places people at risk.
- Kitchen areas were not all being kept clean, particularly the microwave and fridge. There was a lack of effective checks on food items to ensure they were not being served to people after their use-by dates.

The provider failed to ensure staff were following correct procedures to prevent and control the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to effectively assess risks to the health and safety of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People's risks were being assessed however they were not being monitored or managed safely.
- Risks associated with people's skin integrity were not being managed effectively. People were not always supported in a timely manner with their repositioning and continence needs. Pressure relieving mattresses were not always on the right setting, which placed people at an increased risk of developing pressure damage.
- People experienced very long waits after calling for support or help. A person told us "I'm just so fed up I ask someone for something, and no one comes. I pressed the bell, but no one came. I've been waiting to get up since 7:30."
- The call bell system had been silenced and not all care staff carried around buzzers that were linked to the system, this meant staff may not be alerted to people who may be trying to get help in an emergency.

The provider failed to manage risks safely. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff deployment meant people's needs were not being met in a timely manner.

● The provider did not have a comprehensive dependency tool in place to establish the amount of staffing hours required.

● Staff felt there were not enough care staff on shift and that seniors and nurses had other duties and were unable to assist with supporting people. Staff explained, "We need more staff obviously, we are doing 10 things at once, we can't do that."

● Staff had not been trained in specific areas to be able to support with people's specific needs. For example, in wound management and behaviour that may challenge. The provider did not ensure all staff were completing other areas of required training, such as infection control.

● Staff had been recruited in a safe way, with the appropriate pre-employment checks, such as seeking references, had been carried out.

The provider failed to ensure staff were deployed in such a way to meet people's needs and failed to ensure staff had the appropriate training. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

● People were supported with their medicines in safe way, however we found concerns with the medicine's documentation and management.

● The transcribing of certain medicines meant there was increased potential for errors to be made. We escalated this to the service on the first day of inspection and they promptly rectified the paperwork to make it clearer for staff and reduce the risk of errors.

● Checks on the temperature of the medicines room and on medicine stock were not carried out consistently.

● We found supplements used to assist people who have difficulty swallowing stored inappropriately.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People felt safe in the home and relatives told us they believed their loved ones were being looked after safely.

● There were clear systems and processes in place to protect people, however these were not always being followed. For example, following an incident that resulted in a person suffering a fracture; no follow up investigation, risk management or learning took place.

● Staff were not all trained in safeguarding, however staff we spoke with understood the principles of safeguarding. Staff did not know where the policies relating to safeguarding or whistleblowing were kept and did not have much confidence in management to act if they raised concerns.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had plans in place for all aspects of their care. These were personalised and written from the viewpoint of the individual. Care plans included information about people's life history's as well as their religious and cultural preferences, although we did find inconsistencies throughout them.
- People all had communication plans in place however these did not always reflect people's current needs. For example, one stated a person was non-verbal, however on the day of the inspection they were able to clearly communicate verbally.
- Whilst people were regularly receiving bed baths; records showed there were very limited offers of showers or baths. The home had a bath and shower list in place, which is not a personalised approach. We fed this back to the area director who stated that it should not be in place and would remove it immediately.
- People were not always supported to avoid social isolation. Whilst we did see some people having visits from family, there were very limited interactions between staff and people, particularly for those who resided upstairs. There were very limited activities on offer for people to engage in. This meant people were at risk of social isolation.

The provider failed to ensure a personalised approach to care and support was being delivered. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- People had end of life care plans in place, those who were nearing the end of their life had a template for a more detailed plan in place.
- Both type of plans were very limited and contained basic essential information, neither had been fully completed. They were not very personalised or holistic. Care plans did not contain information which allowed staff to provide quality end of life care and personalised support.
- A relative spoke very positively about the care their loved one was receiving and said the home had

spoken with them about their loved ones wishes. They said, "[named family member] needs to be safe and comfortable and they defiantly are."

Improving care quality in response to complaints or concerns

- There had been no complaints received. The provider has a procedure and policy in place to be able to respond to any complaints if they were to be received.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The home did not have a registered manager in post and the home manager was absent. The deputy manager was only allocated part-time hours for managerial duties.
- There were systems and processes in place to ensure the safety and quality of the service, but these were not being utilised effectively or being carried out consistently. For example, there were audits in place to check medicines that had been completed however they did not pick up on the significant concerns we found.
- Daily checks, such as the managers walkaround and flash meeting with staff, were not being carried out regularly. This meant concerns around staff competency, infection control and personalised care planning were not being identified or addressed.
- Concerns around the safety of the service were not being picked up. For example, the area director had carried out random tests on the call bell to check how quickly staff responded. However, they had not addressed the issue of the lack of buzzers or analysed the call bell data to see how long people were waiting for help in reality.
- Due to the lack of consistent leadership within the home, where actions had been identified following investigations or audits, they were not being carried out and therefore quality of service was not being improved upon.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff meetings were being held regularly however staff we spoke with did not always feel supported. Staff did not always feel listened to when they raised concerns and morale was low.
- Residents meetings were being held regularly, however there appeared to be little engagement with people on a day to day basis.
- We saw evidence that the home worked with other healthcare professionals, the local authority and the clinical commissioners.

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

● The provider did act on the duty of candour on most occasions and relatives told us they were contacted when incidents with their family members occurred.

● A relative explained, "They call me when they have seen the doctor…they keep me informed."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's care plans contained relevant, up-to-date information and failed to ensure people received personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were up to date with relevant training and failed to ensure they had enough staff to meet peoples needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people were being monitored and managed safely. The provider failed to ensure they were following infection control guidelines and best practice.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the service was being managed effectively and failed to ensure comprehensive quality and safety monitoring.

The enforcement action we took:

We issued a warning notice