New Outlook Housing Association Limited

Beech House

Inspection report

21 Gravelly Hill North
Erdington
Birmingham
West Midlands
B23 6BT

Tel: 01213826163

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Beech House is a care home that provides accommodation for up to six people who need help with their personal care. The home supports people who live with a visual impairment and other complex support needs. At the time of the inspection 6 people lived in the home. The home is a two storey building. There are two bedrooms on the ground floor and four bedrooms on the first floor. Each bedroom has its own en-suite facilities. There is a communal lounge and dining room for people to share.

People's experience of using this service:
The overall rating for this service is 'inadequate' so therefore the service is in special measures.

The systems and processes in place to monitor the quality and safety of the service failed to identify and drive up improvements in the service. This has resulted in people being exposed to ongoing risks.

The provider's fire safety arrangements were unsafe as they did not ensure people were evacuated in the event of a fire. There was also a lack of emergency evacuation equipment to help people with mobility difficulties evacuate the building.

Where people's capacity to consent to decisions about their care was in question, the provider had not always followed the Mental Capacity Act 2005 to ensure that any decisions made on people's behalf were legally consented to and in the people's best interests.

Where people had health conditions, their care plans did not always contain sufficient information about these conditions and the support they required. Care plans were not always consistently updated when people's needs changed and some of the language used to describe people's needs was at times inappropriate.

Regular meetings took place with people's relatives to involve them in the running of the service and seek their feedback. The opinions and views of the people who lived at the home were however not sought in any meaningful way.

We saw that staff members treated people kindly and with respect. They were aware of people's needs and preferences and the things that were important to them.

People received the medicines they needed to keep them safe and well. Staff had received training on how to administer medication safely and their competency to do so was checked.

People had enough to eat and drink and the relatives we spoke with told us that their loved ones were happy with life at the home.

People's needs were met by a range of health and social care professionals.
The premises were clean and well maintained. There were regular health and safety checks to ensure that the premises and the moving and handling equipment in place was safe to use.

Staff told us they felt supported by the manager and records showed staff received supervision in their job role. Staff received training and the most of the training was up to date.

The atmosphere at the home was warm and inclusive. The culture of the staff team was open and transparent.

You can see what action we told the provider to take at the back of the full version of the report.

Rating at last inspection and why we inspected: This was the first inspection of the service since it registered as a regulated provider with CQC.

Follow up: Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

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 effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

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

Beech House

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection was undertaken by two adult social care inspectors.
Service and service type: Beech House is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
The registered manager was not in work on day one of the inspection. The provider's quality improvement manager therefore assisted the inspector on this day.

Notice of inspection: This inspection was unannounced.

What we did: We reviewed information we had received about the service since the service was registered. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

We talked to some of the people who lived at the home during our inspection. Due to communication difficulties, some people were not always able to verbally respond. We spoke therefore to two relatives to gain an understanding of the support the person received. During our visit we also spoke with two members of care staff, the deputy manager, the registered manager and the quality improvement co-ordinator.

We reviewed a range of records. This included three people's care records and a sample of medication records. We viewed two staff recruitment files and other records relating to staff training and support of staff and the management of the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● The fire safety procedure at the home was unsafe. The provider had a 'Stay Put' policy which meant that people who lived at the home would not be evacuated to a place of safety outside of the building in the event of an emergency.

● There was no emergency evacuation equipment to assist people with mobility difficulties to evacuate the building in the event of an emergency.

● People's risk assessment and support plans contained information about the person's day to day needs and risks. This documentation had not always been consistently updated when people's needs and risks changed.

● Some people had specific health conditions that were not properly assessed or described. One person had a detailed care plan for a health condition but another person with the same health condition did not. This placed people at risk of inappropriate and unsafe care.

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels had not been determined based upon an assessment of people's needs. Night time staffing levels were insufficient to meet people's needs and keep them safe.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at the recruitment records for two staff. Pre-employment checks were carried out prior to employment to ensure staff members were safe and suitable to work with vulnerable people. For example, a criminal conviction check, previous employer references and proof of identification were all sought prior to employment.

● Where potential staff members had declared a criminal conviction, the provider had not always adhered to their own policy to ensure these convictions were adequately risk assessed prior to employment. This was not good practice.

Learning lessons when things go wrong

● Accident and incidents were well documented with the action taken by staff to support the person's wellbeing at the time the accident or incident occurred.

● There was little evidence that accident and incident information was used in any meaningful way to learn from how accident and incidents occurred so that preventative action could be taken.

● We were told that the manager analysed accident and incident information and discussed these at team meetings. No evidence of these analyses was however provided during the inspection.

Systems and processes to safeguard people from the risk of abuse
● The staff had received safeguarding training. A staff member we spoke with although committed to reporting potential abuse was unclear as to which outside organisations to report safeguarding concerns to. This aspect of staff knowledge required improvement.

Using medicines safely
● Medicines were administered safely and people received the medicines they needed to keep them safe and well.

● Staff had completed medication administration training and their competency to administer medication had been assessed.

● Checks on the management of medication were undertaken regularly to ensure medication practice were safe.

Preventing and controlling infection
● We looked around the home and saw that it was clean and tidy. The home was well maintained and standards of infection control were good.

● Staff had received training in infection control. They had access to sufficient equipment to prevent the spread of infection for example personal and protective gloves and antibacterial soap.

● There were arrangements in place to monitor the risk of Legionella bacteria developing in the home's water system.

Requires Improvement

Is the service effective?

Our findings

Ensuring consent to care and treatment in line with law and guidance

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".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that this legislation had not been followed to protect people's legal right to consent to their care.

●People's care plans indicated that some decisions were made without the correct legal processes being followed.

● Deprivation liberty safeguards (DoLS) had been put into place without a mental capacity assessment being undertaken to determine if this was legally justified. There was also limited evidence that discussions had taken place to ensure these safeguards were in the person's best interests.

● For example, one person had a DoLS in place without a proper mental capacity assessment and best interest process being undertaken. The person's assessment had not been fully completed and the person's best interest record referred to a different person.

● Under the MCA legislation, using bed rails on people's beds can be considered a form of potential restraint and legal consent for their use must be obtained. There was no evidence that the provider had followed the MCA legislation in respect of these areas of support.

● Some people had protective equipment in place to protect them from potential injury. This equipment could be considered restrictive in terms of the MCA. There was no evidence that the MCA had been followed, or that the provider had ensured the equipment in use was the least restrictive option to protect the person from harm.

This demonstrates a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Staff had information on how each person would communicate their day to day choices and what was important to the person in respect of their day to day care. Staff were heard giving people choices and respecting their wishes.

● There was clear information in people's care files about the type of facial expressions or behaviours they would display when they did not consent to the day to day support they received.

● Staff were able to describe these facials expressions and behaviours and what they meant. This showed that staff knew people well and understood the various ways in which people communicated their wishes.

Staff support: induction, training, skills and experience
● The majority of staff training was up to date and sufficient to meet people's needs. Training in first aid, medication administration, infection control, mental capacity, DoLS, moving and handling and safeguarding was provided.

● Staff had access to regular supervision sessions with their line manager and a yearly appraisal of their skills and abilities in respect of their job role.

● Relatives told us they thought staff members had the skills and ability to support the people who lived in the home.

Supporting people to eat and drink enough to maintain a balanced diet
● People had eating and drinking care plans in place that provided staff with information about their nutritional needs and the support they required.

● One person needed a special diet. Staff we spoke with were able to explain how they prepared this person's meals in accordance with professional advice. On one occasion however the person had been given a food type that was not recommended. This had placed the person at potential risk of harm.

Adapting service, design, decoration to meet people's needs
● The building was suitable for the people who lived there. There were ground floor bedrooms and a passenger lift to access the bedrooms and communal bathroom on the first floor.

● People had their own en-suite bathroom facilities. The communal bathroom contained specialist equipment to enable people with mobility problems to have a bath. There was no specialist equipment however to help people evacuate in the event of a fire. The quality co-ordinator told us they would review this without delay.

● The front entrance to the home and the back garden were wheelchair accessible and the garden was well maintained.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
●Referrals had been made to a range of health care professionals as and when required in support of people's needs. For example, dieticians, opticians, GP's and specialist medical teams.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

● Some of the language used in people's care files was not always appropriate. For example one person's daily routines referred to "My routine during feeding" as opposed to referring to the support the person needed to eat and drink. The use of the term 'feeding' de-personalised the person.

● Care plans contained information about people's preferred daily routines. This showed that the service respected that people wanted to live their life and receive their care in different ways.

● People's care plans were detailed about their preferences. It was obvious that the person and/or their family had been involved in developing the care plan when they first started using the service.

● People's support networks were identified with the family members and friends who were close to them. People's important relationships were fostered by the service to ensure the person felt well supported.

● Staff were aware of the different personal belongings critical to each person's emotional well-being. We heard them talking to people about their items. It was clear people enjoyed talking about them to staff and that staff were genuinely interested in them. It was obvious that staff cared about the people they supported and the things that were important to them.

● A relative told us "Generally, overall it's a nice home". Another said they "Felt blessed" that the person lived at the home and that they "Could not praise them (staff at the home) enough".

Supporting people to express their views and be involved in making decisions about their care

● Regular relatives meetings took place to enable relatives to express their views on the service and any improvements required. There was no evidence that people who lived at the home participated in these meetings or had a meeting of their own.

● Reviews of people's care had not always been undertaken with the person and/or their family. It was difficult to tell whether people were able to be involved in making decisions about the support they received and we saw that some decisions had been made without the MCA legislation being followed.

Respecting and promoting people's privacy, dignity and independence

●People's care plans identified what they could do independently and what they needed help with

● One person's care records showed that they liked to help in the kitchen and around the home and we saw from their daily records that these abilities were fostered by staff.

● Staff were observed to discreetly support people when they needed help with their personal care and protected the person's privacy and dignity at all times. Staff members were kind and caring in all of their interactions with people who lived at the home.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns
● The home had a policy and procedure in place for receiving and responding to complaints about the service. The procedure did not provide the names and address for the service manager, operations manager and chief executive officer to whom complaints should be addressed. This meant there was a risk that people would not know how or who to send their complaint to.

● Despite this, people's relatives told us they would know how to make a complaint if they needed to. They said people who lived at the home were happy there.

●A record was kept of any complaints or compliments the service received. At the time of our inspection, there were no formal complaints about the service recorded.

● End of life care and support
● None of the people who lived in the home were in receipt of end of life care at the time of the inspection.

● There were no adequate advanced care plans in place in the care plans we looked at to evidence that people's end of life choices had been discussed and planned for. This aspect of service delivery required further development.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People's care plans were person-centred. They contained information about people's specific needs with regards to their mobility, nutrition, personal hygiene, finances, communication and information about their background, behaviours and personality. Where people had specific health conditions, people's care and support had not always been clearly identified.

● Staff had guidance on how each person liked to be cared for and their preferences. For example, what they liked to eat and drink, what time they usually liked to get up or go to bed and what activities they enjoyed.

● Staff spent time with people, talking to them socially and offering them reassurance and support as and when needed. One person's gained comfort from certain items and staff had ensured they had these items with them at all times.

● On the days we visited, some of the people who lived in the home had chosen to go to a day centre. Others had preferred to stay at home. Relatives we spoke with told us that their loved one enjoyed attending the day centre.

●One relative said they were "Amazed at how much they (the person) had come on (since living at the home)". "They are more confident and interact more (with other people). Every part of them has developed".

● Staff spent time with people, talking to them socially and offering them reassurance and support as and when needed. One person's gained comfort from certain items and staff had ensured they had these items with them at all times.

● Daily records of the day to day support people received were maintained by staff so that staff on different shifts had information on people's wellbeing each day.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Systems and arrangements were not always used to monitor and improve the quality and safety of the service. There was a lack of adequate fire safety arrangements, night time staffing levels were insufficient and the provider had failed to adhere to MCA legislation designed to protect people's human rights. It was clear that neither the provider of the manager were clear about their role and responsibility in these areas.

● A fire risk assessment was completed in February 2018. We found that a number of the fire safety recommendations were still outstanding at the time of our visit 12 months later. There was no fire evacuation equipment in place and the provider's fire procedure was unsafe. We raised concerns about this with the provider. When we returned to the service several days later, we found the provider had failed to take sufficient or adequate action to address our concerns. This did not demonstrate the provider was proactive and responsive in mitigating risks to people's health, safety and welfare.

● The management systems in place at the home had not identified that the number of staff on duty at night was insufficient to meet people's needs or keep them safe in an emergency. This did not show that the provider's method of determining safe staffing levels was robust.

●The provider audited the quality and safety of the service on a monthly basis. Regular staff meetings also took place to ensure that the staff team were involving in the running of the service. Neither of these mechanisms were effective in identifying and mitigating risks to people's health, safety and welfare.

●For example, a team meeting in January 2019 identified that some of the documentation in respect of people's care was not fully completed by staff. At this visit, we found similar concerns. One person's advance care plan, care plan review and goals and aspiration information was blank. Another person's documentation in respect of a meeting they had with their keyworker was not fully completed.

● Provider audits undertaken in October and December 2018 identified that the planning and review of people's care was not always fully completed. Similar issues were identified again during our inspection. This indicated little effective action had been taken to address these concerns despite systems and processes being in place to do so.

● Relatives meetings took place to gauge their views but there were limited opportunities for people who lived at the home to do so. This aspect of service delivery required improvement.

●There was a suggestion box for people to use but this was located in the manager's office. The location of the suggestion box may have made some people feel uncomfortable using it. Most of the people who lived at the home were visually impaired. This meant it would have been difficult for them to physically write a suggestion and locate the suggestion box independently. The service needed to improve the way in which people' feedback was sought to make it more accessible.

This demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.

● People who lived at the home were observed to be relaxed and comfortable in the company of staff. It was clear that staff and the people who lived at the home had developed positive relationships.

● Staff told us they worked well together as a team to support people. The staff we spoke with knew people well.

●The relatives we spoke with were overall happy with the support people received and everyone said their loved one was happy at the home.

●The atmosphere at the home was warm and homely and the culture was open and transparent.

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

● The provider worked closely with a range of health and social care agencies to ensure people's equality needs were met.

● The service had good links with the local community and the provider worked in partnership with a local day centre to ensure people's social and activity needs were met.

● The provider organised regular events for people and their families to enjoy. For example, a Christmas disco, an Easter tea party and a Vaisakhi Celebration (a religious festival) took place in 2018. The quality improvement co-ordinator told us these events were well attended by people who lived at the home, their families and the local community.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the Mental Capacity Act 2005 was followed to obtain people's legal consent to specific decision made in relation to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were governance systems in place were ineffective in identifying and mitigating risks to people's health, safety and welfare. There were no adequate opportunities for people who lived at the home to express their views about the service they received.

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 fire safety arrangements in the home were inadequate. People's health conditions were not properly assessed or described. People's care plans had not always been updated consistently when people's needs changed to mitigate risks to their health and welfare.

The enforcement action we took:

A notice of decision was served on the provider which imposed conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient staff were on duty at all times to keep people safe and meet their needs.

The enforcement action we took:

A notice of decision was served on the provider which imposed conditions on their registration.