Skolak Healthcare Limited

Beechill Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2016. The first day was unannounced which meant the service did not know we were coming. The second day was by arrangement. At the last inspection in September 2014 we had found the service to be meeting the regulations we looked at.

Beechill Nursing Home provides accommodation, personal care and nursing care for up to 31 people who have a variety of needs, including some with a history of alcohol or substance misuse. There were 28 people living in the home at the time of our inspection. The home is situated in the Cheetham Hill area of Manchester, within easy reach of shops and other local facilities. There are 23 single bedrooms and 4 double bedrooms on two floors, a lounge and dining area, a conservatory and a smoking room.

Beechill Nursing Home has a registered manager, who is also one of the directors of the company that is the provider. 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.

People considered themselves to be safe in the home. Although there had recently been some violent incidents action was taken to prevent a recurrence.

We found a range of issues relating to medicines. These included a lack of instructions as to how to give medicines prescribed to be given 'as required', and incomplete instructions about giving insulin. These issues were a breach of the regulation relating to the proper and safe administration of medicines.

The building was designed to be safe for people living in the home. However, we were concerned about a possible lack of security due to the absence of a proper signing in book and the CCTV not functioning.

Staff were trained in safeguarding and knew their responsibility in this area. People were protected from the risk of fire.

Staffing numbers were calculated in relation to dependency levels and we considered there were enough staff on duty.

Recruitment records showed that steps were taken to ensure only suitable people were employed. There were effective disciplinary procedures. The home was kept clean and action had been taken following an infection control report.

Consent to care and treatment was recorded on care files but in some cases consent was given by a relative which is not in accordance with the Mental Capacity Act 2005. Consent had not been obtained for bedrails and the home did not conduct mental capacity assessments when needed. This was a breach of the

regulation relating to consent.

Applications had been made appropriately under the Deprivation of Liberty Safeguards (DoLS).

The majority of staff had received the relevant training for their role, but there were some gaps. Staff at the home were trained to support people at the end of life. Regular supervision took place but sometimes the sessions were used to communicate messages to staff rather than allow staff to raise issues.

The cook was popular with people in the home and the food was well liked. People had access to health professionals. We have recommended that guidance should be followed to make the environment more suitable for people living with dementia.

Staff had a caring attitude towards people in the home but were often busy with paperwork. We saw one example where someone's needs for assistance were neglected for a long period during breakfast. We found this to be a breach of the regulation relating to meeting people's needs.

People's experiences varied but on the whole they found the home was supportive and encouraged their independence. Provision was made for people whose first language was not English. We saw that people were encouraged to reduce their dependence on alcohol.

People's personal privacy was respected although there were examples of the confidentiality of documents not being protected.

Care plans and risk assessments were thorough and specific to each individual. Some people told us they had signed their care plan but most could not recall being involved with it. In some cases we found the care planning did not meet all people's needs, for example one person did not have a plan to deal with their risk of pressure ulcers.

There was evidence that some activities had taken place but there was no activities organiser in post and some people told us they wanted more activities. The shortage of meaningful activities was a breach of the relevant regulation.

There were regular residents' meetings. We did not see any recent questionnaires for relatives or people living in the home. Only one formal complaint had been recorded in the last nine years.. The complaints policy was not clearly written. The notice in the lounge about how to make a complaint was out of date.

Beechill Nursing Home had a huge range of policies. It was not clear that these were accessible for staff. Staff meetings were held but there were no recent minutes. A statement had been read out at a previous meeting which was patronising towards staff. A memo issued to staff about their conduct in February 2016 was also demeaning.

The registered manager stated that he regarded the home as a business. There were two examples where the emphasis seemed to be on money rather than the safety and wellbeing of people living in the home. Nevertheless, staff we spoke with regarded him as a good manager.

Certain notifications required by regulations had been incomplete. Audits were conducted to monitor the quality of the service.

In relation to the breaches of regulations, you can see what action we told the provider to take at the end of

the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were a number of problems in the way medicines were administered.
Clearer instructions were needed for staff.

The building was well designed to meet people's needs but some improvements were needed in relation to security.

Staffing levels and recruitment procedures were adequate. The home was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always correctly recorded in line with the Mental Capacity Act 2005.

Training was generally good but with some gaps. The food was popular.

Improvements could be made to the building to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw examples of good care but one example when someone who needed assistance was ignored.

The home encouraged people's independence. Some people were supported to reduce their dependence on alcohol.

Privacy was respected. The home was equipped to support people at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was effective although in some cases there were elements missing.

Activities had been reduced and there was no activities organiser.
Residents' meetings were held.

The information about how to make a complaint was confusing.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a comprehensive set of policies but it was not clear that staff had access to them. Staff meeting minutes had not been kept recently. The staff were not always treated respectfully.

The registered manager regarded Beechill Nursing Home primarily as a business, which had an impact on people living in the home.

There was a system of audits to check on the quality of the service.

Beechill Nursing 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.

This inspection took place on 22 and 23 March 2016. The first day was unannounced. The second day was by arrangement.

The inspection was carried out by two adult social care inspectors.

Before the inspection we asked the registered provider 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. It was submitted to us on 18 November 2015. We reviewed the PIR along with other information we held about the service, including notifications received from the service and information from other sources.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits.

We talked with five people using the service, one visiting relative, four members of staff, and two visiting professionals.

We looked at four care records in detail, four medicine administration records, five staff files, and staff rotas. The registered manager sent us a number of documents at our request, including policies, training records, staff meeting notes and other information.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living in Beechill Nursing Home. One person said, "Yes. I feel quite safe. I can lock my door, I asked for a key." Another person said, "In a way yes, because staff get on the phone if something happens." A third person said, "Yes, I feel safe. Everything's right." A relative said. "Safe? Yes. Everybody is so caring. They look after him well. I feel it's safe and secure. If there are problems they phone me immediately." No-one we spoke with expressed any concerns for their personal safety. Beechill Nursing Home catered for people of a variety of ages, many of whom had issues with alcohol or substance misuse in their history. We were aware from notifications received that at times there was tension, aggression and fights between people living in the home, but the notifications stated that these incidents were managed and when required additional staff were deployed to prevent a recurrence. The fact that everyone we asked said they felt safe was evidence that such incidents were handled effectively.

It was the policy at Beechill Nursing Home that medicines were administered by registered nurses. This was stated by the registered manager in the Provider Information Return (PIR), although the senior carer told us that they sometimes assisted the nurse on duty with dispensing medicines. The senior carer told us they had trained as a nurse but were not currently registered in England. Administering medicines to all 28 people living in the home was a lengthy process which required the nurse's attention for about two hours.

One person living in the home told us, "Medicines are perfect, always dispensed at the right time." We looked in detail at medicine administration records (MARs) for four people. The MAR file had a staff signature sheet, so that staff who had signed the MARs could be identified.

We observed the nurse on duty at the medicines trolley in the dining room during breakfast. The nurse gave seven people their medication without looking at or signing the MAR or reading the instructions on dosette or pill boxes. There was a risk the nurse might not remember everything, especially when most of those seven people were asked if they wanted 'as required' (PRN) medicines. That means, medicines which people take only when they need them. One person asked for a PRN medication (Lactulose) and the nurse took the bottle without reading it, and without looking at the MAR, and poured some out and gave it. It was not clear that they checked on the correct amount. The nurse also gave people tablets and then walked away without watching to check if they were taken.

We asked the nurse why they did not check or sign the MAR each time a medicine was given. They responded by saying they knew all the people well and knew what they took. This is not good practice and may lead to mistakes, especially when new medications are introduced or people have short course medicines (e.g. antibiotics).

We told the nurse we had observed that they gave tablets and walked away before checking they were taken. At first they said they would watch people from the trolley, but we saw they did not do this for at least four people, including one person who was having problems getting tablets out of the small pot and could have dropped them. The nurse said she knew which people would take medicines without a problem and which people needed to be watched. However, not observing medicines being consumed creates the risk

that it might be thrown away or alternatively other people might take the medication accidentally or on purpose.

We saw that the nurse asked people if they wanted PRN pain relief. They also asked people if they wanted water or juice with their tablets.

The nurse locked the medicines trolley when they left the room for a few minutes. This was good practice, but there was a pot of thickener and packets of antibiotics left on the top of the trolley. This meant that someone might remove and consume them.

There were no PRN protocols in place. These are instructions stating when PRN medicines should be offered. Some of the instructions on MARs were very limited; for example they stated 'as directed' on eye drops but gave no direction as to the dose, which eye or the frequency. Most topical creams were 'as directed'. We discussed the lack of detail on MARs with the nurse. Either the nurse should be challenging the GP or pharmacy which produces the MAR, or adding the detail themselves. We found no body maps to show where and how creams should be applied.

One person who was diagnosed as living with dementia had PRN paracetamol on their MAR. There was no PRN protocol to say when the medicine should be offered or given. The MAR showed they had been given two tablets, four times a day since 14 March 2016 (when the MAR started). This meant that the doctor's instructions to give the medicine "as required" had not been followed.

Another person was receiving insulin to treat diabetes. The dose plan from the community diabetes nurse was confusing. It said that the person received a set dose of long acting insulin morning and evening, and underneath, there was a set of instructions for short acting insulin. This stated that the blood glucose level should be measured to determine how many units of insulin to give. We asked the nurse what this meant and she said that an hour after breakfast she measured the person's levels and then followed these instructions. We asked how she knew when to do this, as the dose plan did not say when to do the blood measurements. The nurse replied that they just knew. The nurse should have asked the diabetic nurse to clarify the plan or checked and added the detail. There was a risk that an agency nurse or a nurse unfamiliar with this person's insulin regime would not follow the same procedure and might put the person's health at risk.

We checked on the recording of controlled drugs. These are drugs which by their nature require special storage and recording. The records were all correct except in one case. We saw that one person was receiving methadone. They received the medicine at the GP's surgery except on Sundays. We understood they brought the methadone in themselves once a week from the GP's surgery then handed it in for safe keeping. The last dose recorded in the controlled drugs book was logged in on Saturday 20 February 2016 and recorded as taken on 21 February 2016, but then there was no record until 19 March 2016. This meant that there was no record of the methadone coming into the home, or being administered, for three consecutive weekends.

Topical creams and liquid medications were not all dated upon opening. This had been a finding in the December 2015 audit by the pharmacy, and a box of 'date opened' stickers had been purchased, but we did not see them in use. Some of the topical medications in the drugs trolley were dated, using a pen.

On one care record we saw that someone living in the home had been prescribed an analgesic patch (painkiller) by the GP on 16 March 2016. The prescription was misplaced which meant the person did not receive their analgesic patch until 18 March 2016. The delay chasing up the prescription meant that the

person had unnecessarily suffered pain for two days.

The medicines storage room was very hot; as we entered the nurse said "It's hot in here." Medication storage rooms should be temperature controlled as some medicines need to be kept cool. We checked the temperature records for the room and found that the room had been at or above 25 degrees 12 times since 8 March 2016.

We found that the range of concerns relating to the safe administration and storage of medicines were a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was designed to be reasonably safe for the people living in Beechill Nursing Home. All bedrooms and bathrooms were fitted with overhead tracks to enable people to be hoisted if necessary. There was enough space in the corridors downstairs for people using wheelchairs to pass each other. The main lounge was spacious and people could also sit in the dining room if they chose to. Some people chose to stay in their bedrooms. There was a conservatory and a separate smoking room with windows that could be safely opened. We knew from notifications that arguments occasionally broke out in the smoking room. The senior carer told us that staff did not sit in the smoking room itself which meant they were not immediately on hand if an argument was developing. The registered manager said he would consider how there could be greater observation of that area, perhaps by installing a glass door.

In terms of keeping people safe, services are recommended to require visitors to sign in and out, so that there is a record of who has visited. This is also necessary for fire safety procedures. At the date of our visit there was no signing in book available, just loose A4 sheets of paper, which could get lost more easily. We were not asked to sign in when we arrived at 7.30am. Beechill Nursing Home was equipped with CCTV. At the time of our visit the cameras were working but the recording equipment was not. The registered manager told us it had not been working for a long time. There had been an incident outside the front door the previous evening, which could potentially have escalated, and which had not been recorded.

We obtained a copy of the safeguarding policy, which had last been updated in January 2015. It required updating to refer to the new (2014) regulations which came into force in April 2015, but in other respects was fit for purpose. It stated that all staff were made aware of the policy and instructed in the specific procedures for preventing, observing and reporting suspicions or signs of abuse. It added, "Any member of staff who knows or believes that abuse is occurring has an obligation to report it as quickly as possible to their manager." We spoke with one of the nurses who could describe the possible types of abuse and said they would report any concerns to the registered manager.

We saw from the record of training that care staff had received training in safeguarding, although in the case of the nurses this had been in 2014 and was due for renewal.

We saw that emergency systems, namely fire prevention and fire detection systems and the emergency lighting system, were regularly serviced. Individual personal emergency evacuation plans (PEEPS) were kept in a folder in an office by the front door. They were in room number order which would make it easier for the emergency services to identify where people were. This meant that people were being protected from the risks of fire.

We saw on care files detailed risk assessments which were specific to each individual. They were reviewed monthly, and changes made if needed. Incidents such as injuries and altercations between individuals were recorded. There had been nine accidents recorded so far in 2016, but we did not see any indication that

these records had been checked or analysed with a view to preventing recurrences.

We asked people living in the home whether they felt there were enough staff on duty at all times. Everyone we spoke with said they thought there were enough staff. One person said, "Oh yeah, there's enough"; another said, "Yes, everything is perfect." A relative said "Yes, but you could always do with more." We asked the same question of staff. One said "Yes there is enough staff." We saw from the rota there were seven staff on duty during the daytime, including one nurse and a senior carer, and one nurse and two care staff at night. The senior carer who was responsible for staff rotas said, "Yes we have enough staff. I increase staff if we get a higher occupancy." Agency nurses and care workers were used when necessary, but we were told that the agency supplied regular staff who got to know the people living in the home. The registered manager said he calculated the needs and dependency levels of people in the home in order to decide the necessary staffing level. He told us he was regularly in correspondence with the local authority requesting funding for 1:1 support for individuals whose behaviour was a matter of concern. He showed us examples of this correspondence.

We checked the recruitment records of five members of staff to see whether appropriate steps had been taken to ensure suitable members of staff were appointed. We saw that a number of people had been employed who originated from outside the European Union. When this was the case there was a copy of their residence permit on file. The application forms required people to state their employment record and account for any gaps in their history. References had been obtained. The registered manager who conducted job interviews made a few notes of the candidates' answers on their application forms, rather than in a separate record. We also saw that there was a DBS certificate on one file. Only the number on the certificate should be retained, and the certificate itself should be destroyed. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups. These measures meant that Beechill Nursing Home was taking appropriate steps to ensure that only suitable people were employed.

We looked at staff disciplinary procedures to see whether they were robust and ensured any conduct which affected the safety and wellbeing of people using the service was dealt with. We saw one recent incident had been handled well by the senior carer, to whom the registered manager had delegated the incident.

Beechill Nursing Home had received an infection control inspection by officers from Manchester City Council who had sent us their report dated 28 January 2015. We saw that actions had been taken following their recommendations. On the days of our inspection we saw a cleaner was working effectively. The home looked clean and there were no lingering unpleasant odours. As one relative said, "There's no odour of any kind. They're always cleaning." The registered manager had recently attended a study day entitled 'Effective cleaning for care homes' run by the Community Infection Control Team of Public Health Manchester, and told us he intended to share the learning from it with the cleaning team.

We were informed that there had recently been an outbreak of a vomiting bug, which the senior carer had reported to the local authority. Following advice the people affected had been isolated, and there was a deep clean of potentially infected areas. The outbreak had been contained and only two or three people caught it. The home had demonstrated effective measures to limit its spread.

Requires Improvement

Is the service effective?

Our findings

We saw that there were consent forms on care files which people had signed to indicate they consented to care and treatment and, for example, to the use of their photographs on MARs. In one case staff had recorded, "Cannot sign, signed by daughter." It was not clear whether the person was physically unable to sign their name, or lacked the mental capacity to understand what it meant. If the latter, it was also uncertain if this was intended to show only that the daughter had seen the care plan, or was giving consent on behalf of the person using the service. Under the principles of the Mental Capacity Act 2005, a relative cannot give consent (unless they have a relevant power of attorney) on behalf of a person who lacks capacity to do so themselves. There has to be a best interests decision, in which the relative can participate but does not have the final say.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

Beechill Nursing Home was supporting people with a variety of needs and a wide age range. Some were able to go out into the community independently, for example to visit local shops. Other people were unable to do so. In some cases they were physically unable to leave the building independently; in other cases they may have lacked the mental capacity to do so. There were other people who potentially lacked capacity to consent to their care and treatment. For example some people had bedrails but there was no record that they had consented to them or alternatively no mental capacity assessment to confirm they lacked the capacity to give consent. We learnt that Beechill Nursing Home did not routinely conduct their own mental capacity assessments which meant they were unable to demonstrate they were working within the principles of the MCA. This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can 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). Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

Providers are required by legislation to notify CQC when an application for a standard DoLS authorisation is either refused or granted. We had not received notification about any DoLS authorisations. The registered manager told us there were three DoLS applications outstanding with the local authority. In one case an application had been made in July 2015 on the grounds that the person was resistant to receiving personal care. The registered manager said that the council contacted Beechill Nursing Home in February 2016 inviting them to renew the application because the authorisation had expired on 15 February 2016.

However, he said that he had never been notified that the application had been granted. If that was the case he could not reasonably be expected to notify CQC about the authorisation. In any event the registered manager told us that there was now much less of an issue in regards to the person refusing personal care and therefore the DoLS application did not need to be renewed.

Beechill Nursing Home had a detailed policy about DoLS and four of the nurses had received training in this area while at the home, albeit three of them in 2012, so they would benefit from refresher training. None of the care staff had yet received training on mental capacity and DoLS. However, the registered manager had stated in the PIR that he was intending to arrange workshops for staff on this area. Although they might not be involved in submitting DoLS applications, it is important that all care staff are aware of the principles of the MCA and are aware of the process of assessing mental capacity and what to do if they think a person's mental capacity is declining or fluctuating.

A visiting relative told us, when we asked whether the staff were well trained, "They know what they're doing. They're efficient." The training record showed that there were a wide range of training topics undertaken by staff. One nurse told us "Yes, we get training regularly." All of the care staff with one or two exceptions, had received training in manual handling, health and safety, food hygiene, infection control and safeguarding. There were more significant gaps in other topics such as challenging behaviour, communication and dementia awareness. Given the history of some of the people living in Beechill Nursing Home, and the occasional incidents of physical aggression which occurred within the home, all care staff should be trained in those areas.

The registered manager had a policy on the induction of new care staff. Recent recruits were also undertaking the Care Certificate in addition to the induction. The Care Certificate is a set of minimum standards designed for the induction training of new care workers.

The registered manager and the senior carer conducted supervisions of nurses and care staff respectively. We saw the supervision schedule for 2016, which showed that all staff were receiving regular supervision roughly every three months. One supervision record of a nurse from September 2015 was a typed document referring to an issue within the home. The same document was used for other staff supervisions at the same period. This indicated that the supervision sessions had been used to promote a message that the registered manager wanted to convey, rather than for the purpose of allowing staff to discuss their individual work situation and any problems they might be having.

The senior carer conducted some group supervisions (of groups of five staff) and some individual 1:1 supervisions. We saw records showing that issues raised by the individual were discussed at the 1:1 sessions. This meant that the care staff were being supported in their work.

All staff had received an annual appraisal within the last 12 months. These would be an opportunity for staff to assess the previous year and set goals for the year to come. The registered manager commented to us that staff linked appraisals with receiving a pay rise, which was not necessarily on the agenda.

We asked people about the food provided at the service. One person said, "The food's nice," and described having a choice of food at mealtimes. Another person said, "[the cook] is brilliant, the food is decent." They added, however, that all the ingredients were cheap value range. A third person said, "The food is 10 out of 10 – the cook is fantastic. They're always laughing and joking. They make the place."

We spent time in the kitchen with the cook. The cook could describe every person living in the home in detail, saying what they liked and did not like to eat. They were knowledgeable about special diets, for

example who was diabetic or had other dietary needs. There was a set weekly menu which changed twice a year. Lunch and dinner had two choices each day but people could ask for a different meal if they didn't like either choice. The lunch on the day we visited the kitchen was meat loaf with mashed potato or chips and vegetables, or there was a choice of sandwiches. There was roast lamb every Sunday and a curry night once a week The kitchen assistant made homemade cakes for people's birthdays.

We observed the breakfast was relaxed. People came to the dining room as they got up and shouted what they wanted through the hatch into the kitchen. We saw people asking for fried egg butties, cereals and toast, and cups of tea.

There was a record of food temperatures and fridge/freezer temperatures. The kitchen was clean and tidy. We saw cleaning schedules for each day of the week.

The ingredients were all value range, including the tea and coffee. The cook said they made the orders and this is what arrived. Our view was the cook was doing a good job with basic quality ingredients. People were positive about the food and very positive about the cook and what they brought to the home. It was obvious the cook cared for the people deeply and loved working there.

We asked people whether they had access to health care professionals. One person said, "Anything at all, they're excellent. They'll even go to the chemist for you." We saw records on care files of access to GPs, dentists, opticians, dietitians and other relevant medical professionals.

There were a number of people in Beechill Nursing Home living with dementia or related cognitive difficulties. There was an absence of signs to indicate people's rooms or toilets and bathrooms in a suitable way. No attempt had been made to decorate the walls in appropriate colours. We did not see any specific items around the home which could help people living with dementia, no tactile objects, very few pictures or objects for discussion between people or with staff. There were no items for triggering memories.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We spent some time observing how people in the home interacted with each other and with staff. We saw there was a mainly good humoured atmosphere within the home, with cheerful banter amongst the people living there and with the staff. Staff made time to spend chatting with people, although it was evident that staff had considerable paperwork to complete which interfered with their ability to be with people in the home. In particular we observed that staff were completing hourly notes of what everyone was doing in the home, and we questioned whether these were necessary, except in special circumstances where there may be a reason for such recording.

We saw staff using correct moving and handling techniques with those people who needed help getting in and out of chairs, for example. Staff explained what they were doing as they went along, and were patient with people. We also noticed at times that staff were busy, and could not always respond to people's requests immediately. One person in the lounge asked for a blanket and a member of staff said "Just a second", but it was several minutes before the blanket was brought. We were concerned that one person needed assistance to eat at breakfast but staff did not help them. The person was sat in their wheelchair at the table for 90 minutes. A cup and a sandwich were placed in their hand but they nearly dropped the cup and did drop the sandwich. Staff were either too busy or were neglecting this person's needs. This was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about their experience within Beechill Nursing Home. One person said to us, "I've no complaints – it's a good home." Another person said. "There's nowt wrong with this place."
A third person said they got on with most people in the home. They had witnessed some arguments but never seen any violence. They added. "I used to drink too much. Now I just have the occasional can of beer."
A visiting relative said, "They're caring and kind. If someone needs something they sort it straightaway." A professional recalled that when one person had been upset "the staff were all very concerned and caring."

There were several people living in Beechill Nursing Home whose first language was not English. Where possible, staff who spoke their language were assigned to them as keyworkers or to spend time with them. On one occasion a Polish interpreter had been used for an important meeting with someone in the home. This showed that people's rights to understand their situation and decisions being made were respected. The senior carer told us that some people had advocates. If people needed an advocate the home would report this to their social worker and expect them to arrange it.

People's privacy was respected when they were being supported with personal care. We read an account written by a care worker of an incident which had occurred when they were supporting someone with their personal care. It was clear that the care worker had at all times respected the person they were supporting and ensured their dignity was maintained. Independence was encouraged where possible. Nine people were managing their own finances, but were able to keep their money in the communal safe. For other people the office kept a record of their income and how much personal allowance they were given. This meant that people were given the appropriate level of control over their own money.

Many of the people living in the home had previous experience of dependency on alcohol or other substances. Alcohol was not banned from the premises, but those people who wished to reduce their dependency on it were supported. We were told of one person who had arrived in the home in 2015 with a serious alcohol dependency. Beechill staff negotiated a plan with them to reduce their alcohol intake until it was four cans of beer a week. The person told us they had signed a commitment to this plan and were sticking to it. They added that the staff all gave them support and encouragement to achieve this goal. The registered manager told us about another person who had now left Beechill Nursing Home and returned to their own home, having successfully stopped drinking. There were two other current residents who had given up alcohol successfully, one of whom had lived in the home for many years. These success stories demonstrated that Beechill Nursing Home was able to support people to recover their independence and promote their wellbeing. The registered manager acknowledged, however, that this approach did not work for everyone.

We had concerns that the staff did not always maintain confidentiality of all care records. At times in the day the nurses' office was propped open when no-one was in there. The office contained confidential files. We also observed a care worker was completing the hourly notes of what people were doing. These were kept in their own folder. The care worker responded promptly to a buzzer but in so doing left the folder unattended on a table in the lounge for over 20 minutes. We considered, however, that the notes in the folder were not sensitive information because they merely described where people were in the home and what they were doing. Nevertheless, ideally all information about people using the service should be kept confidentially.

Three of the nurses and the senior carer had received training in end of life care but this training had not yet been disseminated to the rest of the staff. The home had previously been accredited by the Six Steps, a programme based in the North West designed to develop and improve the care people received at the end of their lives in care homes. No-one was receiving end of life care at the time of our inspection. We knew from notifications of deaths that people were able to stay in the home until the end of their lives. Anticipatory drugs were used; these are special drugs used to relieve pain and help with breathing. The nurses were trained to administer these drugs. One person recently had died peacefully with the aid of these drugs, in the presence of their family.

Requires Improvement

Is the service responsive?

Our findings

We looked at four care records in detail. Assessments were completed before people came to live in Beechill Nursing Home. The assessments were usually completed by either the registered manager or the senior carer, who had nursing qualifications, visiting the person in advance. This process was intended to ensure that the home could meet the needs of people coming to live there. We were aware of some instances where people's behaviour was difficult for the staff soon after they moved in, and they were quickly moved on to another provider. People's behaviour may not have been apparent at the initial assessment, but this may have identified the need for more thorough pre-admission assessments.

Once people had moved into Beechill, risk assessments and care plans were drawn up. We saw that the risk assessments were detailed and were specific to the individual, based on their health needs and social factors. For example one person had a risk assessment in relation to their Ipad getting lost or stolen. Someone else's risk assessments included the risk of an epileptic fit or aspiration. There were risk assessments relating to bathing, weight loss, smoking and incontinence. Each of the records we looked at included a monthly Waterlow assessment. This is a tool to assess the risk of pressure ulcers developing.

The risk assessments were thorough and appropriate. We saw that they were reviewed monthly and changes were noted. This review, described as an 'evaluation', was not just a tick box exercise on the files we saw, because staff had identified changing needs. Communication sheets and progress notes which recorded significant events were also kept in care records. This meant there was a contemporaneous record of people's care and treatment.

The care plans were based on the risk assessments. The template referred to each plan as a 'problem', and we discussed with the registered manager whether alternative language could be used such as 'care need' or 'objective' to encourage a more positive person-centred approach. The plans themselves were short and easy for staff to understand, including agency staff who might be unfamiliar with the people in the home. As with the risk assessments, people had multiple care plans which were specific to their needs. These too were evaluated monthly and new details included. A visiting social worker said to us they thought the care plans were appropriate. They said, "All the information is there and the assessment has been read by staff." Some people told us they knew they had a care plan, and one person said they had signed their care plan. Others said they had never heard of them. Most of the people we spoke with could not recall being involved or consulted in the care planning process.

We were concerned that one person whose Waterlow score identified them as being at high risk of pressure ulcers did not have a skin integrity care plan. This person's low weight and other health conditions should have identified such a care plan as necessary. Another person's plan stated simply "Dementia" on the front sheet but we could not find a care plan relating to that person's dementia and how they should be supported. We also observed that all the care plans were task-orientated, and there was very little personal history or information recorded on most of the care plans, which would have enabled staff to deal with people in a more person-centred manner (for example by talking about what interested them). On one person's file we found a 'resident profile' written at the time of their arrival, which gave a brief history, but

this was not found in other people's files. In other respects the detail in the care plans relating to each individual's needs was sufficient.

We observed the handover between night staff and the morning shift. Detailed information was handed over, including details of events during the previous night, the day's appointments and new medicines in use. We saw that staff knew people well as individuals. There was a system of keyworkers so that each person had a named member of staff. Not everyone, however, knew who their keyworker was.

In terms of activities, we found a mixed picture. We saw evidence that activities did take place, for example there were photographs of people taking part in activities in the foyer. There was also an activity plan on the notice board, which however dated from 2015 and had not been updated. We saw from care records that there were outings from time to time, which were risk assessed. One person had asked to see a particular film in the cinema, and a member of the office staff had gone with them. We saw the risk assessment which had covered all aspects of the outing. A member of staff told us that reflexology took place twice a week, and the hairdresser came in. These activities had to be paid for by people living in the home.

One person told us there was not a great deal to do inside the home. They said, "I sit and play my guitar and watch telly." They added, "I'd like a little day out somewhere, just to get away from the place." Another person said, "There's nothing to do downstairs. They used to have groups of singers, a pool table in the conservatory, bingo, raffles, but that's all stopped." The pool table was recalled by another person, who was sorry it had gone.

There was currently no activities organiser employed by the home; there had been one in the past. It fell to the staff to organise activities and the staff were often busy with their roles. Because people's physical and mental abilities varied widely a wide range of activities needed to be provided. Some people were being nursed in bed and we did not see staff spending time with them beyond attending to their care needs. There was an activities folder which recorded what people were doing. A common entry was "relaxing in bedroom", which indicated an absence of activity.

The provider was not ensuring that there were enough activities for people in order to improve their quality of life. This was a breach of Regulation 9(1) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they had never been to a residents' meeting and had not received a questionnaire. Another person said they were never asked to attend a residents' meeting but did remember getting a questionnaire. We saw minutes of residents' meetings which had taken place once a month with the exception of January 2016. At the meeting in December 2015 they had discussed their planned Christmas activities. At the meeting on 7 March 2016, attended by 11 people, it was recorded that "All are enjoying ongoing activities. All residents are happy with the food." Exactly the same sentence about the food was found in the minutes of the meeting on 5 February 2016. This raised doubts about the authenticity of the comment.

We saw completed questionnaires from 2013-14 but nothing more recent than that.

We asked people whether they had made a complaint. One person told us they had not, but would speak to their social worker if they had a complaint. Another person said they had made a verbal complaint to a nurse, but had not heard anything back. The provider's complaints policy stated that informal complaints should be passed to the registered manager who would then record it in the complaints register. This had not happened in this instance. The complaint file contained only one

complaint received since 2007, which had been in February 2015. This appeared unlikely given the volatile nature of some of the people living in the home.

The complaints policy had been adapted for use by the provider from a commercial supplier, and it referred to some job titles which did not exist such as "The Care Services Manager at our head office." It also talked of "the home or service you receive." If the policy is handed to people using the service, it should be accurate and easy to use. Moreover, we saw information about how to make a complaint was on the wall in the lounge which gave the name of a former registered manager who had left in early 2014. We pointed this out to the current registered manager who immediately removed the notice. This suggested that the provider's stated policy of making it easy for people to complain had not always been carried out in practice.

Requires Improvement

Is the service well-led?

Our findings

The mission of Beechill Nursing Home, set out in a document called "Statement of purpose and functions", is "Ensuring a place of continuing care with respect and dignity." We saw that information about Beechill's philosophy of care and its commitment to quality of care was displayed in the foyer, and a 'Charter of residents' rights' was on the wall in the lounge. We aimed to find out how the values of respect and dignity influenced the way the service was led.

The registered manager supplied us with an index listing over 70 policies. Of these we looked at a sample of significant policies, on safeguarding, complaints, whistleblowing and physical restraint. They were adapted from a template supplied by a commercial company, but were fit for their purpose. The policies were recorded as having been reviewed on the same date, which appeared unlikely given the number of them. The registered manager explained that the date was an administrative convenience. This would make it difficult for him to know when each of the policies in fact needed to be reviewed. The safeguarding policy for example had recently passed the review date of January 2016 stated on the policy itself, although the review date recorded on the index was June 2016, the same as all the other policies. More importantly, it did require updating as it referred to CQC outcomes which have not been used in inspections since October 2014, and to the old regulations which were superseded in April 2015.

The registered manager told us he encouraged staff to read the policies which were available in the downstairs office. Staff meetings were held every three months. We asked to see minutes of the last three meetings. We were given a nearly identical document relating to the staff meetings in July 2015 and December 2015. These were both headed "Staff meeting statement" and the only difference was the date; one said "Staff meeting on 10/07/2015", the other said "Staff meeting on 18/12/2015". The document was not in fact minutes of a meeting, but a prepared statement which the registered manager had read out at the meeting. We queried this with the registered manager who said he had read out the statement only at the July meeting. He said the document relating to December 2015 must be a clerical error. He stated that there were in fact no minutes of the July or December meetings. This meant that staff who had not managed to attend those meetings would not be able to find out what had happened, including any important messages.

The statement read out at the July 2015 staff meeting referred to tension amongst the staff which the registered manager was attempting to address. Some of the language used in the statement was patronising and confrontational, and did not portray a culture of respect for the staff. To quote one example: "I am personally getting fed up at having to deal with the same issues over and over again as though I am dealing with children rather than responsible adults." This same attitude was mirrored in a "Memo to carers/domestic staff" from the senior carer dated 4 February 2016. This listed 11 areas of improvement required, including a blame culture where care staff had been blaming each other when things had gone wrong. The memo said: "I cannot keep chasing staff all the time to make sure that they are doing their jobs correctly and asking them to explain their actions." There followed a threat of disciplinary action. It is perfectly appropriate to draw staff's attention to deficiencies and areas for improvement, but not in a way which may undermine their confidence.

One concern about the ethos of Beechill Nursing Home and the registered manager was the emphasis on money. The registered manager told us, "This is a business." He said at one point, "I want to get as much money as possible from the council." Of course a care home must be well managed financially, but its primary purpose is not to make money, and that was not the stated mission of Beechill Nursing Home quoted above.

There were two current examples where the focus on money had perhaps obscured the needs of the people living in the home. One person had recently been given notice to leave after ten years living in Beechill Nursing Home. We learnt that there were valid reasons why the person had been given notice, relating to inappropriate and threatening behaviour within the home. The night before our inspection started they had returned to the home and attempted to gain entry, but the police had been called and had removed the person. The registered manager made it clear to us that they could have stayed if the council had been willing to come up with funding for 1:1 care. He stated, "If the money's right we'll take him back." The focus seemed to be on the money rather than the person's needs, having lived in Beechill Nursing Home for ten years.

The second example was similar, a person who had been given notice which was due to expire the week after our inspection. We met this person's care manager during the inspection and obtained a copy of the letter giving 28 days' notice. The letter was itself undated but had been sent by email on 3 March 2016. It listed nine reasons why the notice was being given, and then stated, there would be a significant extra charge for the person to remain in the home after the notice expired. On 9 March 2016 the care manager received a further email stating that the fee would increase by double that amount. The registered manager explained to us that this followed another incident within the home, and represented the cost of providing 1:1 cover around the clock. However, he also stated that this was a bargaining ploy, and that he expected the care manager to reply with a counter offer. The care manager told us that they and the council had never agreed that any 1:1 care was necessary or would be funded. The person concerned did subsequently leave Beechill Nursing Home.

We considered that the registered manager's emphasis on money risked paying less attention to the needs of the vulnerable people who were the subject of the eviction notices. We raised these points with the registered manager at the end of the inspection. We acknowledged that the staff were not necessarily affected by these negotiations but the people who use the service are.

In relation to the registered manager one member of staff said to us, "Oh yes, it's well managed. The manager makes sure there are enough staff and communicates well with care managers." Another staff member said of the registered manager, "He's confident. He can manage difficult situations."

It is a requirement of the regulations that certain events within the home must be reported to the CQC. We knew from notifications received that the registered manager was prompt in reporting incidents or allegations of abuse. We discussed with him that in some cases there was insufficient detail in the notifications and we had to request explanations. We were aware that in one instance the registered manager did not co-operate fully with investigations into safeguarding matters by Manchester City Council. This meant that the local authority had been hampered in its investigation of allegations.

Similarly we had received notifications of deaths of people who had been using the service. In three cases there had not been enough information on the notifications to enable us to understand the events. It is important that these notifications are informative so we can assess whether we need to investigate further. We discussed these examples with the registered manager.

A series of audits were conducted by the registered manager and other staff. We saw recent audits of care planning and development, the kitchen, and staff training and development. This covered recruitment and training. There was an audit of drugs and medicines, and in addition the pharmacy conducted a periodic audit of the medicines. These had not identified the deficiencies we found in relation to the safe administration of medicines. There was a monthly audit of all the rooms, reporting on safety features such as the water temperature and the window restrictors, and also on the décor. We also saw a cleaning checklist which covered all areas of the home. These audits meant that there were systems in place to assess monitor and improve the quality and safety 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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users did not always meet their needs at mealtimes. Regulation 9(1)(b) The provider was not meeting people's needs for activities Regulation 9(1), (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the provisions of the Mental Capacity Act 2005 Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring the proper and safe management of medicines Regulation 12(1) and 12(2)(g)